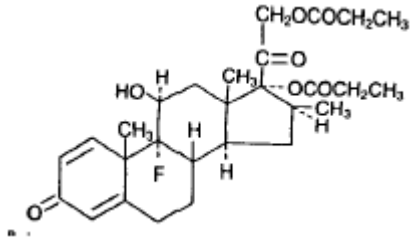


PRODUCT INFORMATION
DIPROSONE® OV (OPTIMISED VEHICLE) CREAM AND OINTMENT

NAME OF THE MEDICINE

DIPROSONE® OV Cream and Ointment
(Betamethasone dipropionate)



Chemistry Abstracts Service (CAS) registry number: [5593-20-4]

DESCRIPTION

Betamethasone dipropionate is a white or almost white, crystalline powder, practically insoluble in water, freely soluble in acetone and in methylene chloride, sparingly soluble in alcohol.

Chemically betamethasone dipropionate is a synthetic corticosteroid which has the chemical formula: 9 α -fluoro-11 β ,17,21-trihydroxy-16 β -methylpregna-1,4-diene-3,20-dione-17,21-dipropionate.

DIPROSONE OV Cream (0.05%): Each g contains 0.64 mg betamethasone dipropionate, equivalent to betamethasone 0.5 mg in an optimised vehicle consisting of propylene glycol, carbomer 980, titanium dioxide, sodium hydroxide and purified water.

DIPROSONE OV Ointment (0.05%): Each g contains 0.64 mg betamethasone dipropionate, equivalent to betamethasone 0.5 mg in an optimised vehicle consisting of propylene glycol, soft white paraffin, white beeswax and propylene glycol monostearate.

DIPROSONE OV Cream and Ointment do not contain preservatives, parabens or lanolin.

ACTIONS

Topical Corticosteroid: DIPROSONE OV is effective because of its anti-inflammatory, antipruritic and vasoconstrictive actions. The optimised vehicle with the propylene glycol component increases penetration and enhances the local effectiveness of the betamethasone dipropionate.

Pharmacology

Betamethasone dipropionate is a potent topically-active corticosteroid, producing prompt, marked and prolonged anti-inflammatory, antipruritic and vasoconstrictive effects.

According to the McKenzie-Stoughton Vasoconstrictor Test, betamethasone dipropionate was demonstrated to be significantly more active ($p < 0.05$) than betamethasone valerate, fluocinolone acetonide, fluocortolone caproate plus fluocortolone, and flumethasone pivalate. While the direct applicability of this vasoconstrictor test to clinical situations has not been demonstrated conclusively, the results showed betamethasone dipropionate to be active in a

concentration of 0.000016%, the lowest concentration tested which showed activity. To enhance the skin penetration of betamethasone dipropionate, various vehicles were evaluated based on the McKenzie Vasoconstrictor Test. Propylene glycol was determined to be an excellent solvent. The vasoconstrictor potency of the betamethasone dipropionate with propylene glycol (DIPROSONE OV) was demonstrated to be significantly greater than for DIPROSONE as measured by the McKenzie Test.

In controlled clinical trials, patients with moderate to severe chronic psoriasis who had at least a marked improvement in their symptoms (i.e., approximately $\geq 80\%$ improvement) following 3 to 4 weeks of treatment with DIPROSONE OV Ointment, were entered into a pulse dose regimen (three consecutive applications applied twelve hours apart once each week) for the maintenance of remission. Of these patients, 65% were kept in remission with this regimen of DIPROSONE OV Ointment for a period of 6 months and no significant HPA axis suppression or skin atrophy was observed. Effectiveness and safety of this regimen have been clinically determined for a period of 6 months use.

Pharmacokinetics

The extent of percutaneous absorption of topical corticosteroids is determined by many factors including vehicle, integrity of the epidermal barrier and the use of occlusive dressings. While topical corticosteroids can be absorbed from normal intact skin, dermal inflammation and/or other dermatologic disease processes may increase percutaneous absorption. Occlusive dressings also substantially increase percutaneous absorption.

After dermal absorption, topical corticosteroids enter pharmacokinetic pathways similar to those of systemically administered corticosteroids. In varying degrees, corticosteroids are bound to plasma proteins. They are metabolised primarily in the liver and excreted by the kidneys. Some topical corticosteroids and their metabolites undergo biliary excretion.

