

To be sold by retail on the prescription of a Specialist only

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**ROVOR**

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**1. Generic Name:**

Rivaroxaban Tablets

**2. Qualitative and quantitative composition:**

ROVOR 10

Each film coated tablet contains:

Rivaroxaban ..... 10 mg

Excipients.....q.s.

Colours: Red oxide of Iron and Titanium Dioxide I.P.

The other ingredients are:.

Microcrystalline cellulose, Lactose monohydrate, Croscarmellose sodium, Sodium Lauryl Sulphate, Hydroxypropylmethylcellulose, Talc, Magnesium Stearate , Instacoat Universal A05R04590 (Hypromellose, PEG 400, PEG 6000, Titanium Dioxide, Red Oxide of Iron)

ROVOR 15

Each film coated tablet contains:

Rivaroxaban ..... 15 mg

Excipients.....q.s.

Colours: Red oxide of Iron and Titanium Dioxide I.P.

The other ingredients are:.

Microcrystalline cellulose, Lactose monohydrate, Croscarmellose sodium, Sodium Lauryl Sulphate, Hydroxypropylmethylcellulose, Talc, Magnesium Stearate, Instacoat Universal A05R04589 (Hypromellose, PEG 400, PEG 6000, Titanium Dioxide, Red Oxide of Iron)

ROVOR 20

Each film coated tablet contains:

Rivaroxaban ..... 20 mg

Excipients.....q.s.

Colours: Red oxide of Iron and Titanium Dioxide I.P.

The other ingredients are:.

Microcrystalline cellulose, Lactose monohydrate, Croscarmellose sodium, Sodium Lauryl Sulphate, Hydroxypropylmethylcellulose, Talc, Magnesium Stearate, Instacoat Aqua II A02R00356 (Polyvinyl alcohol, PEG 6000, Talc, Titanium Dioxide, Red Oxide of Iron)

### 3. Dosage form and strength:

**Dosage form:** Film coated tablet

**Strength:** Rivaroxaban 10/15/20 mg

### 4. Clinical particulars:

#### 4.1 Therapeutic indication:

##### 10mg

- For the prevention of venous thromboembolism in patients (VTE) in adult patients undergoing hip or knee replacement surgery.

##### 15mg, 20mg

- Treatment of deep vein thrombosis and for prevention of recurrent DVT and pulmonary embolism.
- For the prevention of stroke and systemic embolism in patient with non-valvular atrial fibrillation.

#### 4.2 Posology and method of administration:

##### Posology

##### Prevention of stroke and systemic embolism

The recommended dose is 20 mg once daily, which is also the recommended maximum dose.

Therapy with Rivaroxaban should be continued long term provided the benefit of prevention of stroke and systemic embolism outweighs the risk of bleeding.

If a dose is missed, the patient should take Rivaroxaban immediately and continue on the following day with the once daily intake as recommended. The dose should not be doubled within the same day to make up for a missed dose.

##### Treatment of DVT, treatment of PE and prevention of recurrent DVT and PE

The recommended dose for the initial treatment of acute DVT or PE is 15 mg twice daily for the first three weeks followed by 20 mg once daily for the continued treatment and prevention of recurrent DVT and PE.

Short duration of therapy (at least 3 months) should be considered in patients with DVT or PE provoked by major transient risk factors (i.e. recent major surgery or trauma). Longer duration of therapy should be considered in patients with provoked DVT or PE not related to major transient risk factors, unprovoked DVT or PE, or a history of recurrent DVT or PE.

When extended prevention of recurrent DVT and PE is indicated (following completion of at least 6 months therapy for DVT or PE), the recommended dose is 10 mg once daily. In patients in whom the risk of recurrent DVT or PE is considered high, such as those with complicated comorbidities, or who have developed recurrent DVT or PE on extended prevention with Rivaroxaban 10 mg once daily, a dose of Rivaroxaban 20 mg once daily should be considered.

The duration of therapy and dose selection should be individualised after careful assessment of the treatment benefit against the risk for bleeding.

	<b>Time period</b>	<b>Dosing schedule</b>	<b>Total daily dose</b>
Treatment and prevention of recurrent DVT and PE	Day 1 – 21	15 mg twice daily	30 mg
	Day 22 onwards	20 mg once daily	20 mg
Prevention of recurrent DVT and PE	Following completion of at least 6 months therapy for DVT or PE	10 mg once daily or 20 mg once daily	10 mg or 20 mg

To support the dose switch from 15 mg to 20 mg after Day 21 a first 4 weeks treatment initiation pack of Rivaroxaban for treatment of DVT/PE is available.

If a dose is missed during the 15 mg twice daily treatment phase (day 1 - 21), the patient should take Rivaroxaban immediately to ensure intake of 30 mg Rivaroxaban per day. In this case two 15 mg tablets may be taken at once. The patient should continue with the regular 15 mg twice daily intake as recommended on the following day.

If a dose is missed during the once daily treatment phase, the patient should take Rivaroxaban immediately, and continue on the following day with the once daily intake as recommended. The dose should not be doubled within the same day to make up for a missed dose.

#### Converting from Vitamin K Antagonists (VKA) to Rivaroxaban

For patients treated for prevention of stroke and systemic embolism, VKA treatment should be stopped and Rivaroxaban therapy should be initiated when the International Normalised Ratio (INR) is  $\leq 3.0$ .

For patients treated for DVT, PE and prevention of recurrence, VKA treatment should be stopped and Rivaroxaban therapy should be initiated once the INR is  $\leq 2.5$ .

When converting patients from VKAs to Rivaroxaban, INR values will be falsely elevated after the intake of Rivaroxaban. The INR is not valid to measure the anticoagulant activity of Rivaroxaban, and therefore should not be used.

#### Converting from Rivaroxaban to Vitamin K antagonists (VKA)

There is a potential for inadequate anticoagulation during the transition from Rivaroxaban to VKA. Continuous adequate anticoagulation should be ensured during any transition to an alternate anticoagulant. It should be noted that Rivaroxaban can contribute to an elevated INR.

In patients converting from Rivaroxaban to VKA, VKA should be given concurrently until the INR is  $\geq 2.0$ . For the first two days of the conversion period, standard initial dosing of VKA should be used followed by VKA dosing, as guided by INR testing. While patients are on both Rivaroxaban and VKA the INR should not be tested earlier than 24 hours after the previous dose but prior to the next dose of Rivaroxaban. Once Rivaroxaban is discontinued INR testing may be done reliably at least 24 hours after the last dose.

#### Converting from parenteral anticoagulants to Rivaroxaban

For patients currently receiving a parenteral anticoagulant, discontinue the parenteral anticoagulant and start Rivaroxaban 0 to 2 hours before the time that the next scheduled administration of the parenteral medicinal product (e.g. low molecular weight heparins) would be due or at the time of discontinuation of a continuously administered parenteral medicinal product (e.g. intravenous unfractionated heparin).

### Converting from Rivaroxaban to parenteral anticoagulants

Give the first dose of parenteral anticoagulant at the time the next Rivaroxaban dose would be taken.

### **Special populations**

#### Renal impairment

Limited clinical data for patients with severe renal impairment (creatinine clearance 15 - 29 ml/min) indicate that rivaroxaban plasma concentrations are significantly increased. Therefore, Rivaroxaban is to be used with caution in these patients. Use is not recommended in patients with creatinine clearance < 15 ml/min.

In patients with moderate (creatinine clearance 30 - 49 ml/min) or severe (creatinine clearance 15 - 29 ml/min) renal impairment the following dose recommendations apply:

- For the prevention of stroke and systemic embolism in patients with non-valvular atrial fibrillation, the recommended dose is 15 mg once daily.
- For the treatment of DVT, treatment of PE and prevention of recurrent DVT and PE: patients should be treated with 15 mg twice daily for the first 3 weeks. Thereafter, when the recommended dose is 20 mg once daily, a reduction of the dose from 20 mg once daily to 15 mg once daily should be considered if the patient's assessed risk for bleeding outweighs the risk for recurrent DVT and PE. The recommendation for the use of 15 mg is based on PK modelling and has not been studied in this clinical setting.

When the recommended dose is 10 mg once daily, no dose adjustment from the recommended dose is necessary.

No dose adjustment is necessary in patients with mild renal impairment (creatinine clearance 50 - 80 ml/min).

#### Hepatic impairment

Rivaroxaban is contraindicated in patients with hepatic disease associated with coagulopathy and clinically relevant bleeding risk including cirrhotic patients with Child Pugh B and C.

#### Elderly population

No dose adjustment

#### Body weight

No dose adjustment

#### Gender

No dose adjustment

#### Paediatric population

The safety and efficacy of Rivaroxaban in children aged 0 to 18 years have not been established. No data are available. Therefore, Rivaroxaban is not recommended for use in children below 18 years of age.

#### Patients undergoing cardioversion

Rivaroxaban can be initiated or continued in patients who may require cardioversion.

For transesophageal echocardiogram (TEE) guided cardioversion in patients not previously treated with anticoagulants, Rivaroxaban treatment should be started at least 4 hours before

cardioversion to ensure adequate anticoagulation. For all patients, confirmation should be sought prior to cardioversion that the patient has taken Rivaroxaban as prescribed. Decisions on initiation and duration of treatment should take established guideline recommendations for anticoagulant treatment in patients undergoing cardioversion into account.

*Patients with non-valvular atrial fibrillation who undergo PCI (percutaneous coronary intervention) with stent placement*

There is limited experience of a reduced dose of 15 mg Rivaroxaban once daily (or 10 mg Rivaroxaban once daily for patients with moderate renal impairment [creatinine clearance 30 - 49 ml/min]) in addition to a P2Y12 inhibitor for a maximum of 12 months in patients with non-valvular atrial fibrillation who require oral anticoagulation and undergo PCI with stent placement.

**Method of administration**

Rivaroxaban is for oral use.

The tablets are to be taken with food.

For patients who are unable to swallow whole tablets, Rivaroxaban tablet may be crushed and mixed with water or apple puree immediately prior to use and administered orally. After the administration of crushed Rivaroxaban 15 mg or 20 mg film-coated tablets, the dose should be immediately followed by food.

The crushed Rivaroxaban tablet may also be given through gastric tubes after confirmation of the correct gastric placement of the tube. The crushed tablet should be administered in a small amount of water via a gastric tube after which it should be flushed with water. After the administration of crushed Rivaroxaban 15 mg or 20 mg film-coated tablets, the dose should then be immediately followed by enteral feeding.

**4.3 Contraindications:**

- Hypersensitivity to the active substance or to any of the excipients.
- Active clinically significant bleeding.
- Lesion or condition, if considered to be a significant risk for major bleeding. This may include current or recent gastrointestinal ulceration, presence of malignant neoplasms at high risk of bleeding, recent brain or spinal injury, recent brain, spinal or ophthalmic surgery, recent intracranial haemorrhage, known or suspected oesophageal varices, arteriovenous malformations, vascular aneurysms or major intraspinal or intracerebral vascular abnormalities.
- Concomitant treatment with any other anticoagulants, e.g. unfractionated heparin (UFH), low molecular weight heparins (enoxaparin, dalteparin, etc.), heparin derivatives (fondaparinux, etc.), oral anticoagulants (warfarin, dabigatran etexilate, apixaban, etc.) except under specific circumstances of switching anticoagulant therapy or when UFH is given at doses necessary to maintain an open central venous or arterial catheter.
- Hepatic disease associated with coagulopathy and clinically relevant bleeding risk including cirrhotic patients with Child Pugh B and C.
- Pregnancy and breast-feeding.

