

# Summary of Product Characteristics

## 1 NAME OF THE MEDICINAL PRODUCT

AirFluSal® Forspiro® 50 microgram/500 microgram/dose, inhalation powder, predispensed

## 2 QUALITATIVE AND QUANTITATIVE COMPOSITION

Each metered dose of AirFluSal® Forspiro® provides:

For 50 microgram/500 microgram/dose, inhalation powder, predispensed:

50 micrograms of salmeterol (as salmeterol xinafoate) and 500 micrograms of fluticasone propionate

Corresponding with a delivered dose of:

45 micrograms of Salmeterol (as salmeterol xinafoate) and 465 micrograms of fluticasone propionate

Excipient with known effect: lactose monohydrate: 11.95 mg per metered dose.

For the full list of excipients, see section 6.1.

## 3 PHARMACEUTICAL FORM

Inhalation powder, pre-dispensed.

White, homogenous powder.

The pre-dispensed powder, contained in blister, is delivered by a purple plastic dry-powder inhalation device.

## 4 CLINICAL PARTICULARS

### 4.1 Therapeutic Indications

#### **Asthma**

AirFluSal® Forspiro® is indicated in the regular treatment of asthma where use of a combination product (long-acting  $\beta_2$ agonist and inhaled corticosteroid) is appropriate:

- patients not adequately controlled with inhaled corticosteroids and 'as needed' inhaled short acting  $\beta_2$ agonist

or

- patients already adequately controlled on both inhaled corticosteroid and long-acting  $\beta_2$ agonist.

#### **Chronic Obstructive Pulmonary Disease (COPD)**

AirFluSal® Forspiro® is indicated for the symptomatic treatment of patients with COPD, with a FEV<sub>1</sub> <60% predicted normal (pre-bronchodilator) and a history of repeated exacerbations, who have significant symptoms despite regular bronchodilator therapy.

### 4.2 Posology and method of administration

#### Method of administration:

AirFluSal® Forspiro® is for inhalation use only.

Patients should be made aware that AirFluSal® Forspiro® must be used daily for optimum benefit, even when asymptomatic. Patients should be regularly reassessed by a doctor, so that the strength of AirFluSal® Forspiro® they are receiving remains optimal and is only changed on medical advice.

**The dose should be titrated to the lowest dose at which effective control of symptoms is maintained. Where the control of symptoms is maintained with the lowest strength of the combination given twice daily then the next step could include a test of inhaled corticosteroid alone.**

As an alternative, patients requiring a long acting  $\beta_2$ agonist could be titrated to AirFluSal<sup>®</sup> Forspiro<sup>®</sup> given once daily if, in the opinion of the prescriber, it would be adequate to maintain disease control. In the event of once daily dosing when the patient has a history of nocturnal symptoms the dose should be given at night and when the patient has a history of mainly daytime symptoms the dose should be given in the morning.

Patients should be given the strength of AirFluSal<sup>®</sup> Forspiro<sup>®</sup> containing the appropriate fluticasone propionate dosage for the severity of their disease. If an individual patient should require dosages outside the recommended regimen, appropriate doses of  $\beta_2$ agonist and/or corticosteroid should be prescribed.

Posology:

Recommended Doses:

***Asthma***

Adults and adolescents 12 years and older:

One inhalation of 250 micrograms fluticasone propionate and 50 micrograms salmeterol twice daily.

or

One inhalation of 500 micrograms fluticasone propionate and 50 micrograms salmeterol twice daily.

A short term trial of AirFluSal<sup>®</sup> Forspiro<sup>®</sup> may be considered as initial maintenance therapy in adults or adolescents with moderate persistent asthma (defined as patients with daily symptoms, daily rescue use and moderate to severe airflow limitation) for whom rapid control of asthma is essential. In these cases, the recommended initial dose is one inhalation of 100 micrograms fluticasone propionate and 50 micrograms salmeterol (given singly or as fixed combination) twice daily.

Once control of asthma is attained treatment should be reviewed and consideration given as to whether patients should be stepped down to an inhaled corticosteroid alone. Regular review of patients as treatment is stepped down is important.