INDICATIONS

DIPROSONE OV Cream, Ointment and Lotion are indicated for the relief of the inflammatory and pruritic manifestations of resistant or severe corticosteroid-responsive dermatoses. These include atopic eczema, nummular eczema, contact dermatitis, neurodermatitis, anogenital and senile pruritus, lichen planus and psoriasis.

DIPROSONE OV Ointment is also indicated for the maintenance of remission in chronic psoriasis.

CONTRAINDICATIONS

Hypersensitivity to betamethasone dipropionate, other corticosteroids or any of the components in DIPROSONE OV. Like other topical corticosteroids, DIPROSONE OV is contraindicated in most viral infections of the skin, such as vaccinia, varicella and Herpes simplex, also tuberculosis and acne rosacea.

PRECAUTIONS

DIPROSONE OV should not be used in or near the eyes.

If irritation or sensitisation develops with the use of DIPROSONE OV, treatment should be discontinued and appropriate therapy instituted.

In the presence of an infection, an appropriate antifungal or antibacterial agent should be administered. If a favourable response does not occur promptly, DIPROSONE OV should be discontinued until the infection has been controlled adequately.

Corticosteroids are known to be absorbed percutaneously, therefore in patients under prolonged and extensive topical treatment, the possibility of systemic effects should be kept in mind.

DIPROSONE OV Cream has been shown to suppress the hypothalamic-pituitary adrenal (HPA) axis with repeated application of 7 g/day. In patients with psoriasis, application of 14 g per day of DIPROSONE OV Cream for eight days produced a depression of adrenocortical hormonal levels in plasma. Shortly after treatment cessation, adrenal output returned to normal.

At 14 g per day for nine days, DIPROSONE OV Ointment was shown to depress the plasma cortisol levels following repeated applications to diseased skin in patients with psoriasis. These effects were reversible upon discontinuation of treatment.

At 7g per day (applied as 3.5 g twice daily), DIPROSONE OV Ointment was shown to cause minimal inhibition of the hypothalamic-pituitary-adrenal (HPA) axis when applied for two to three weeks in normal patients and in patients with psoriasis and eczematous disorders. With 6 to 7 g of DIPROSONE OV Ointment applied once daily for three weeks, no significant inhibition of the HPA axis was observed in patients with psoriasis and atopic dermatitis, as measured by plasma cortisol and 24-hour urinary 17-hydroxy-corticosteroid levels.

Systemic absorption of topical corticosteroids will be increased if extensive body surface areas are treated. Suitable precautions should be taken under these conditions or when long-term use is anticipated, particularly in infants and children as adrenal suppression may occur. Therefore, patients applying large doses of potent topical corticosteroids over large body surface areas should be evaluated periodically for evidence of HPA axis suppression. If HPA axis suppression occurs, an attempt should be made to withdraw the drug, to reduce the frequency of application, or to substitute with a less potent corticosteroid agent.

Recovery of HPA axis function is generally prompt and complete upon discontinuation of the drug. Infrequently, signs and symptoms of corticosteroid withdrawal may occur, requiring supplemental systemic corticosteroid therapy.

Any of the side effects that are reported following systemic use of corticosteroids, including adrenal suppression, may also occur with topical corticosteroids, especially in infants and children.

DIPROSONE OV is not intended for use under occlusive dressings since this will also increase systemic absorption of the corticosteroid. In infants the napkin may act as an occlusive dressing and increase absorption.

Patients should not use more than 45 g DIPROSONE OV weekly.

Suitable precautions should be taken when using topical corticosteroids in patients with stasis dermatitis and other skin diseases with impaired circulation.

Unless specifically indicated, application to the face is undesirable, as is prolonged use on flexures and intertriginous areas.

Prolonged use of topical corticosteroid preparations may produce striae or atrophy of the skin or subcutaneous tissue. If this occurs, treatment should be discontinued.

As with all highly active topical corticosteroid preparations, treatment should be discontinued when the dermatologic disorder is controlled. According to clinical response, duration of therapy may vary from a few days to a longer period of time. However, treatment should not be continued for more than four weeks without patient re-evaluation.