**4.4 Special warnings and precautions for use:**

Clinical surveillance in line with anticoagulation practice is recommended throughout the treatment period.

### Haemorrhagic risk

As with other anticoagulants, patients taking are to be carefully observed for signs of bleeding. It is recommended to be used with caution in conditions with increased risk of haemorrhage. Rivaroxaban administration should be discontinued if severe haemorrhage occurs.

Based on the clinical studies, mucosal bleedings (i.e. epistaxis, gingival, gastrointestinal, genito urinary including abnormal vaginal or increased menstrual bleeding) and anaemia were seen more frequently during long term treatment compared with VKA treatment. Thus, in addition to adequate clinical surveillance, laboratory testing of haemoglobin/haematocrit could be of value to detect occult bleeding and quantify the clinical relevance of overt bleeding, as judged to be appropriate.

Several sub-groups of patients, as detailed below, are at increased risk of bleeding. These patients are to be carefully monitored for signs and symptoms of bleeding complications and anaemia after initiation of treatment.

Any unexplained fall in haemoglobin or blood pressure should lead to a search for a bleeding site.

Although treatment with does not require routine monitoring of exposure, levels measured with a calibrated quantitative anti-factor Xa assay may be useful in exceptional situations where knowledge of exposure may help to inform clinical decisions, e.g. overdose and emergency surgery.

### Renal impairment

In patients with severe renal impairment (creatinine clearance < 30 ml/min) plasma levels may be significantly increased (1.6 fold on average) which may lead to an increased bleeding risk. Rivaroxaban is to be used with caution in patients with creatinine clearance 15 - 29 ml/min. Use is not recommended in patients with creatinine clearance < 15 ml/min.

Should be used with caution in patients with renal impairment concomitantly receiving other medicinal products which increase plasma concentrations.

### Interaction with other medicinal products

The use of Rivaroxaban is not recommended in patients receiving concomitant systemic treatment with azole-antimycotics (such as ketoconazole, itraconazole, voriconazole and posaconazole) or HIV protease inhibitors (e.g. ritonavir). These active substances are strong inhibitors of both CYP3A4 and P-gp and therefore may increase Rivaroxaban plasma concentrations to a clinically relevant degree (2.6 fold on average) which may lead to an increased bleeding risk.

Care is to be taken if patients are treated concomitantly with medicinal products affecting haemostasis such as non-steroidal anti-inflammatory medicinal products (NSAIDs), acetylsalicylic acid and platelet aggregation inhibitors or selective serotonin reuptake inhibitors (SSRIs), and serotonin norepinephrine reuptake inhibitors (SNRIs). For patients at risk of ulcerative gastrointestinal disease an appropriate prophylactic treatment may be considered.

### Other haemorrhagic risk factors

As with other antithrombotics, Rivaroxaban is not recommended in patients with an increased bleeding risk such as:

- Congenital or acquired bleeding disorders
- Uncontrolled severe arterial hypertension

- Other gastrointestinal disease without active ulceration that can potentially lead to bleeding complications (e.g. inflammatory bowel disease, oesophagitis, gastritis and gastroesophageal reflux disease)
- Vascular retinopathy
- Bronchiectasis or history of pulmonary bleeding

#### Patients with prosthetic valves

Rivaroxaban should not be used for thromboprophylaxis in patients having recently undergone transcatheter aortic valve replacement (TAVR). Safety and efficacy of Rivaroxaban have not been studied in patients with prosthetic heart valves; therefore, there are no data to support that Rivaroxaban provides adequate anticoagulation in this patient population. Treatment with Rivaroxaban is not recommended for these patients.

#### Patients with antiphospholipid syndrome

Direct acting Oral Anticoagulants (DOACs) including Rivaroxaban are not recommended for patients with a history of thrombosis who are diagnosed with antiphospholipid syndrome. In particular for patients that are triple positive (for lupus anticoagulant, anticardiolipin antibodies, and anti-beta 2-glycoprotein I antibodies), treatment with DOACs could be associated with increased rates of recurrent thrombotic events compared with vitamin K antagonist therapy.

#### Patients with non-valvular atrial fibrillation who undergo PCI with stent placement

Based on a clinical data available from a reported interventional study with the primary objective to assess safety in patients with non-valvular atrial fibrillation who undergo PCI with stent placement. Data on efficacy in this population are limited. No data are available for such patients with a history of stroke/TIA.

#### Haemodynamically unstable PE patients or patients who require thrombolysis or pulmonary embolectomy

Rivaroxaban is not recommended as an alternative to unfractionated heparin in patients with pulmonary embolism who are haemodynamically unstable or may receive thrombolysis or pulmonary embolectomy since the safety and efficacy of Rivaroxaban have not been established in these clinical situations.

#### Spinal/epidural anaesthesia or puncture

When neuraxial anaesthesia (spinal/epidural anaesthesia) or spinal/epidural puncture is employed, patients treated with antithrombotic agents for prevention of thromboembolic complications are at risk of developing an epidural or spinal haematoma which can result in long-term or permanent paralysis. The risk of these events may be increased by the post-operative use of indwelling epidural catheters or the concomitant use of medicinal products affecting haemostasis. The risk may also be increased by traumatic or repeated epidural or spinal puncture. Patients are to be frequently monitored for signs and symptoms of neurological impairment (e.g. numbness or weakness of the legs, bowel or bladder dysfunction). If neurological compromise is noted, urgent diagnosis and treatment is necessary. Prior to neuraxial intervention the physician should consider the potential benefit versus the risk in anticoagulated patients or in patients to be anticoagulated for thromboprophylaxis. There is no clinical experience with the use of 20 mg Rivaroxaban in these situations.

To reduce the potential risk of bleeding associated with the concurrent use of Rivaroxaban and neuraxial (epidural/spinal) anaesthesia or spinal puncture, consider the pharmacokinetic profile of Rivaroxaban. Placement or removal of an epidural catheter or lumbar puncture is best

performed when the anticoagulant effect of Rivaroxaban is estimated to be low. However, the exact timing to reach a sufficiently low anticoagulant effect in each patient is not known.

For the removal of an epidural catheter and based on the general PK characteristics at least 2x half-life, i.e. at least 18 hours in young patients and 26 hours in elderly patients should elapse after the last administration of . Following removal of the catheter, at least 6 hours should elapse before the next Rivaroxaban dose is administered.

If traumatic puncture occurs the administration of Rivaroxaban is to be delayed for 24 hours.

#### Dosing recommendations before and after invasive procedures and surgical intervention

If an invasive procedure or surgical intervention is required, Rivaroxaban should be stopped at least 24 hours before the intervention, if possible and based on the clinical judgement of the physician.

If the procedure cannot be delayed the increased risk of bleeding should be assessed against the urgency of the intervention.

Rivaroxaban should be restarted as soon as possible after the invasive procedure or surgical intervention provided the clinical situation allows and adequate haemostasis has been established as determined by the treating physician.

#### Elderly population

Increasing age may increase haemorrhagic risk.

#### Dermatological reactions

Serious skin reactions, including Stevens-Johnson syndrome/toxic epidermal necrolysis and DRESS syndrome, have been reported during post-marketing surveillance in association with the use of Rivaroxaban. Patients appear to be at highest risk for these reactions early in the course of therapy: the onset of the reaction occurring in the majority of cases within the first weeks of treatment. Rivaroxaban should be discontinued at the first appearance of a severe skin rash (e.g. spreading, intense and/or blistering), or any other sign of hypersensitivity in conjunction with mucosal lesions.

#### Information about excipients

Rivaroxaban contains lactose. Patients with rare hereditary problems of galactose intolerance, total lactase deficiency or glucose-galactose malabsorption should not take this medicinal product.

### **4.5 Drug-Interaction:**

#### CYP3A4 and P-gp inhibitors

Co-administration of rivaroxaban with ketoconazole (400 mg once a day) or ritonavir (600 mg twice a day) led to a 2.6 fold / 2.5 fold increase in mean rivaroxaban AUC and a 1.7 fold / 1.6 fold increase in mean rivaroxaban  $C_{max}$ , with significant increases in pharmacodynamic effects which may lead to an increased bleeding risk. Therefore, the use of Rivaroxaban is not recommended in patients receiving concomitant systemic treatment with azole-antimycotics such as ketoconazole, itraconazole, voriconazole and posaconazole or HIV protease inhibitors. These active substances are strong inhibitors of both CYP3A4 and P-gp.

Active substances strongly inhibiting only one of the rivaroxaban elimination pathways, either CYP3A4 or P-gp, are expected to increase rivaroxaban plasma concentrations to a lesser extent. Clarithromycin (500 mg twice a day), for instance, considered as a strong CYP3A4 inhibitor and moderate P-gp inhibitor, led to a 1.5 fold increase in mean rivaroxaban AUC and a 1.4 fold

increase in  $C_{max}$ . The interaction with clarithromycin is likely not clinically relevant in most patients but can be potentially significant in high-risk patients.

Erythromycin (500 mg three times a day), which inhibits CYP3A4 and P-gp moderately, led to a 1.3 fold increase in mean rivaroxaban AUC and  $C_{max}$ . The interaction with erythromycin is likely not clinically relevant in most patients but can be potentially significant in high-risk patients.

In subjects with mild renal impairment erythromycin (500 mg three times a day) led to a 1.8 fold increase in mean rivaroxaban AUC and 1.6 fold increase in  $C_{max}$  when compared to subjects with normal renal function. In subjects with moderate renal impairment, erythromycin led to a 2.0 fold increase in mean rivaroxaban AUC and 1.6 fold increase in  $C_{max}$  when compared to subjects with normal renal function. The effect of erythromycin is additive to that of renal impairment.

Fluconazole (400 mg once daily), considered as a moderate CYP3A4 inhibitor, led to a 1.4 fold increase in mean rivaroxaban AUC and a 1.3 fold increase in mean  $C_{max}$ . The interaction with fluconazole is likely not clinically relevant in most patients but can be potentially significant in high-risk patients.

Given the limited clinical data available with dronedarone, co-administration with rivaroxaban should be avoided.

#### Anticoagulants

After combined administration of enoxaparin (40 mg single dose) with rivaroxaban (10 mg single dose) an additive effect on anti-factor Xa activity was observed without any additional effects on clotting tests (PT, aPTT). Enoxaparin did not affect the pharmacokinetics of rivaroxaban.

Due to the increased bleeding risk care is to be taken if patients are treated concomitantly with any other anticoagulants.

#### NSAIDs/platelet aggregation inhibitors

No clinically relevant prolongation of bleeding time was observed after concomitant administration of rivaroxaban (15 mg) and 500 mg naproxen. Nevertheless, there may be individuals with a more pronounced pharmacodynamic response.

No clinically significant pharmacokinetic or pharmacodynamic interactions were observed when rivaroxaban was co-administered with 500 mg acetylsalicylic acid.

Clopidogrel (300 mg loading dose followed by 75 mg maintenance dose) did not show a pharmacokinetic interaction with rivaroxaban (15 mg) but a relevant increase in bleeding time was observed in a subset of patients which was not correlated to platelet aggregation, P-selectin or GPIIb/IIIa receptor levels.