A clear benefit has not been shown as compared to inhaled fluticasone propionate alone used as initial maintenance therapy when one or two of the criteria of severity are missing. In general inhaled corticosteroids remain the first line treatment for most patients. AirFluSal<sup>®</sup> Forspiro<sup>®</sup> is not intended for the initial management of mild asthma.

Salmeterol/fluticasone propionate 50 microgram/100 micrograms strength is not appropriate in adults and children with severe asthma; it is recommended to establish the appropriate dosage of inhaled corticosteroid before any fixed combination can be used in patients with severe asthma.

For dosages, which cannot be achieved with AirFluSal<sup>®</sup> Forspiro<sup>®</sup> other strengths of salmeterol/fluticasone medicinal products are available.

***COPD***

Adults:

One inhalation of 500 micrograms fluticasone propionate and 50 micrograms salmeterol twice daily.

***Special patient groups:***

There is no need to adjust the dose in elderly patients or in those with renal impairment. There are no data available for use of AirFluSal<sup>®</sup> Forspiro<sup>®</sup> in patients with hepatic impairment.

***Paediatric population:***

Asthma:

AirFluSal<sup>®</sup> Forspiro<sup>®</sup> should not be used in children.

COPD:

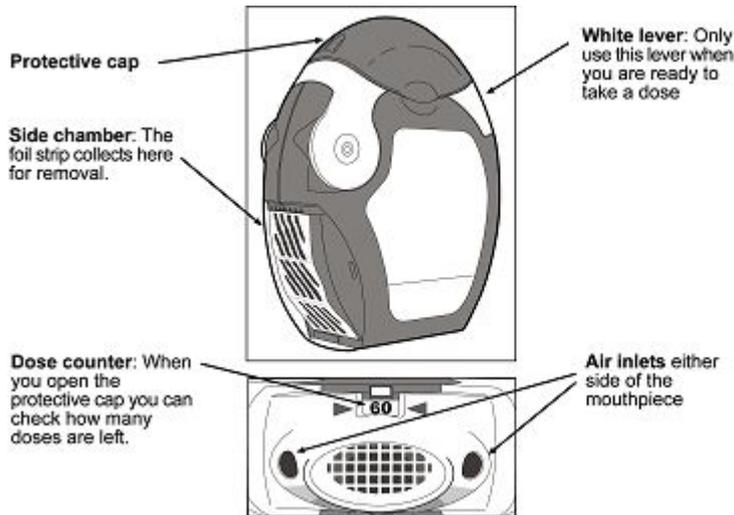
AirFluSal® Forspiro® should not be used in children and adolescents.

**Instructions for use:**

Patients should be demonstrated how to use the Forspiro inhaler and correct use should be checked regularly.

The inhaler contains 60 doses of powder medication in a coiled strip of foil. It has a dose counter which indicates how many doses are left counting down from 60 to 0. When the last 10 doses have been reached the numbers will be on a red background.

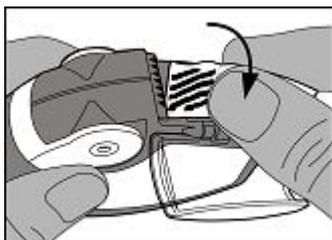
The inhaler is not refillable – it should be disposed of when it is empty and be replaced with a new one.



**Before using the inhaler**

- The transparent side chamber door should be opened.

The foil strip should be removed from the side chamber by carefully tearing away the full length of strip against the ‘teeth’ of the side chamber as shown below. The strip should **not be pulled or tugged**.



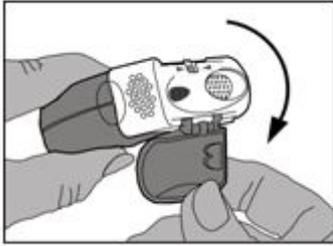
- The side chamber door should be closed and the used strip should be disposed of.

**Note:** As the inhaler is used the side chamber will gradually fill up with used strip. The foil strips with **black bars don't contain medication**. Eventually the numbered sections of the strip will appear in the side chamber. **There should never be more than 2 sections of foil strip** in the side chamber as they may cause the inhaler to jam. The strip should be torn away carefully as shown above, and disposed of safely.