DIPROSONE OV Ointment: Patients who are to use the pulse dosing regimen to maintain remission in chronic psoriasis should be instructed specifically as to where the medication should be applied.

Any of the side effects that are reported following systemic use of corticosteroids, including adrenal suppression, may also occur with topical corticosteroids, especially in infants and children.

Use in Pregnancy (Category A)

Topical corticosteroids should not be used extensively on pregnant patients in large amounts or for prolonged periods of time.

Use in Lactation

Since it is not known whether the components of DIPROSONE OV are excreted in the milk of nursing mothers, caution should be exercised when DIPROSONE OV is administered to nursing women.

Paediatric use

DIPROSONE OV is not recommended for use in children under 12 years of age.

Chronic corticosteroid therapy may interfere with the growth and development of children.

Paediatric patients may demonstrate greater susceptibility to topical corticosteroid-induced HPA axis suppression and to exogenous corticosteroid effects than mature patients because of greater absorption due to a larger skin surface area to body weight ratio.

HPA axis suppression, Cushing's syndrome, linear growth retardation, delayed weight gain, and intracranial hypertension have been reported in children receiving topical corticosteroids. Manifestations of adrenal suppression in children include low plasma cortisol levels and absence of response to ACTH stimulation. Manifestations of intracranial hypertension include a bulging fontanelle, headaches and bilateral papilloedema.

ADVERSE EFFECTS

The most frequent side effects reported with DIPROSONE OV are mild to moderate transient burning/stinging, dry skin, pruritus, irritation and folliculitis.

Rarely reported adverse effects include tingling, prickly skin, tightening or cracking of skin, warm feeling, laminar scaling and perilesional scaling, follicular rash, skin atrophy, erythema, urticaria, vesiculation and telangiectasia.

Adverse reactions reported with the use of the DIPROSONE OV Ointment pulse dose regimen were mild intermittent hypertension (one case) and paraesthesia (two cases).

Other local adverse reactions that have been reported with the use of topical corticosteroids include: itching, hypertrichosis, acneiform eruptions, hypopigmentation, perioral dermatitis, allergic contact dermatitis, maceration of the skin, secondary infection, striae and miliaria.

DOSAGE AND ADMINISTRATION

DIPROSONE OV Cream and Ointment: Apply a thin film once or twice daily to cover completely the affected area once or twice daily.

Patients with chronic psoriasis who have achieved at least a marked improvement in their psoriatic lesion(s) (i.e., approximately $\geq 80\%$ improvement) with DIPROSONE OV Ointment may be maintained in remission with a pulse dosing regimen consisting of three consecutive applications of up to 3.5 g each of DIPROSONE OV Ointment, twelve hours apart (e.g., morning, evening, following morning) to the previously affected areas once each week. For this purpose, the DIPROSONE OV Ointment should be applied to the lesion sites previously affected and treated.

Patients on this pulse dose regimen who relapse should be reverted back to the conventional dosing regimen.

OVERDOSAGE

Symptoms: Excessive prolonged use of topical corticosteroids can suppress pituitary-adrenal function resulting in secondary adrenal insufficiency and produce manifestations of hypercorticism, including Cushing's disease.

Treatment: Appropriate symptomatic treatment is indicated. Acute hypercorticotoid symptoms are virtually reversible. Treat electrolyte imbalance, if necessary. In cases of chronic toxicity, slow withdrawal of corticosteroids is advised.

PRESENTATION AND STORAGE CONDITIONS

DIPROSONE® OV 0.5mg/g Cream (AUST R 18825) and Ointment (AUST R 18823): 5g* and 30 g. tube

Cream and Ointment: Store below 25°C.

** Not available in Australia*

POISONS SCHEDULES OF THE MEDICINE

S4

SPONSOR NAME AND ADDRESS

Merck Sharp & Dohme (Australia) Pty Limited
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Macquarie Park, NSW 2113
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DATE OF FIRST INCLUSION IN THE AUSTRALIAN REGISTER OF THERAPEUTIC GOODS

Diprosone OV Cream AUST R 18825: 8 October 1991

Diprosone OV ointment AUST R 18823: 8 October 1991

DATE OF MOST RECENT AMENDMENT: 29 July 2014