Care is to be taken if patients are treated concomitantly with NSAIDs (including acetylsalicylic acid) and platelet aggregation inhibitors because these medicinal products typically increase the bleeding risk.

#### SSRIs/SNRIs

As with other anticoagulants the possibility may exist that patients are at increased risk of bleeding in case of concomitant use with SSRIs or SNRIs due to their reported effect on platelets. When concomitantly used in the rivaroxaban clinical programme, numerically higher rates of major or non-major clinically relevant bleeding were observed in all treatment groups.

### Warfarin

Converting patients from the vitamin K antagonist warfarin (INR 2.0 to 3.0) to rivaroxaban (20 mg) or from rivaroxaban (20 mg) to warfarin (INR 2.0 to 3.0) increased prothrombin time/INR (Neoplastin) more than additively (individual INR values up to 12 may be observed), whereas effects on aPTT, inhibition of factor Xa activity and endogenous thrombin potential were additive.

If it is desired to test the pharmacodynamic effects of rivaroxaban during the conversion period, anti-factor Xa activity, PiCT, and Heptest can be used as these tests were not affected by warfarin. On the fourth day after the last dose of warfarin, all tests (including PT, aPTT, inhibition of factor Xa activity and ETP) reflected only the effect of rivaroxaban.

If it is desired to test the pharmacodynamic effects of warfarin during the conversion period, INR measurement can be used at the  $C_{\text{trough}}$  of rivaroxaban (24 hours after the previous intake of rivaroxaban) as this test is minimally affected by rivaroxaban at this time point.

No pharmacokinetic interaction was observed between warfarin and rivaroxaban.

### CYP3A4 inducers

Co-administration of rivaroxaban with the strong CYP3A4 inducer rifampicin led to an approximate 50% decrease in mean rivaroxaban AUC, with parallel decreases in its pharmacodynamic effects. The concomitant use of rivaroxaban with other strong CYP3A4 inducers (e.g. phenytoin, carbamazepine, phenobarbital or St. John's Wort (*Hypericum perforatum*)) may also lead to reduced rivaroxaban plasma concentrations. Therefore, concomitant administration of strong CYP3A4 inducers should be avoided unless the patient is closely observed for signs and symptoms of thrombosis.

### Other concomitant therapies

No clinically significant pharmacokinetic or pharmacodynamic interactions were observed when rivaroxaban was co-administered with midazolam (substrate of CYP3A4), digoxin (substrate of P-gp), atorvastatin (substrate of CYP3A4 and P-gp) or omeprazole (proton pump inhibitor). Rivaroxaban neither inhibits nor induces any major CYP isoforms like CYP3A4.

### Laboratory parameters

Clotting parameters (e.g. PT, aPTT, HepTest) are affected as expected by the mode of action of rivaroxaban.

## **4.6 Use in special populations**

### Pregnancy

Safety and efficacy of rivaroxaban have not been established in pregnant women. Studies in animals have shown reproductive toxicity. Due to the potential reproductive toxicity, the intrinsic risk of bleeding and the evidence that rivaroxaban passes the placenta, rivaroxaban is contraindicated during pregnancy.

Women of child-bearing potential should avoid becoming pregnant during treatment with rivaroxaban.

### Breast-feeding

Safety and efficacy of rivaroxaban have not been established in breast-feeding women. Data from animals indicate that rivaroxaban is secreted into milk. Therefore rivaroxaban is contraindicated during breast-feeding. A decision must be made whether to discontinue breast-feeding or to discontinue/abstain from therapy.

### Fertility

No specific studies with rivaroxaban in humans have been conducted to evaluate effects on fertility. In a study on male and female fertility in rats no effects were seen.

#### **4.7 Effects on ability to drive and use machines:**

Rivaroxaban has minor influence on the ability to drive and use machines. Adverse reactions like syncope (frequency: uncommon) and dizziness (frequency: common) have been reported. Patients experiencing these adverse reactions should not drive or use machines.

#### **4.8 Undesirable effects:**

##### Summary of the safety profile

The safety of rivaroxaban has been evaluated in thirteen phase III studies including 53,103 patients exposed to rivaroxaban.

##### **Number of patients studied, total daily dose and maximum treatment duration in phase III studies**

<b>Indication</b>	<b>Number of patients*</b>	<b>Total daily dose</b>	<b>Maximum treatment duration</b>
Prevention of venous thromboembolism (VTE) in adult patients undergoing elective hip or knee replacement surgery	6,097	10 mg	39 days
Prevention of VTE in medically ill patients	3,997	10 mg	39 days
Treatment of DVT, PE and prevention of recurrence	6,790	Day 1 - 21: 30 mg Day 22 and onwards: 20 mg After at least 6 months: 10 mg or 20 mg	21 months
Prevention of stroke and systemic embolism in patients with non-valvular atrial fibrillation	7,750	20 mg	41 months
Prevention of atherothrombotic events in patients after an acute coronary syndrome (ACS)	10,225	5 mg or 10 mg respectively, co-administered with either ASA or ASA plus clopidogrel or ticlopidine	31 months

Prevention of atherothrombotic events in patients with CAD/PAD	18,244	5 mg co-administered with ASA or 10 mg alone	47 months
* Patients exposed to at least one dose of rivaroxaban			

The most commonly reported adverse reactions in patients receiving rivaroxaban were bleedings. The most commonly reported bleedings were epistaxis (4.5%) and gastrointestinal tract haemorrhage (3.8%).

**Bleeding\* and anaemia events rates in patients exposed to rivaroxaban across the completed phase III studies**

Indication	Any bleeding	Anaemia
Prevention of VTE in adult patients undergoing elective hip or knee replacement surgery	6.8% of patients	5.9% of patients
Prevention of VTE in medically ill patients	12.6% of patients	2.1% of patients
Treatment of DVT, PE and prevention of recurrence	23% of patients	1.6% of patients
Prevention of stroke and systemic embolism in patients with non-valvular atrial fibrillation	28 per 100 patient years	2.5 per 100 patient years
Prevention of atherothrombotic events in patients after an ACS	22 per 100 patient years	1.4 per 100 patient years
Prevention of atherothrombotic events in patients with CAD/PAD	6.7 per 100 patient years	0.15 per 100 patient years**
* For all rivaroxaban studies all bleeding events are collected, reported and adjudicated. ** In the reported COMPASS study, there is a low anaemia incidence as a selective approach to adverse event collection was applied		

Tabulated list of adverse reactions

The frequencies of adverse reactions reported with rivaroxaban are summarised in below by system organ class (in MedDRA) and by frequency.

Frequencies are defined as:

- very common ( $\geq 1/10$ )
- common ( $\geq 1/100$  to  $< 1/10$ )
- uncommon ( $\geq 1/1,000$  to  $< 1/100$ )
- rare ( $\geq 1/10,000$  to  $< 1/1,000$ )
- very rare ( $< 1/10,000$ )

- not known (cannot be estimated from the available data)

**All adverse reactions reported in patients in phase III clinical trials or through post-marketing use\***

<b>Common</b>	<b>Uncommon</b>	<b>Rare</b>	<b>Very rare</b>	<b>Not known</b>
<b>Blood and lymphatic system disorders</b>				
Anaemia (incl. respective laboratory parameters)	Thrombocytosis (incl. platelet count increased) <sup>A</sup> , Thrombocytopenia			
<b>Immune system disorders</b>				
	Allergic reaction, dermatitis allergic, Angioedema and allergic oedema		Anaphylactic reactions including anaphylactic shock	
<b>Nervous system disorders</b>				
Dizziness, headache	Cerebral and intracranial haemorrhage, syncope			
<b>Eye disorders</b>				
Eye haemorrhage (incl. conjunctival haemorrhage)				
<b>Cardiac disorders</b>				
	Tachycardia			
<b>Vascular disorders</b>				
Hypotension, haematoma				
<b>Respiratory, thoracic and mediastinal disorders</b>				
Epistaxis, haemoptysis				

<b>Gastrointestinal disorders</b>				
Gingival bleeding, gastrointestinal tract haemorrhage (incl. rectal haemorrhage), gastrointestinal and abdominal pains, dyspepsia, nausea, constipation <sup>A</sup> , diarrhoea, vomiting <sup>A</sup>	Dry mouth			
<b>Hepatobiliary disorders</b>				
Increase in transaminases	Hepatic impairment, Increased bilirubin, increased blood alkaline phosphatase <sup>A</sup> , increased GGT <sup>A</sup>	Jaundice, Bilirubin conjugated increased (with or without concomitant increase of ALT), Cholestasis, Hepatitis (incl. hepatocellular injury)		
<b>Skin and subcutaneous tissue disorders</b>				
Pruritus (incl. uncommon cases of generalised pruritus), rash, ecchymosis, cutaneous and subcutaneous haemorrhage	Urticaria		Stevens-Johnson syndrome/ Toxic Epidermal Necrolysis , DRESS syndrome	
<b>Musculoskeletal and connective tissue disorders</b>				
Pain in extremity <sup>A</sup>	Haemarthrosis	Muscle haemorrhage		Compartment syndrome secondary to a bleeding
<b>Renal and urinary disorders</b>				
Urogenital tract haemorrhage (incl.				Renal failure/acute

haematuria and menorrhagia <sup>B</sup> ), renal impairment (incl. blood creatinine increased, blood urea increased)				renal failure secondary to a bleeding sufficient to cause hypoperfusion
<b>General disorders and administration site conditions</b>				
Fever <sup>A</sup> , peripheral oedema, decreased general strength and energy (incl. fatigue and asthenia)	Feeling unwell (incl. malaise)	Localised oedema <sup>A</sup>		
<b>Investigations</b>				
	Increased LDH <sup>A</sup> , increased lipase <sup>A</sup> , increased amylase <sup>A</sup>			
<b>Injury, poisoning and procedural complications</b>				
Postprocedural haemorrhage (incl. postoperative anaemia, and wound haemorrhage), contusion, wound secretion <sup>A</sup>		Vascular pseudoaneurysm <sup>C</sup>		
<p>A: observed in prevention of VTE in adult patients undergoing elective hip or knee replacement surgery</p> <p>B: observed in treatment of DVT, PE and prevention of recurrence as very common in women &lt; 55 years</p> <p>C: observed as uncommon in prevention of atherothrombotic events in patients after an ACS (following percutaneous coronary intervention)</p> <p>* A pre-specified selective approach to adverse event collection was applied. As incidence of adverse reactions did not increase and no new adverse reaction was identified, COMPASS study data were not included for frequency calculation in this table.</p>				

*Description of selected adverse reactions*

Due to the pharmacological mode of action, the use of rivaroxaban may be associated with an increased risk of occult or overt bleeding from any tissue or organ which may result in post haemorrhagic anaemia. The signs, symptoms, and severity (including fatal outcome) will vary according to the location and degree or extent of the bleeding and/or anaemia. Based on the

clinical studies, mucosal bleedings (i.e. epistaxis, gingival, gastrointestinal, genito urinary including abnormal vaginal or increased menstrual bleeding) and anaemia were seen more frequently during long term rivaroxaban treatment compared with VKA treatment. Thus, in addition to adequate clinical surveillance, laboratory testing of haemoglobin/haematocrit could be of value to detect occult bleeding and quantify the clinical relevance of overt bleeding, as judged to be appropriate. The risk of bleedings may be increased in certain patient groups, e.g. those patients with uncontrolled severe arterial hypertension and/or on concomitant treatment affecting haemostasis. Menstrual bleeding may be intensified and/or prolonged. Haemorrhagic complications may present as weakness, paleness, dizziness, headache or unexplained swelling, dyspnoea and unexplained shock. In some cases as a consequence of anaemia, symptoms of cardiac ischaemia like chest pain or angina pectoris have been observed.