**Using the inhaler**

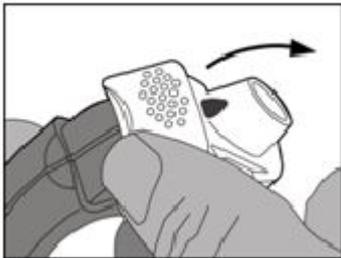
The inhaler should be held in hands, as seen in the pictures.

**1. Open**



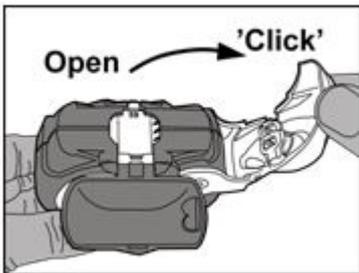
- The protective **cap should be opened downwards** to reveal the mouthpiece.
- The dose counter should be checked to see how many doses are left.

## 2. Preparation of the dose

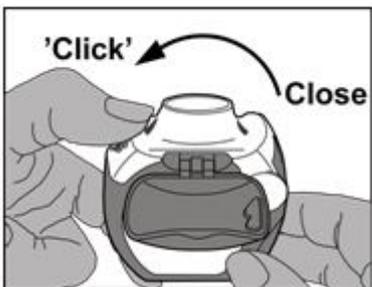


- The edge of the **white lever should be lifted up**. The side chamber should be closed.

**Note:** The white lever should only be operated when the patient is ready to inhale a dose of the medication. If the patient plays with the white lever he/she will waste doses.



- **Open:** The **white lever should be moved over fully** as far as it will go and **until it clicks**. This action moves a new dose into position with the number at the top.



- **Close:** Afterwards the **white lever should be closed fully** so that it **clicks** back into its original position. The inhaler is now ready for immediate use.

## 3. Inhalation of the dose

- Away from the inhaler mouthpiece, the patient should breathe out as much as is comfortable. It should **never be breathed directly into** the inhaler as this could affect the dose.

- The inhaler should be held level with the **protective cap pointing downwards**.

- The lips should be closed firmly around the mouthpiece.
- The patient should breathe in steadily and deeply through the inhaler, not through the nose.



- The inhaler should be removed from the mouth and the **breath should be held for 5-10 seconds** or as long as is possible without causing discomfort.
- Afterwards, the patient should breathe out slowly, **but not into the inhaler**.
- The protective cap should be closed over the mouthpiece.
- The mouth should be rinsed with water, which should be spat out afterwards. This may help to prevent getting fungal infection in the mouth and becoming hoarse.

### Cleaning

- The outside of the mouthpiece should be wiped with a clean, dry tissue if necessary.
- The inhaler should not be taken apart to clean it or for any other purpose!
- The inhaler parts must not be cleaned with water or wet wipes as dampness can affect the dose!
- Pins or other sharp objects must never be inserted into the mouthpiece, or any other part, as this may damage the inhaler!

Any unused medicinal product or waste material should be disposed of in accordance with local requirements.

### 4.3 Contraindications

Hypersensitivity to the active substances or to any of the excipients listed in section 6.1.

### 4.4 Special warnings and precautions for use

AirFluSal<sup>®</sup> Forspiro<sup>®</sup> should not be used to treat acute asthma symptoms for which a fast and short acting bronchodilator is required. Patients should be advised to have their inhaler to be used for relief in an acute asthma attack available at all times.

Patients should not be initiated on AirFluSal<sup>®</sup> Forspiro<sup>®</sup> during an exacerbation, or if they have significantly worsening or acutely deteriorating asthma.

Serious asthma-related adverse events and exacerbations may occur during treatment with AirFluSal<sup>®</sup> Forspiro<sup>®</sup>. Patients should be asked to continue treatment but to seek medical advice if asthma symptoms remain uncontrolled or worsen after initiation on AirFluSal<sup>®</sup> Forspiro<sup>®</sup>.