Known complications secondary to severe bleeding such as compartment syndrome and renal failure due to hypoperfusion have been reported for rivaroxaban. Therefore, the possibility of haemorrhage is to be considered in evaluating the condition in any anticoagulated patient.

### **Reporting of side effects:**

If you get any side effects, talk to your doctor, pharmacist or nurse. This includes any possible side effects not listed in this leaflet. You can also report side effects directly via any point of contact of Torrent Pharma available at:

[https://www.torrentpharma.com/index.php/site/info/adverse\\_event\\_reporting](https://www.torrentpharma.com/index.php/site/info/adverse_event_reporting)

## **4.9 Overdose:**

Rare cases of overdose up to 600 mg have been reported without bleeding complications or other adverse reactions. Due to limited absorption a ceiling effect with no further increase in average plasma exposure is expected at supratherapeutic doses of 50 mg rivaroxaban or above.

A specific reversal agent (andexanet alfa) antagonising the pharmacodynamic effect of rivaroxaban is available.

The use of activated charcoal to reduce absorption in case of rivaroxaban overdose may be considered.

### *Management of bleeding*

Should a bleeding complication arise in a patient receiving rivaroxaban, the next administration should be delayed or treatment should be discontinued as appropriate. Rivaroxaban has a half-life of approximately 5 to 13 hours. Management should be individualised according to the severity and location of the haemorrhage. Appropriate symptomatic treatment could be used as needed, such as mechanical compression (e.g. for severe epistaxis), surgical haemostasis with bleeding control procedures, fluid replacement and haemodynamic support, blood products (packed red cells or fresh frozen plasma, depending on associated anaemia or coagulopathy) or platelets.

If bleeding cannot be controlled by the above measures, either the administration of a specific factor Xa inhibitor reversal agent (andexanet alfa), which antagonises the pharmacodynamic effect of , or a specific procoagulant reversal agent, such as prothrombin complex concentrate (PCC), activated prothrombin complex concentrate (APCC) or recombinant factor VIIa (r-FVIIa), should be considered. However, there is currently very limited clinical experience with the use of these medicinal products in individuals receiving rivaroxaban. The recommendation is also based on limited non-clinical data. Re-dosing of recombinant factor VIIa shall be considered and titrated depending on improvement of bleeding. Depending on local availability, a consultation with a coagulation expert should be considered in case of major bleedings.

Protamine sulphate and vitamin K are not expected to affect the anticoagulant activity of rivaroxaban. There is limited experience with tranexamic acid and no experience with aminocaproic acid and aprotinin in individuals receiving rivaroxaban. There is neither scientific rationale for benefit nor experience with the use of the systemic haemostatic desmopressin in individuals receiving rivaroxaban. Due to the high plasma protein binding rivaroxaban is not expected to be dialysable.

## **5. Pharmacological properties:**

### **5.1 Mechanism of Action:**

Rivaroxaban is a highly selective direct factor Xa inhibitor with oral bioavailability. Inhibition of factor Xa interrupts the intrinsic and extrinsic pathway of the blood coagulation cascade, inhibiting both thrombin formation and development of thrombi. Rivaroxaban does not inhibit thrombin (activated factor II) and no effects on platelets have been demonstrated.

### **5.2 Pharmacodynamic properties:**

Dose-dependent inhibition of factor Xa activity was observed in humans. Prothrombin time (PT) is influenced by rivaroxaban in a dose dependent way with a close correlation to plasma concentrations (r value equals 0.98) if Neoplastin is used for the assay. Other reagents would provide different results. The readout for PT is to be done in seconds, because the INR is only calibrated and validated for coumarins and cannot be used for any other anticoagulant.

In patients receiving for treatment of DVT and PE and prevention of recurrence, the 5/95 percentiles for PT (Neoplastin) 2 - 4 hours after tablet intake (i.e. at the time of maximum effect) for 15 mg twice daily ranged from 17 to 32 s and for 20 mg once daily from 15 to 30 s. At trough (8 - 16 h after tablet intake) the 5/95 percentiles for 15 mg twice daily ranged from 14 to 24 s and for 20 mg once daily (18 - 30 h after tablet intake) from 13 to 20s.

In patients with non-valvular atrial fibrillation receiving rivaroxaban for the prevention of stroke and systemic embolism, the 5/95 percentiles for PT (Neoplastin) 1 - 4 hours after tablet intake (i.e. at the time of maximum effect) in patients treated with 20 mg once daily ranged from 14 to 40 s and in patients with moderate renal impairment treated with 15 mg once daily from 10 to 50 s. At trough (16 - 36 h after tablet intake) the 5/95 percentiles in patients treated with 20 mg once daily ranged from 12 to 26 s and in patients with moderate renal impairment treated with 15 mg once daily from 12 to 26 s.

According to a reported clinical pharmacology study, on the reversal of rivaroxaban pharmacodynamics in healthy adult subjects (n=22), the effects of single doses (50 IU/kg) of two different types of PCCs, a 3-factor PCC (Factors II, IX and X) and a 4-factor PCC (Factors II, VII, IX and X) were assessed. The 3-factor PCC reduced mean Neoplastin PT values by approximately 1.0 second within 30 minutes, compared to reductions of approximately 3.5 seconds observed with the 4-factor PCC. In contrast, the 3-factor PCC had a greater and more rapid overall effect on reversing changes in endogenous thrombin generation than the 4-factor PCC.

The activated partial thromboplastin time (aPTT) and HepTest are also prolonged dose-dependently; however, they are not recommended to assess the pharmacodynamic effect of rivaroxaban. There is no need for monitoring of coagulation parameters during treatment with rivaroxaban in clinical routine. However, if clinically indicated rivaroxaban levels can be measured by calibrated quantitative anti-factor Xa tests.

### Clinical efficacy and safety

#### *Prevention of stroke and systemic embolism in patients with non-valvular atrial fibrillation*

The rivaroxaban clinical programme was designed to demonstrate the efficacy of rivaroxaban for the prevention of stroke and systemic embolism in patients with non-valvular atrial fibrillation.

In the reported pivotal double-blind ROCKET AF study, 14,264 patients were assigned either to 20mg once daily (15 mg once daily in patients with creatinine clearance 30 - 49 ml/min) or to warfarin titrated to a target INR of 2.5 (therapeutic range 2.0 to 3.0). The median time on treatment was 19 months and overall treatment duration was up to 41 months.

34.9% of patients were treated with acetylsalicylic acid and 11.4% were treated with class III antiarrhythmic including amiodarone.

Rivaroxaban was non-inferior to warfarin for the primary composite endpoint of stroke and non-CNS systemic embolism. In the per-protocol population on treatment, stroke or systemic embolism occurred in 188 patients on rivaroxaban (1.71% per year) and 241 on warfarin (2.16% per year) (HR 0.79; 95% CI, 0.66 - 0.96; P<0.001 for non-inferiority). Among all randomised patients analysed according to ITT, primary events occurred in 269 on (2.12% per year) and 306 on warfarin (2.42% per year) (HR 0.88; 95% CI, 0.74 - 1.03; P<0.001 for non-inferiority; P=0.117 for superiority). Results for secondary endpoints as tested in hierarchical order in the ITT analysis are displayed.

Among patients in the warfarin group, INR values were within the therapeutic range (2.0 to 3.0) a mean of 55% of the time (median, 58%; interquartile range, 43 to 71). The effect of rivaroxaban did not differ across the level of centre TTR (Time in Target INR Range of 2.0 - 3.0) in the equally sized quartiles (P=0.74 for interaction). Within the highest quartile according to centre, the Hazard Ratio (HR) with rivaroxaban versus warfarin was 0.74 (95% CI, 0.49 - 1.12).

The incidence rates for the principal safety outcome (major and non-major clinically relevant bleeding events) were similar for both treatment groups.

### Efficacy results from reported phase III ROCKET AF

Study population	ITT analyses of efficacy in patients with non-valvular atrial fibrillation		
Treatment dose	Rivaroxaban 20 mg od (15 mg od in patients with moderate renal impairment) Event rate (100 pt-yr)	Warfarin titrated to a target INR of 2.5 (therapeutic range 2.0 to 3.0) Event rate (100 pt-yr)	HR (95% CI) p-value, test for superiority
Stroke and non-CNS systemic embolism	269 (2.12)	306 (2.42)	0.88 (0.74 - 1.03) 0.117
Stroke, non-CNS systemic embolism and vascular death	572 (4.51)	609 (4.81)	0.94 (0.84 - 1.05) 0.265

Stroke, non-CNS systemic embolism, vascular death and myocardial infarction	659 (5.24)	709 (5.65)	0.93 (0.83 - 1.03) 0.158
Stroke	253 (1.99)	281 (2.22)	0.90 (0.76 - 1.07) 0.221
Non-CNS systemic embolism	20 (0.16)	27 (0.21)	0.74 (0.42 - 1.32) 0.308
Myocardial infarction	130 (1.02)	142 (1.11)	0.91 (0.72 - 1.16) 0.464

#### Safety results from reported phase III ROCKET AF

Study population	Patients with non-valvular atrial fibrillation <sup>a)</sup>		
	Rivaroxaban 20 mg once a day (15 mg once a day in patients with moderate renal impairment) Event rate (100 pt-yr)	Warfarin titrated to a target INR of 2.5 (therapeutic range 2.0 to 3.0) Event rate (100 pt-yr)	HR (95% CI) p-value
Major and non-major clinically relevant bleeding events	1,475 (14.91)	1,449 (14.52)	1.03 (0.96 - 1.11) 0.442
Major bleeding events	395 (3.60)	386 (3.45)	1.04 (0.90 - 1.20) 0.576
Death due to bleeding*	27 (0.24)	55 (0.48)	0.50 (0.31 - 0.79) 0.003
Critical organ bleeding*	91 (0.82)	133 (1.18)	0.69 (0.53 - 0.91)

			0.007
Intracranial haemorrhage*	55 (0.49)	84 (0.74)	0.67 (0.47 - 0.93) 0.019
Haemoglobin drop*	305 (2.77)	254 (2.26)	1.22 (1.03 - 1.44) 0.019
Transfusion of 2 or more units of packed red blood cells or whole blood*	183 (1.65)	149 (1.32)	1.25 (1.01 - 1.55) 0.044
Non-major clinically relevant bleeding events	1,185 (11.80)	1,151 (11.37)	1.04 (0.96 - 1.13) 0.345
All-cause mortality	208 (1.87)	250 (2.21)	0.85 (0.70 - 1.02) 0.073
a) Safety population, on treatment			
* Nominally significant			

In addition to the phase III ROCKET AF study, a prospective, single-arm, post-authorization, non-interventional, open-label cohort study (XANTUS) with central outcome adjudication including thromboembolic events and major bleeding has been conducted. 6,785 patients with non-valvular atrial fibrillation were enrolled for prevention of stroke and non-central nervous system (CNS) systemic embolism in clinical practice. The mean CHADS<sub>2</sub> and HAS-BLED scores were both 2.0 in XANTUS, compared to a mean CHADS<sub>2</sub> and HAS-BLED score of 3.5 and 2.8 in ROCKET AF, respectively. Major bleeding occurred in 2.1 per 100 patient years. Fatal haemorrhage was reported in 0.2 per 100 patient years and intracranial haemorrhage in 0.4 per 100 patient years. Stroke or non-CNS systemic embolism was recorded in 0.8 per 100 patient years.

These observations in clinical practice are consistent with the established safety profile in this indication.

#### Patients undergoing cardioversion

A reported prospective, randomised, open-label, multicentre, exploratory study with blinded endpoint evaluation (X-VERT) was conducted in 1504 patients (oral anticoagulant naive and pre-treated) with non-valvular atrial fibrillation scheduled for cardioversion to compare with dose-adjusted VKA (randomised 2:1), for the prevention of cardiovascular events. TEE-guided (1 - 5 days of pre-treatment) or conventional cardioversion (at least three weeks of pre-treatment) strategies were employed. The primary efficacy outcome (all stroke, transient ischaemic attack, non-CNS systemic embolism, myocardial infarction (MI) and cardiovascular death) occurred in

5 (0.5%) patients in the rivaroxaban group (n = 978) and 5 (1.0%) patients in the VKA group (n = 492; RR 0.50; 95% CI 0.15-1.73; modified ITT population). The principal safety outcome (major bleeding) occurred in 6 (0.6%) and 4 (0.8%) patients in the rivaroxaban (n = 988) and VKA (n = 499) groups, respectively (RR 0.76; 95% CI 0.21-2.67; safety population). This exploratory study showed comparable efficacy and safety between rivaroxaban and VKA treatment groups in the setting of cardioversion.

*Patients with non-valvular atrial fibrillation who undergo PCI with stent placement*

A randomised, open-label, multicentre study (PIONEER AF-PCI) was conducted in 2,124 patients with non-valvular atrial fibrillation who underwent PCI with stent placement for primary atherosclerotic disease to compare safety of two rivaroxaban regimens and one VKA regimen. Patients were randomly assigned in a 1:1:1 fashion for an overall 12-month-therapy. Patients with a history of stroke or TIA were excluded.

Group 1 received rivaroxaban 15 mg once daily (10 mg once daily in patients with creatinine clearance 30 - 49 ml/min) plus P2Y12 inhibitor. Group 2 received rivaroxaban 2.5 mg twice daily plus DAPT (dual antiplatelet therapy i.e. clopidogrel 75 mg [or alternate P2Y12 inhibitor] plus low-dose acetylsalicylic acid [ASA]) for 1, 6 or 12 months followed by 15 mg (or 10 mg for subjects with creatinine clearance 30 - 49 ml/min) once daily plus low-dose ASA. Group 3 received dose-adjusted VKA plus DAPT for 1, 6 or 12 months followed by dose-adjusted VKA plus low-dose ASA.

The primary safety endpoint, clinically significant bleeding events, occurred in 109 (15.7%), 117 (16.6%), and 167 (24.0%) subjects in group 1, group 2 and group 3, respectively (HR 0.59; 95% CI 0.47-0.76; p<0.001, and HR 0.63; 95% CI 0.50-0.80; p<0.001, respectively). The secondary endpoint (composite of cardiovascular events CV death, MI, or stroke) occurred in 41 (5.9%), 36 (5.1%), and 36 (5.2%) subjects in the group 1, group 2 and group 3, respectively. Each of the rivaroxaban regimens showed a significant reduction in clinically significant bleeding events compared to the VKA regimen in patients with non-valvular atrial fibrillation who underwent a PCI with stent placement.

The primary objective of PIONEER AF-PCI was to assess safety. Data on efficacy (including thromboembolic events) in this population are limited.

*Treatment of DVT, PE and prevention of recurrent DVT and PE*

The rivaroxaban clinical programme was designed to demonstrate the efficacy of rivaroxaban in the initial and continued treatment of acute DVT and PE and prevention of recurrence.

Over 12,800 patients were studied in four randomised controlled phase III clinical studies (Einstein DVT, Einstein PE, Einstein Extension and Einstein Choice) and additionally a predefined pooled analysis of the Einstein DVT and Einstein PE studies was conducted. The overall combined treatment duration in all studies was up to 21 months.

In Einstein DVT 3,449 patients with acute DVT were studied for the treatment of DVT and the prevention of recurrent DVT and PE (patients who presented with symptomatic PE were excluded from this study). The treatment duration was for 3, 6 or 12 months depending on the clinical judgement of the investigator.

For the initial 3 week treatment of acute DVT 15 mg rivaroxaban was administered twice daily. This was followed by 20 mg rivaroxaban once daily.

In Einstein PE, 4,832 patients with acute PE were studied for the treatment of PE and the prevention of recurrent DVT and PE. The treatment duration was for 3, 6 or 12 months depending on the clinical judgement of the investigator.

For the initial treatment of acute PE 15 mg rivaroxaban was administered twice daily for three weeks. This was followed by 20 mg rivaroxaban once daily.

In both the Einstein DVT and the Einstein PE study, the comparator treatment regimen consisted of enoxaparin administered for at least 5 days in combination with vitamin K antagonist treatment until the PT/INR was in therapeutic range ( $\geq 2.0$ ). Treatment was continued with a vitamin K antagonist dose-adjusted to maintain the PT/INR values within the therapeutic range of 2.0 to 3.0.

In Einstein Extension 1,197 patients with DVT or PE were studied for the prevention of recurrent DVT and PE. The treatment duration was for an additional 6 or 12 months in patients who had completed 6 to 12 months of treatment for venous thromboembolism depending on the clinical judgment of the investigator. Rivaroxaban 20 mg once daily was compared with placebo.

Einstein DVT, PE and Extension used the same pre-defined primary and secondary efficacy outcomes. The primary efficacy outcome was symptomatic recurrent VTE defined as the composite of recurrent DVT or fatal or non-fatal PE. The secondary efficacy outcome was defined as the composite of recurrent DVT, non-fatal PE and all-cause mortality.

In Einstein Choice, 3,396 patients with confirmed symptomatic DVT and/or PE who completed 6-12 months of anticoagulant treatment were studied for the prevention of fatal PE or non-fatal symptomatic recurrent DVT or PE. Patients with an indication for continued therapeutic-dosed anticoagulation were excluded from the study. The treatment duration was up to 12 months depending on the individual randomisation date (median: 351 days). 20 mg once daily and rivaroxaban 10 mg once daily were compared with 100 mg acetylsalicylic acid once daily.

The primary efficacy outcome was symptomatic recurrent VTE defined as the composite of recurrent DVT or fatal or non-fatal PE.

In the Einstein DVT study rivaroxaban was demonstrated to be non-inferior to enoxaparin/VKA for the primary efficacy outcome ( $p < 0.0001$  (test for non-inferiority); HR: 0.680 (0.443 - 1.042),  $p=0.076$  (test for superiority)). The prespecified net clinical benefit (primary efficacy outcome plus major bleeding events) was reported with a HR of 0.67 ((95% CI: 0.47 - 0.95), nominal p value  $p=0.027$ ) in favour of rivaroxaban. INR values were within the therapeutic range a mean of 60.3% of the time for the mean treatment duration of 189 days, and 55.4%, 60.1%, and 62.8% of the time in the 3-, 6-, and 12-month intended treatment duration groups, respectively. In the enoxaparin/VKA group, there was no clear relation between the level of mean centre TTR (Time in Target INR Range of 2.0 - 3.0) in the equally sized tertiles and the incidence of the recurrent VTE ( $P=0.932$  for interaction). Within the highest tertile according to centre, the HR with rivaroxaban versus warfarin was 0.69 (95% CI: 0.35 - 1.35).

The incidence rates for the primary safety outcome (major or clinically relevant non-major bleeding events) as well as the secondary safety outcome (major bleeding events) were similar for both treatment groups.

### **Efficacy and safety results from phase III Einstein DVT**

<b>Study population</b>	<b>3,449 patients with symptomatic acute deep vein thrombosis</b>	
<b>Treatment dose and duration</b>	<b>Rivaroxaban<sup>a)</sup></b> <b>3, 6 or 12 months</b> <b>N=1,731</b>	<b>Enoxaparin/VKA<sup>b)</sup></b> <b>3, 6 or 12 months</b> <b>N=1,718</b>

Symptomatic recurrent VTE*	36 (2.1%)	51 (3.0%)
Symptomatic recurrent PE	20 (1.2%)	18 (1.0%)
Symptomatic recurrent DVT	14 (0.8%)	28 (1.6%)
Symptomatic PE and DVT	1 (0.1%)	0
Fatal PE/death where PE cannot be ruled out	4 (0.2%)	6 (0.3%)
Major or clinically relevant non-major bleeding	139 (8.1%)	138 (8.1%)
Major bleeding events	14 (0.8%)	20 (1.2%)
a) Rivaroxaban 15 mg twice daily for 3 weeks followed by 20 mg once daily b) Enoxaparin for at least 5 days, overlapped with and followed by VKA * $p < 0.0001$ (non-inferiority to a prespecified HR of 2.0); HR: 0.680 (0.443 - 1.042), $p=0.076$ (superiority)		

In the Einstein PE study rivaroxaban was demonstrated to be non-inferior to enoxaparin/VKA for the primary efficacy outcome ( $p=0.0026$  (test for non-inferiority); HR: 1.123 (0.749 - 1.684)). The prespecified net clinical benefit (primary efficacy outcome plus major bleeding events) was reported with a HR of 0.849 ((95% CI: 0.633 - 1.139), nominal  $p$  value  $p= 0.275$ ). INR values were within the therapeutic range a mean of 63% of the time for the mean treatment duration of 215 days, and 57%, 62%, and 65% of the time in the 3-, 6-, and 12-month intended treatment duration groups, respectively. In the enoxaparin/VKA group, there was no clear relation between the level of mean centre TTR (Time in Target INR Range of 2.0 - 3.0) in the equally sized tertiles and the incidence of the recurrent VTE ( $p=0.082$  for interaction). Within the highest tertile according to centre, the HR with rivaroxaban versus warfarin was 0.642 (95% CI: 0.277 - 1.484).

The incidence rates for the primary safety outcome (major or clinically relevant non-major bleeding events) were slightly lower in the rivaroxaban treatment group (10.3% (249/2412)) than in the enoxaparin/VKA treatment group (11.4% (274/2405)). The incidence of the secondary safety outcome (major bleeding events) was lower in the rivaroxaban group (1.1% (26/2412)) than in the enoxaparin/VKA group (2.2% (52/2405)) with a HR 0.493 (95% CI: 0.308 - 0.789).