Increased requirements for use of reliever medication (short-acting bronchodilators), or decreased response to reliever medication indicate deterioration of control and patients should be reviewed by a physician.

Sudden and progressive deterioration in control of asthma is potentially life-threatening and the patient should undergo urgent medical assessment. Consideration should be given to increasing corticosteroid therapy.

Once asthma symptoms are controlled, consideration may be given to gradually reducing the dose of AirFluSal<sup>®</sup> Forspiro<sup>®</sup>. Regular review of patients as treatment is stepped down is important. The lowest effective dose of Salmeterol/Fluticasone should be used (see section 4.2).

For patients with COPD experiencing exacerbations, treatment with systemic corticosteroids is typically indicated, therefore patients should be instructed to seek medical attention if symptoms deteriorate with AirFluSal<sup>®</sup> Forspiro<sup>®</sup>.

Treatment with AirFluSal<sup>®</sup> Forspiro<sup>®</sup> should not be stopped abruptly in patients with asthma due to risk of exacerbation. Therapy should be down-titrated under physician supervision. For patients with COPD cessation of therapy may also be associated with symptomatic decompensation and should be supervised by a physician.

As with all inhaled medication containing corticosteroids, AirFluSal<sup>®</sup> Forspiro<sup>®</sup> should be administered with caution in patients with active or quiescent pulmonary tuberculosis and fungal, viral or other infections of the airway. Appropriate treatment should be promptly instituted, if indicated.

Rarely, AirFluSal<sup>®</sup> Forspiro<sup>®</sup> may cause cardiac arrhythmias e.g. supraventricular tachycardia, extrasystoles and atrial fibrillation, and a mild transient reduction in serum potassium at high therapeutic doses. AirFluSal<sup>®</sup> Forspiro<sup>®</sup> should be used with caution in patients with severe cardiovascular disorders or heart rhythm abnormalities and in patients with diabetes mellitus, thyrotoxicosis, uncorrected hypokalaemia or patients predisposed to low levels of serum potassium.

There have been very rare reports of increases in blood glucose levels (see section 4.8) and this should be considered when prescribing to patients with a history of diabetes mellitus.

As with other inhalation therapy paradoxical bronchospasm may occur with an immediate increase in wheezing and shortness of breath after dosing. Paradoxical bronchospasm responds to a rapid-acting bronchodilator and should be treated straightaway. AirFluSal<sup>®</sup> Forspiro<sup>®</sup> should be discontinued immediately, the patient assessed and alternative therapy instituted if necessary.

The pharmacological side effects of  $\beta_2$  agonist treatment, such as tremor, palpitations and headache, have been reported, but tend to be transient and reduce with regular therapy.

*For 50 microgram/250 microgram/dose, inhalation powder, predispensed:*

AirFluSal<sup>®</sup> Forspiro<sup>®</sup> contains 12.2 mg lactose/dose. This amount does not normally cause problems in lactose intolerant people.

*For 50 microgram/500 microgram/dose, inhalation powder, predispensed:*

AirFluSal<sup>®</sup> Forspiro<sup>®</sup> contains 11.95 mg lactose/dose. This amount does not normally cause problems in lactose intolerant people.

Systemic effects may occur with any inhaled corticosteroid, particularly at high doses prescribed for long periods. These effects are much less likely to occur than with oral corticosteroids. Possible systemic effects include Cushing's syndrome, Cushingoid features, adrenal suppression, decrease in bone mineral density, cataract and glaucoma and more rarely, a range of psychological or behavioural

effects including psychomotor hyperactivity, sleep disorders, anxiety, depression or aggression (particularly in children) (see *Paediatric population* sub-heading below for information on the systemic effects of inhaled corticosteroids in children and adolescents). **It is important, therefore, that the patient is reviewed regularly and the dose of inhaled corticosteroid is reduced to the lowest dose at which effective control of asthma is maintained.**

Prolonged treatment of patients with high doses of inhaled corticosteroids may result in adrenal suppression and acute adrenal crisis. Very rare cases of adrenal suppression and acute adrenal crisis have also been described with doses of fluticasone propionate between 500 and less than 1000 micrograms. Situations, which could potentially trigger acute adrenal crisis, include

trauma, surgery, infection or any rapid reduction in dosage. Presenting symptoms are typically vague and may include anorexia, abdominal pain, weight loss, tiredness, headache, nausea, vomiting, hypotension, decreased level of consciousness, hypoglycaemia, and seizures. Additional systemic corticosteroid cover should be considered during periods of stress or elective surgery.