### Efficacy and safety results from phase III Einstein PE

<b>Study population</b>	<b>4,832 patients with an acute symptomatic PE</b>	
<b>Treatment dose and duration</b>	<b>Rivaroxaban<sup>a)</sup></b> <b>3, 6 or 12 months</b> <b>N=2,419</b>	<b>Enoxaparin/VKA<sup>b)</sup></b> <b>3, 6 or 12 months</b> <b>N=2,413</b>
Symptomatic recurrent VTE*	50 (2.1%)	44 (1.8%)
Symptomatic recurrent PE	23 (1.0%)	20 (0.8%)
Symptomatic recurrent DVT	18 (0.7%)	17 (0.7%)
Symptomatic PE and DVT	0	2 (<0.1%)
Fatal PE/death where PE cannot be ruled out	11 (0.5%)	7 (0.3%)
Major or clinically relevant non-major bleeding	249 (10.3%)	274 (11.4%)
Major bleeding events	26 (1.1%)	52 (2.2%)
<p>a) Rivaroxaban 15 mg twice daily for 3 weeks followed by 20 mg once daily</p> <p>b) Enoxaparin for at least 5 days, overlapped with and followed by VKA</p> <p>* <math>p &lt; 0.0026</math> (non-inferiority to a prespecified HR of 2.0); HR: 1.123 (0.749 - 1.684)</p>		

A prespecified pooled analysis of the outcome of the Einstein DVT and PE studies was conducted.

### Efficacy and safety results from pooled analysis of phase III Einstein DVT and Einstein PE

<b>Study population</b>	<b>8,281 patients with an acute symptomatic DVT or PE</b>	
<b>Treatment dose and duration</b>	<b>Rivaroxaban<sup>a)</sup></b> <b>3, 6 or 12 months</b> <b>N=4,150</b>	<b>Enoxaparin/VKA<sup>b)</sup></b> <b>3, 6 or 12 months</b> <b>N=4,131</b>

Symptomatic recurrent VTE*	86 (2.1%)	95 (2.3%)
Symptomatic recurrent PE	43 (1.0%)	38 (0.9%)
Symptomatic recurrent DVT	32 (0.8%)	45 (1.1%)
Symptomatic PE and DVT	1 (<0.1%)	2 (<0.1%)
Fatal PE/death where PE cannot be ruled out	15 (0.4%)	13 (0.3%)
Major or clinically relevant non-major bleeding	388 (9.4%)	412 (10.0%)
Major bleeding events	40 (1.0%)	72 (1.7%)
a) Rivaroxaban 15 mg twice daily for 3 weeks followed by 20 mg once daily b) Enoxaparin for at least 5 days, overlapped with and followed by VKA * p < 0.0001 (non-inferiority to a prespecified HR of 1.75); HR: 0.886 (0.661 - 1.186)		

The prespecified net clinical benefit (primary efficacy outcome plus major bleeding events) of the pooled analysis was reported with a HR of 0.771 ((95% CI: 0.614 - 0.967), nominal p value p = 0.0244).

In the Einstein Extension study rivaroxaban was superior to placebo for the primary and secondary efficacy outcomes. For the primary safety outcome (major bleeding events) there was a non-significant numerically higher incidence rate for patients treated with rivaroxaban 20 mg once daily compared to placebo. The secondary safety outcome (major or clinically relevant non-major bleeding events) showed higher rates for patients treated with rivaroxaban 20 mg once daily compared to placebo.

### **Efficacy and safety results from phase III Einstein Extension**

<b>Study population</b>	<b>1,197 patients continued treatment and prevention of recurrent venous thromboembolism</b>	
<b>Treatment dose and duration</b>	<b>Rivaroxaban<sup>a)</sup></b> <b>6 or 12 months</b> <b>N=602</b>	<b>Placebo</b> <b>6 or 12 months</b> <b>N=594</b>

Symptomatic recurrent VTE*	8 (1.3%)	42 (7.1%)
Symptomatic recurrent PE	2 (0.3%)	13 (2.2%)
Symptomatic recurrent DVT	5 (0.8%)	31 (5.2%)
Fatal PE/death where PE cannot be ruled out	1 (0.2%)	1 (0.2%)
Major bleeding events	4 (0.7%)	0 (0.0%)
Clinically relevant non-major bleeding	32 (5.4%)	7 (1.2%)
a) Rivaroxaban 20 mg once daily * p < 0.0001 (superiority), HR: 0.185 (0.087 - 0.393)		

In the Einstein Choice study rivaroxaban 20 mg and 10 mg were both superior to 100 mg acetylsalicylic acid for the primary efficacy outcome. The principal safety outcome (major bleeding events) was similar for patients treated with rivaroxaban 20 mg and 10 mg once daily compared to 100 mg acetylsalicylic acid.

### Efficacy and safety results from reported phase III Einstein Choice

<b>Study population</b>	<b>3,396 patients continued prevention of recurrent venous thromboembolism</b>		
<b>Treatment dose</b>	<b>Rivaroxaban 20 mg od N=1,107</b>	<b>Rivaroxaban 10 mg od N=1,127</b>	<b>ASA 100 mg od N=1,131</b>
Treatment duration median [interquartile range]	349 [189-362] days	353 [190-362] days	350 [186-362] days
Symptomatic recurrent VTE	17 (1.5%)*	13 (1.2%)**	50 (4.4%)
Symptomatic recurrent PE	6 (0.5%)	6 (0.5%)	19 (1.7%)

Symptomatic recurrent DVT	9 (0.8%)	8 (0.7%)	30 (2.7%)
Fatal PE/death where PE cannot be ruled out	2 (0.2%)	0 (0.0%)	2 (0.2%)
Symptomatic recurrent VTE, MI, stroke, or non-CNS systemic embolism	19 (1.7%)	18 (1.6%)	56 (5.0%)
Major bleeding events	6 (0.5%)	5 (0.4%)	3 (0.3%)
Clinically relevant non-major bleeding	30 (2.7)	22 (2.0)	20 (1.8)
Symptomatic recurrent VTE or major bleeding (net clinical benefit)	23 (2.1%) <sup>+</sup>	17 (1.5%) <sup>++</sup>	53 (4.7%)
<p>* p&lt;0.001(superiority) Rivaroxaban 20 mg od vs ASA 100 mg od; HR=0.34 (0.20-0.59)</p> <p>** p&lt;0.001 (superiority) Rivaroxaban 10 mg od vs ASA 100 mg od; HR=0.26 (0.14-0.47)</p> <p><sup>+</sup> Rivaroxaban 20 mg od vs. ASA 100 mg od; HR=0.44 (0.27-0.71), p=0.0009 (nominal)</p> <p><sup>++</sup> Rivaroxaban 10 mg od vs. ASA 100 mg od; HR=0.32 (0.18-0.55), p&lt;0.0001 (nominal)</p>			

In addition to the phase III EINSTEIN programme, a prospective, non-interventional, open-label cohort study (XALIA) with central outcome adjudication including recurrent VTE, major bleeding and death has been conducted. 5,142 patients with acute DVT were enrolled to investigate the long-term safety of compared with standard-of-care anticoagulation therapy in clinical practice. Rates of major bleeding, recurrent VTE and all-cause mortality for were 0.7%, 1.4% and 0.5%, respectively. There were differences in patient baseline characteristics including age, cancer and renal impairment. A pre-specified propensity score stratified analysis was used to adjust for measured baseline differences but residual confounding may, in spite of this, influence the results. Adjusted HRs comparing and standard-of-care for major bleeding, recurrent VTE and all-cause mortality were 0.77 (95% CI 0.40 - 1.50), 0.91 (95% CI 0.54 - 1.54) and 0.51 (95% CI 0.24 - 1.07), respectively.

These results in clinical practice are consistent with the established safety profile in this indication.

#### Patients with high risk triple positive antiphospholipid syndrome

In a reported investigator sponsored, randomized open-label multicenter study with blinded endpoint adjudication, was compared to warfarin in patients with a history of thrombosis, diagnosed with antiphospholipid syndrome and at high risk for thromboembolic events (positive for all 3 antiphospholipid tests: lupus anticoagulant, anticardiolipin antibodies, and anti-beta 2-glycoprotein I antibodies). The trial was terminated prematurely after the enrolment of 120

patients due to an excess of events among patients in the arm. Mean follow-up was 569 days. 59 patients were randomized to 20 mg (15 mg for patients with creatinine clearance (CrCl) <50 mL/min) and 61 to warfarin (INR 2.0-3.0). Thromboembolic events occurred in 12% of patients randomized to (4 ischaemic strokes and 3 myocardial infarctions). No events were reported in patients randomized to warfarin. Major bleeding occurred in 4 patients (7%) of the group and 2 patients (3%) of the warfarin group.

#### Paediatric population

The European Medicines Agency has deferred the obligation to submit the results of studies with in one or more subsets of the paediatric population in the treatment of thromboembolic events. The European Medicines Agency has waived the obligation to submit the results of studies with in all subsets of the paediatric population in the prevention of thromboembolic events.

### **5.3 Pharmacokinetic properties:**

#### Absorption

Rivaroxaban is rapidly absorbed with maximum concentrations ( $C_{max}$ ) appearing 2 - 4 hours after tablet intake.

Oral absorption of rivaroxaban is almost complete and oral bioavailability is high (80 - 100%) for the 2.5 mg and 10 mg tablet dose, irrespective of fasting/fed conditions. Intake with food does not affect rivaroxaban AUC or  $C_{max}$  at the 2.5 mg and 10 mg dose.

Due to a reduced extent of absorption an oral bioavailability of 66% was determined for the 20 mg tablet under fasting conditions. When Rivaroxaban 20 mg tablets are taken together with food increases in mean AUC by 39% were observed when compared to tablet intake under fasting conditions, indicating almost complete absorption and high oral bioavailability. Rivaroxaban 15 mg and 20 mg are to be taken with food.

Rivaroxaban pharmacokinetics are approximately linear up to about 15 mg once daily in fasting state. Under fed conditions Rivaroxaban 10 mg, 15 mg and 20 mg tablets demonstrated dose-proportionality. At higher doses rivaroxaban displays dissolution limited absorption with decreased bioavailability and decreased absorption rate with increased dose.

Variability in rivaroxaban pharmacokinetics is moderate with inter-individual variability (CV%) ranging from 30% to 40%.

Absorption of rivaroxaban is dependent on the site of its release in the gastrointestinal tract. A 29% and 56% decrease in AUC and  $C_{max}$  compared to tablet was reported when rivaroxaban granulate is released in the proximal small intestine. Exposure is further reduced when rivaroxaban is released in the distal small intestine, or ascending colon. Therefore, administration of rivaroxaban distal to the stomach should be avoided since this can result in reduced absorption and related rivaroxaban exposure.

Bioavailability (AUC and  $C_{max}$ ) was comparable for 20 mg rivaroxaban administered orally as a crushed tablet mixed in apple puree, or suspended in water and administered via a gastric tube followed by a liquid meal, compared to a whole tablet. Given the predictable, dose-proportional pharmacokinetic profile of rivaroxaban, the bioavailability results from this study are likely applicable to lower rivaroxaban doses.

#### Distribution

Plasma protein binding in humans is high at approximately 92% to 95%, with serum albumin being the main binding component. The volume of distribution is moderate with  $V_{ss}$  being approximately 50 litres.

### Biotransformation and elimination

Of the administered rivaroxaban dose, approximately 2/3 undergoes metabolic degradation, with half then being eliminated renally and the other half eliminated by the faecal route. The final 1/3 of the administered dose undergoes direct renal excretion as unchanged active substance in the urine, mainly via active renal secretion.

Rivaroxaban is metabolised via CYP3A4, CYP2J2 and CYP-independent mechanisms. Oxidative degradation of the morpholinone moiety and hydrolysis of the amide bonds are the major sites of biotransformation. Based on *in vitro* investigations rivaroxaban is a substrate of the transporter proteins P-gp (P-glycoprotein) and Bcrp (breast cancer resistance protein).

Unchanged rivaroxaban is the most important compound in human plasma, with no major or active circulating metabolites being present. With a systemic clearance of about 10 l/h, rivaroxaban can be classified as a low-clearance substance. After intravenous administration of a 1 mg dose the elimination half-life is about 4.5 hours. After oral administration the elimination becomes absorption rate limited. Elimination of rivaroxaban from plasma occurs with terminal half-lives of 5 to 9 hours in young individuals, and with terminal half-lives of 11 to 13 hours in the elderly.

### Special populations

#### Gender

There were no clinically relevant differences in pharmacokinetics and pharmacodynamics between male and female patients.

#### Elderly population

Elderly patients exhibited higher plasma concentrations than younger patients, with mean AUC values being approximately 1.5 fold higher, mainly due to reduced (apparent) total and renal clearance. No dose adjustment is necessary.

#### Different weight categories

Extremes in body weight (< 50 kg or > 120 kg) had only a small influence on rivaroxaban plasma concentrations (less than 25%). No dose adjustment is necessary.

#### Inter-ethnic differences

No clinically relevant inter-ethnic differences among Caucasian, African-American, Hispanic, Japanese or Chinese patients were observed regarding rivaroxaban pharmacokinetics and pharmacodynamics.

#### Hepatic impairment

Cirrhotic patients with mild hepatic impairment (classified as Child Pugh A) exhibited only minor changes in rivaroxaban pharmacokinetics (1.2 fold increase in rivaroxaban AUC on average), nearly comparable to their matched healthy control group. In cirrhotic patients with moderate hepatic impairment (classified as Child Pugh B), rivaroxaban mean AUC was significantly increased by 2.3 fold compared to healthy volunteers. Unbound AUC was increased 2.6 fold. These patients also had reduced renal elimination of rivaroxaban, similar to patients with moderate renal impairment. There are no data in patients with severe hepatic impairment.

The inhibition of factor Xa activity was increased by a factor of 2.6 in patients with moderate hepatic impairment as compared to healthy volunteers; prolongation of PT was similarly increased by a factor of 2.1. Patients with moderate hepatic impairment were more sensitive to rivaroxaban resulting in a steeper PK/PD relationship between concentration and PT.

Rivaroxaban is contraindicated in patients with hepatic disease associated with coagulopathy and clinically relevant bleeding risk, including cirrhotic patients with Child Pugh B and C.

#### Renal impairment

There was an increase in rivaroxaban exposure correlated to decrease in renal function, as assessed via creatinine clearance measurements. In individuals with mild (creatinine clearance 50 - 80 ml/min), moderate (creatinine clearance 30 - 49 ml/min) and severe (creatinine clearance 15 - 29 ml/min) renal impairment, rivaroxaban plasma concentrations (AUC) were increased 1.4, 1.5 and 1.6 fold respectively. Corresponding increases in pharmacodynamic effects were more pronounced. In individuals with mild, moderate and severe renal impairment the overall inhibition of factor Xa activity was increased by a factor of 1.5, 1.9 and 2.0 respectively as compared to healthy volunteers; prolongation of PT was similarly increased by a factor of 1.3, 2.2 and 2.4 respectively. There are no data in patients with creatinine clearance < 15 ml/min.

Due to the high plasma protein binding rivaroxaban is not expected to be dialysable.

Use is not recommended in patients with creatinine clearance < 15 ml/min. Rivaroxaban is to be used with caution in patients with creatinine clearance 15 - 29 ml/min.

#### Pharmacokinetic data in patients

In patients receiving rivaroxaban for treatment of acute DVT 20 mg once daily the geometric mean concentration (90% prediction interval) 2 - 4 h and about 24 h after dose (roughly representing maximum and minimum concentrations during the dose interval) was 215 (22 - 535) and 32 (6 - 239) mcg/l, respectively.

#### Pharmacokinetic/pharmacodynamic relationship

The pharmacokinetic/pharmacodynamic (PK/PD) relationship between rivaroxaban plasma concentration and several PD endpoints (factor Xa inhibition, PT, aPTT, Heptest) has been evaluated after administration of a wide range of doses (5 - 30 mg twice a day). The relationship between rivaroxaban concentration and factor Xa activity was best described by an  $E_{max}$  model. For PT, the linear intercept model generally described the data better. Depending on the different PT reagents used, the slope differed considerably. When Neoplastin PT was used, baseline PT was about 13 s and the slope was around 3 to 4 s/(100 mcg/l). The results of the PK/PD analyses in Phase II and III were consistent with the data established in healthy subjects.

#### Paediatric population

Safety and efficacy have not been established for children and adolescents up to 18 years.

### **6. Nonclinical properties:**

Non-clinical data reveal no special hazard for humans based on conventional studies of safety pharmacology, single dose toxicity, phototoxicity, genotoxicity, carcinogenic potential and juvenile toxicity.

Effects observed in repeat-dose toxicity studies were mainly due to the exaggerated pharmacodynamic activity of rivaroxaban. In rats, increased IgG and IgA plasma levels were seen at clinically relevant exposure levels.

In rats, no effects on male or female fertility were seen. Animal studies have shown reproductive toxicity related to the pharmacological mode of action of rivaroxaban (e.g. haemorrhagic complications). Embryo-foetal toxicity (post-implantation loss, retarded/progressed ossification, hepatic multiple light coloured spots) and an increased incidence of common malformations as well as placental changes were observed at clinically relevant plasma concentrations. In the

reported pre- and post-natal study in rats, reduced viability of the offspring was observed at doses that were toxic to the dams.

## **7. Description:**

**10mg** - Round, light red, biconvex film-coated tablets having “A1” debossed on one side and plain on other side.

**15mg** - Round, red, biconvex film-coated tablets having “A2” debossed on one side and plain on other side.

**20mg** - Dark red colored, oval shaped, biconvex, and film coated tablet having “A3” debossed on one side and plain on other side.

## **8. Pharmaceutical particulars:**

### **8.1 Incompatibilities:**

Not applicable.

### **8.2 Shelf-life:**

Do not use later than the date of expiry.

### **8.3 Packaging information:**

Available in blister pack of 10 tablets.

### **8.4 Storage and handing instructions:**

- Store at a temperature not exceeding 30°C, protected from light and moisture.
- Keep out of reach of children.

## **9. Patient Counselling Information**

### **Package leaflet: Information for the user**

#### **ROVOR**

Rivaroxaban 10/15/20 mg tablets

Read all of this leaflet carefully before you start taking this medicine because it contains important information for you.

- Keep this leaflet. You may need to read it again.
- If you have any further questions, ask your doctor or pharmacist.
- This medicine has been prescribed for you only. Do not pass it on to others. It may harm them, even if their signs of illness are the same as yours.
- If you get any side effects, talk to your doctor or pharmacist. This includes any possible side effects not listed in this leaflet. See section 4.

What is in this leaflet?

9.1 What ROVOR is and what it is used for

9.2 What you need to know before you take ROVOR

9.3 How to take ROVOR

9.4 Possible side effects

9.5 How to store ROVOR

## 9.6 Contents of the pack and other information

### 9.1. What ROVOR is and what it is used for

ROVOR contains the active substance rivaroxaban and is used in adults to:

- Prevent blood clots in brain (stroke) and other blood vessels in your body if you have a form of irregular heart rhythm called non-valvular atrial fibrillation.
- Treat blood clots in the veins of your legs (deep vein thrombosis) and in the blood vessels of your lungs (pulmonary embolism), and to prevent blood clots from re-occurring in the blood vessels of your legs and/or lungs. ROVOR belongs to a group of medicines called antithrombotic agents. It works by blocking a blood clotting factor (factor Xa) and thus reducing the tendency of the blood to form clots.

### 9.2. What you need to know before you take ROVOR

#### Do not take ROVOR

- if you are allergic to rivaroxaban or any of the other ingredients of this medicine
- if you are bleeding excessively
- if you have a disease or condition in an organ of the body that increases the risk of serious bleeding (e.g. stomach ulcer, injury or bleeding in the brain, recent surgery of the brain or eyes)
- if you are taking medicines to prevent blood clotting (e.g. warfarin, dabigatran, apixaban or heparin), except when changing anticoagulant treatment or while getting heparin through a venous or arterial line to keep it open.
- if you have a liver disease which leads to an increased risk of bleeding
- if you are pregnant or breast-feeding

**Do not take ROVOR and tell your doctor** if any of these apply to you.

#### Warnings and precautions

Talk to your doctor or pharmacist before taking ROVOR.

#### Take special care with ROVOR

- ❖ if you have an increased risk of bleeding, as could be the case in situations such as:
  - severe kidney disease, since your kidney function may affect the amount of medicine that works in your body
  - if you are taking other medicines to prevent blood clotting (e.g. warfarin, dabigatran, apixaban or heparin), when changing anticoagulant treatment or while getting heparin through a venous or arterial line to keep it open
  - bleeding disorders
  - very high blood pressure, not controlled by medical treatment
  - diseases of your stomach or bowel that might result in bleeding, e.g. inflammation of the bowels or stomach, or inflammation of the oesophagus (gullet), e.g. due to gastroesophageal reflux disease (disease where stomach acid goes upwards into the oesophagus)

- a problem with the blood vessels in the back of your eyes (retinopathy)
- a lung disease where your bronchi are widened and filled with pus (bronchiectasis), or previous bleeding from your lung
- ❖ if you have a prosthetic heart valve
- ❖ if you know that you have a disease called antiphospholipid syndrome (a disorder of the immune system that causes an increased risk of blood clots), tell your doctor who will decide if the treatment may need to be changed.
- ❖ if your doctor determines that your blood pressure is unstable or another treatment or surgical procedure to remove the blood clot from your lungs is planned.

**If any of the above apply to you, tell your doctor** before you take ROVOR. Your doctor will decide, if you should be treated with this medicine and if you should be kept under closer observation.

### **If you need to have an operation**

- ❖ It is very important to take ROVOR before and after the operation exactly at the times you have been told by your doctor.
- ❖ If your operation involves a catheter or injection into your spinal column (e.g. for epidural or spinal anaesthesia or pain reduction).
- ❖ It is very important to take ROVOR before and after the injection or removal of the catheter exactly at the times you have been told by your doctor.
- ❖ Tell your doctor immediately if you get numbness or weakness of your legs or problems with your bowel or bladder after the end of anaesthesia, because urgent care is necessary.

### **Children and adolescents**

ROVOR is **not recommended for people under 18 years of age**. There is not enough information on its use in children and adolescents.

### **Other medicines and ROVOR**

Tell your doctor or pharmacist if you are taking, have recently taken or might take any other medicines, including medicines obtained without a prescription.