The benefits of inhaled fluticasone propionate therapy should minimise the need for oral steroids, but patients transferring from oral steroids may remain at risk of impaired adrenal reserve for a considerable time. Therefore these patients should be treated with special care and adrenocortical function regularly monitored. Patients who have required high dose emergency corticosteroid therapy in the past may also be at risk. This possibility of residual impairment should always be borne in mind in emergency and elective situations likely to produce stress, and appropriate corticosteroid treatment must be considered. The extent of the adrenal impairment may require specialist advice before elective procedures.

Ritonavir can greatly increase the concentration of fluticasone propionate in plasma. Therefore, concomitant use should be avoided, unless the potential benefit to the patient outweighs the risk of systemic corticosteroid side effects in which case patients should be monitored for systemic corticosteroid side-effects. There is also an increased risk of systemic side-effects when combining fluticasone propionate with other potent CYP3A inhibitors, including cobicistat-containing products (see section 4.5).

#### Pneumonia in patients with COPD

An increase in the incidence of pneumonia, including pneumonia requiring hospitalisation, has been observed in patients with COPD receiving inhaled corticosteroids. There is some evidence of an increased risk of pneumonia with increasing steroid dose but this has not been demonstrated conclusively across all studies.

There is no conclusive clinical evidence for intra-class differences in the magnitude of the pneumonia risk among inhaled corticosteroid products.

Physicians should remain vigilant for the possible development of pneumonia in patients with COPD as the clinical features of such infections overlap with the symptoms of COPD exacerbations.

Risk factors for pneumonia in patients with COPD include current smoking, older age, low body mass index (BMI) and severe COPD.

Data from a large clinical trial (the Salmeterol Multi-Center Asthma Research Trial, SMART) suggested African-American patients were at increased risk of serious respiratory-related events or deaths when using salmeterol compared with placebo (see section 5.1). It is not known if this was due to pharmacogenetic or other factors. Patients of black African or Afro-Caribbean ancestry should therefore be asked to continue treatment but to seek medical advice if asthma symptoms remain uncontrolled or worsen whilst using AirFluSal<sup>®</sup> Forspiro<sup>®</sup>.

Concomitant use of systemic ketoconazole significantly increases systemic exposure to salmeterol. This may lead to an increase in the incidence of systemic effects (e.g. prolongation in the QTc interval and palpitations). Concomitant treatment with ketoconazole or other potent CYP3A4 inhibitors should therefore be avoided unless the benefits outweigh the potentially increased risk of systemic side effects of salmeterol treatment (see section 4.5).

#### Visual disturbance

Visual disturbance may be reported with systemic and topical corticosteroid use. If a patient presents with symptoms such as blurred vision or other visual disturbances, the patient should be considered for referral to an ophthalmologist for evaluation of possible causes which may include cataract, glaucoma or rare diseases such as central serous chorioretinopathy (CSCR) which have been reported after use of systemic and topical corticosteroids.

#### Paediatric Population

Children and adolescents <16 years taking high doses of fluticasone propionate (typically  $\geq 1000$  micrograms/day) may be at particular risk. Systemic effects may occur, particularly at high doses prescribed for long periods. Possible systemic effects include Cushing's syndrome, Cushingoid features, adrenal suppression, acute adrenal crisis and growth retardation in children and adolescents, and more rarely, a range of psychological or behavioural effects including psychomotor hyperactivity, sleep

disorders, anxiety, depression or aggression. Consideration should be given to referring the child or adolescent to a paediatric respiratory specialist.

It is recommended that the height of children receiving prolonged treatment with inhaled corticosteroid is regularly monitored.

**The dose of inhaled corticosteroid should be reduced to the lowest dose at which effective control of asthma is maintained.**

#### **4.5 Interaction with other medicinal products and other forms of interactions**

$\beta$  adrenergic blockers may weaken or antagonise the effect of salmeterol. Both non-selective and selective  $\beta$  blockers should be avoided unless there are compelling reasons for their use.

Potentially serious hypokalaemia may result from  $\beta_2$  agonist therapy. Particular caution is advised in acute severe asthma as this effect may be potentiated by concomitant treatment with xanthine derivatives, steroids and diuretics.

Concomitant use of other  $\beta$  adrenergic containing drugs can have a potentially additive effect.

##### Fluticasone Propionate

Under normal circumstances, low plasma concentrations of fluticasone propionate are achieved after inhaled dosing, due to extensive first pass metabolism and high systemic clearance mediated by cytochrome P450 3A4 in the gut and liver. Hence, clinically significant drug interactions mediated by fluticasone propionate are unlikely.

In an interaction study in healthy subjects with intranasal fluticasone propionate, ritonavir (a highly potent cytochrome P450 3A4 inhibitor) 100 mg b.i.d. increased the fluticasone propionate plasma concentrations several hundred fold, resulting in markedly reduced serum cortisol concentrations. Information about this interaction is lacking for inhaled fluticasone propionate, but a marked increase in fluticasone propionate plasma levels is expected. Cases of Cushing's syndrome and adrenal suppression have been reported. The combination should be avoided unless the benefit outweighs the increased risk of systemic glucocorticoid side-effects.

In a small study in healthy volunteers, the slightly less potent CYP3A inhibitor ketoconazole increased the exposure of fluticasone propionate after a single inhalation by 150%. This resulted in a greater reduction of plasma cortisol as compared with fluticasone propionate alone. Co-treatment with other potent CYP3A inhibitors, such as itraconazole and cobicistat-containing products, and moderate CYP3A inhibitors, such as erythromycin, is also expected to increase the systemic fluticasone propionate exposure and the risk of systemic side effects. The combination should be avoided unless the benefit outweighs the increased risk of systemic corticosteroid side-effects, in which case patients should be monitored for systemic corticosteroid side-effects.

##### Salmeterol

Potent CYP3A4 inhibitors

Co-administration of ketoconazole (400 mg orally once daily) and salmeterol (50 mcg inhaled twice daily) in 15 healthy subjects for 7 days resulted in a significant increase in plasma salmeterol exposure (1.4-fold C<sub>max</sub> and 15-fold AUC). This may lead to an increase in the incidence of other systemic effects of salmeterol treatment (e.g. prolongation of QTc interval and palpitations) compared with salmeterol or ketoconazole treatment alone (see Section 4.4).

Clinically significant effects were not seen on blood pressure, heart rate, blood glucose and blood potassium levels. Co-administration with ketoconazole did not increase the elimination half-life of salmeterol or increase salmeterol accumulation with repeat dosing.

The concomitant administration of ketoconazole should be avoided, unless the benefits outweigh the potentially increased risk of systemic side effects of salmeterol treatment. There is likely to be a similar risk of interaction with other potent CYP3A4 inhibitors (e.g. itraconazole, telithromycin, ritonavir).

Moderate CYP 3A4 inhibitors

Co-administration of erythromycin (500mg orally three times a day) and salmeterol (50mcg inhaled twice daily) in 15 healthy subjects for 6 days resulted in a small but non-statistically significant increase in salmeterol exposure (1.4-fold C<sub>max</sub> and 1.2-fold AUC). Co-administration with erythromycin was not associated with any serious adverse effects.

#### **4.6 Fertility, pregnancy and lactation**

Pregnancy

A moderate amount of data on pregnant women (between 300-1000 pregnancy outcomes) indicates no malformative or fetoneonatal toxicity of salmeterol and fluticasone propionate. Animal studies have shown reproductive toxicity after administration of  $\beta_2$  adrenoreceptor agonists and glucocorticosteroids (see section 5.3).