#### **❖ If you are taking**

- some medicines for fungal infections (e.g. fluconazole, itraconazole, voriconazole, posaconazole), unless they are only applied to the skin
- ketoconazole tablets (used to treat Cushing's syndrome - when the body produces an excess of cortisol)
- some medicines for bacterial infections (e.g. clarithromycin, erythromycin)
- some anti-viral medicines for HIV / AIDS (e.g. ritonavir)
- other medicines to reduce blood clotting (e.g. enoxaparin, clopidogrel or vitamin K antagonists such as warfarin and acenocoumarol)
- anti-inflammatory and pain relieving medicines (e.g. naproxen or acetylsalicylic acid)
- dronedarone, a medicine to treat abnormal heart beat

- some medicines to treat depression (selective serotonin reuptake inhibitors (SSRIs) or serotonin norepinephrine reuptake inhibitors (SNRIs))

**If any of the above apply to you, tell your doctor** before taking ROVOR, because the effect of ROVOR may be increased. Your doctor will decide, if you should be treated with this medicine and if you should be kept under closer observation.

If your doctor thinks that you are at increased risk of developing stomach or bowel ulcers, he may also use a preventative ulcer treatment.

❖ **If you are taking**

- some medicines for treatment of epilepsy (phenytoin, carbamazepine, phenobarbital)
- St John's Wort (*Hypericum perforatum*), a herbal product used for depression
- rifampicin, an antibiotic

**If any of the above apply to you, tell your doctor** before taking ROVOR, because the effect of ROVOR may be reduced. Your doctor will decide, if you should be treated with ROVOR and if you should be kept under closer observation.

**Pregnancy and breast-feeding**

Do not take ROVOR if you are pregnant or breast-feeding. If there is a chance that you could become pregnant, use a reliable contraceptive while you are taking ROVOR. If you become pregnant while you are taking this medicine, tell your doctor immediately, who will decide how you should be treated.

**Driving and using machines**

ROVOR may cause dizziness (common side effect) or fainting (uncommon side effect). You should not drive or use machines if you are affected by these symptoms.

**ROVOR contains lactose and sodium**

If you have been told by your doctor that you have an intolerance to some sugars, contact your doctor before taking this medicine.

This medicine contains less than 1 mmol sodium (23 mg) per tablet that is to say essentially "sodiumfree".

**9.3. How to take ROVOR**

- Always take this medicine exactly as your doctor has told you. Check with your doctor or pharmacist if you are not sure.
- You must take ROVOR together with a meal.
- Swallow the tablet(s) preferably with water.
- If you have difficulty swallowing the tablet whole, talk to your doctor about other ways to take ROVOR. The tablet may be crushed and mixed with water or apple puree immediately before you take it. This mixture should be immediately followed by food.
- If necessary, your doctor may also give you the crushed ROVOR tablet through a stomach tube.

## How much to take

- To prevent blood clots in brain (stroke) and other blood vessels in your body.

The recommended dose is one tablet ROVOR 20 mg once a day.

If you have kidney problems, the dose may be reduced to one tablet ROVOR 15 mg once a day.

- If you need a procedure to treat blocked blood vessels in your heart (called a percutaneous coronary intervention - PCI with an insertion of a stent), there is limited evidence to reduce the dose to one tablet ROVOR 15 mg once a day (or to one tablet ROVOR 10 mg once a day in case your kidneys are not working properly) in addition to an antiplatelet medicinal product such as clopidogrel.
- To treat blood clots in the veins of your legs and blood clots in the blood vessels of your lungs, and for preventing blood clots from re-occurring.

The recommended dose is one tablet ROVOR 15 mg twice a day for the first 3 weeks. For treatment after 3 weeks, the recommended dose is one tablet ROVOR 20 mg once a day.

After at least 6 months blood clot treatment your doctor may decide to continue treatment with either one 10 mg tablet once a day or one 20 mg tablet once a day.

If you have kidney problems and take one tablet ROVOR 20 mg once a day, your doctor may decide to reduce the dose for the treatment after 3 weeks to one tablet ROVOR 15 mg once a day if the risk for bleeding is greater than the risk for having another blood clot.

## When to take ROVOR

- Take the tablet(s) every day until your doctor tells you to stop.
- Try to take the tablet(s) at the same time every day to help you to remember it.
- Your doctor will decide how long you must continue treatment.
- To prevent blood clots in the brain (stroke) and other blood vessels in your body:
- If your heart beat needs to be restored to normal by a procedure called cardioversion, take ROVOR at the times your doctor tells you.

## If you take more ROVOR than you should

Contact your doctor immediately if you have taken too many ROVOR tablets. Taking too much ROVOR increases the risk of bleeding.

## If you forget to take ROVOR

- If you are taking one 20 mg tablet or one 15 mg tablet once a day and have missed a dose, take it as soon as you remember. Do not take more than one tablet in a single day to make up for a forgotten dose. Take the next tablet on the following day and then carry on taking one tablet once a day.
- If you are taking one 15 mg tablet twice a day and have missed a dose, take it as soon as you remember. Do not take more than two 15 mg tablets in a single day. If you forget to take a dose you can take two 15 mg tablets at the same time to get a total of two tablets (30 mg) on one day. On the following day you should carry on taking one 15 mg tablet twice a day.

### **If you stop taking ROVOR**

- Do not stop taking ROVOR without talking to your doctor first, because ROVOR treats and prevents serious conditions.
- If you have any further questions on the use of this medicine, ask your doctor or pharmacist.

### **9.4. Possible side effects**

- Like all medicines, ROVOR can cause side effects, although not everybody gets them.
- Like other similar medicines (antithrombotic agents), ROVOR may cause bleeding which may potentially be life threatening. Excessive bleeding may lead to a sudden drop in blood pressure (shock). In some cases the bleeding may not be obvious.

#### **Possible side effects which may be a sign of bleeding**

**Tell your doctor immediately if you experience any of the following side effects:**

- long or excessive bleeding
- exceptional weakness, tiredness, paleness, dizziness, headache, unexplained swelling, breathlessness, chest pain or angina pectoris, which may be signs of bleeding.

Your doctor may decide to keep you under closer observation or change how you should be treated.

#### **Possible side effects which may be a sign of severe skin reaction**

**Tell your doctor immediately if you experience skin reactions such as:**

- spreading intense skin rash, blisters or mucosal lesions, e.g. in the mouth or eyes (Stevens Johnson syndrome/toxic epidermal necrolysis). The frequency of this side effect is very rare (up to 1 in 10,000).
- a drug reaction that causes rash, fever, inflammation of internal organs, hematologic abnormalities and systemic illness (DRESS syndrome). The frequency of this side effect is very rare (up to 1 in 10,000).

#### **Possible side effects which may be a sign of severe allergic reactions**

**Tell your doctor immediately if you experience any of the following side effects:**

- swelling of the face, lips, mouth, tongue or throat; difficulty swallowing; hives and breathing difficulties; sudden drop in blood pressure. The frequencies of these side effects are very rare (anaphylactic reactions, including anaphylactic shock; may affect up to 1 in 10,000 people) and uncommon (angioedema and allergic oedema; may affect up to 1 in 100 people).

#### **Overall list of possible side effects**

##### **Common (may affect up to 1 in 10 people)**

- reduction in red blood cells which can make the skin pale and cause weakness or breathlessness
- bleeding in the stomach or bowel, urogenital bleeding (including blood in the urine and heavy menstrual bleeding), nose bleed, bleeding in the gum
- bleeding into the eye (including bleeding from the whites of the eyes)
- bleeding into tissue or a cavity of the body (haematoma, bruising)
- coughing up blood

- bleeding from the skin or under the skin
- bleeding following an operation
- oozing of blood or fluid from surgical wound
- swelling in the limbs
- pain in the limbs
- impaired function of the kidneys (may be seen in tests performed by your doctor)
- fever
- stomach ache, indigestion, feeling or being sick, constipation, diarrhoea
- low blood pressure (symptoms may be feeling dizzy or fainting when standing up)
- decreased general strength and energy (weakness, tiredness), headache, dizziness
- rash, itchy skin
- blood tests may show an increase in some liver enzymes

**Uncommon (may affect up to 1 in 100 people)**

- bleeding into the brain or inside the skull
- bleeding into a joint causing pain and swelling
- thrombocytopenia (low number of platelets, which are cells that help blood to clot)
- allergic reactions, including allergic skin reactions
- impaired function of the liver (may be seen in tests performed by your doctor)
- blood tests may show an increase in bilirubin, some pancreatic or liver enzymes or in the number of platelets
- fainting
- feeling unwell
- faster heartbeat
- dry mouth
- hives

**Rare (may affect up to 1 in 1,000 people)**

- bleeding into a muscle
- cholestasis (decreased bile flow), hepatitis incl. hepatocellular injury (inflamed liver incl. liver injury)
- yellowing of the skin and eye (jaundice)
- localised swelling
- collection of blood (haematoma) in the groin as a complication of the cardiac procedure where a catheter is inserted in your leg artery (pseudoaneurysm)

**Not known (frequency cannot be estimated from the available data)**

- kidney failure after a severe bleeding

- increased pressure within muscles of the legs or arms after a bleeding, which leads to pain, swelling, altered sensation, numbness or paralysis (compartment syndrome after a bleeding)

### **Reporting of side effects**

If you get any side effects, talk to your doctor, pharmacist or nurse. This includes any possible side effects not listed in this leaflet. You can also report side effects directly via any point of contact of Torrent Pharma available at:

[https://www.torrentpharma.com/index.php/site/info/adverse\\_event\\_reporting](https://www.torrentpharma.com/index.php/site/info/adverse_event_reporting)

### **9.5. How to store ROVOR**

Keep this medicine out of the sight and reach of children. Do not use this medicine after the expiry date which is stated on the carton and on each blister or bottle after EXP. The expiry date refers to the last day of that month. This medicine does not require any special storage conditions. Do not throw away any medicines via wastewater or household waste. Ask your pharmacist how to throw away medicines you no longer use. These measures will help protect the environment.

### **9.6. Contents of the pack and other information**

#### **What ROVOR contains**

The active substance is rivaroxaban. Each tablet contains 10 mg, 15 mg or 20 mg of rivaroxaban.

The other ingredients are:.

for 10 mg –

Microcrystalline cellulose, Lactose monohydrate, Croscarmellose sodium, Sodium Lauryl Sulphate, Hydroxypropylmethylcellulose, Talc, Magnesium Stearate , Instacoat Universal A05R04590 (Hypromellose, PEG 400, PEG 6000, Titanium Dioxide, Red Oxide of Iron)

for 15 mg –

Microcrystalline cellulose, Lactose monohydrate, Croscarmellose sodium, Sodium Lauryl Sulphate, Hydroxypropylmethylcellulose, Talc, Magnesium Stearate, Instacoat Universal A05R04589 (Hypromellose, PEG 400, PEG 6000, Titanium Dioxide, Red Oxide of Iron)

for 20 mg –

Microcrystalline cellulose, Lactose monohydrate, Croscarmellose sodium, Sodium Lauryl Sulphate, Hydroxypropylmethylcellulose, Talc, Magnesium Stearate, Instacoat Aqua II A02R00356 (Polyvinyl alcohol, PEG 6000, Talc, Titanium Dioxide, Red Oxide of Iron)

### **10. Details of manufacturer**

**Torrent Pharmaceuticals Ltd.**

32 No, Middle Camp, NH-10,

East District, Gangtok, Sikkim-737 135

### **11. Details of permission or licence number with date**

M/563/2010 dated 03.08.2020

### **12. Date of revision**

Not applicable

MARKETED BY



TORRENT PHARMACEUTICALS LTD.

Torrent House, Off Ashram Road,

Ahmedabad-380 009, INDIA

**IN/ROVOR 10/15/20 mg/SEP-20/01/PI**