Administration of AirFluSal<sup>®</sup> Forspiro<sup>®</sup> to pregnant women should only be considered if the expected benefit to the mother is greater than any possible risk to the fetus.

The lowest effective dose of fluticasone propionate needed to maintain adequate asthma control should be used in the treatment of pregnant women.

Breastfeeding

It is unknown whether salmeterol and fluticasone propionate/metabolites are excreted in human milk.

Studies have shown that salmeterol and fluticasone propionate, and their metabolites, are excreted into the milk of lactating rats.

A risk to breastfed newborns/infants cannot be excluded. A decision must be made whether to discontinue breastfeeding or to discontinue AirFluSal<sup>®</sup> Forspiro<sup>®</sup> therapy taking into account the benefit of breastfeeding for the child and the benefit of therapy for the woman.

Fertility

There are no data in humans. However, animal studies showed no effects of salmeterol or fluticasone propionate on fertility.

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

AirFluSal<sup>®</sup> Forspiro<sup>®</sup> has no or negligible influence on the ability to drive and use machines.

**4.8 Undesirable effects**

As AirFluSal<sup>®</sup> Forspiro<sup>®</sup> contains salmeterol and fluticasone propionate, the type and severity of adverse reactions associated with each of the compounds may be expected. There is no incidence of additional adverse events following concurrent administration of the two compounds.

Adverse events which have been associated with salmeterol/fluticasone propionate are given below, listed by system organ class and 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).

Frequencies were derived from clinical trial data. The incidence in placebo was not taken into account.

<b>System Organ Class</b>	<b>Adverse Event</b>	<b>Frequency</b>
Infections & Infestations	Candidiasis of the mouth and throat	Common
	Pneumonia (in COPD patients)	Common <sup>1,3,5</sup>
	Bronchitis	Common <sup>1,3</sup>
	Oesophageal candidiasis	Rare
Immune System Disorders	Hypersensitivity reactions with the following manifestations:	
	Cutaneous hypersensitivity reactions	Uncommon

	Angioedema (mainly facial and oropharyngeal oedema)	Rare
	Respiratory symptoms (dyspnoea)	Uncommon
	Respiratory symptoms (bronchospasm)	Rare
	Anaphylactic reactions including anaphylactic shock	Rare
Endocrine Disorders	Cushing's syndrome, Cushingoid features, adrenal suppression, growth retardation in children and adolescents, decreased bone mineral density	Rare <sup>4</sup>
Metabolism & Nutrition Disorders	Hypokalaemia	Common <sup>3</sup>
	Hyperglycaemia	Uncommon <sup>4</sup>
Psychiatric Disorders	Anxiety	Uncommon
	Sleep disorders	Uncommon
	Behavioural changes, including psychomotor hyperactivity and irritability (predominantly in children)	Rare
	Depression, aggression (predominantly in children)	Not Known
Nervous System Disorders	Headache	Very Common <sup>1</sup>
	Tremor	Uncommon
Eye Disorders	Cataract	Uncommon
	Glaucoma	Rare <sup>4</sup>
	Vision, blurred (see also section 4.4)	Not Known
Cardiac Disorders	Palpitations	Uncommon
	Tachycardia	Uncommon
	Cardiac arrhythmias (including supraventricular tachycardia and extrasystoles).	Rare
	Atrial fibrillation	Uncommon
	Angina pectoris	Uncommon

Respiratory, Thoracic & Mediastinal Disorders	Nasopharyngitis	Very Common <sup>2,3</sup>
	Throat irritation	Common
	Hoarseness/dysphonia	Common
	Sinusitis	Common <sup>1,3</sup>
	Paradoxical bronchospasm	Rare <sup>4</sup>
Skin and subcutaneous tissue disorders	Contusions	Common <sup>1,3</sup>
Musculoskeletal & Connective Tissue Disorders	Muscle cramps	Common
	Traumatic fractures	Common <sup>1,3</sup>
	Arthralgia	Common
	Myalgia	Common

1 Reported commonly in placebo

2 Reported very commonly in placebo

3 Reported over 3 years in a COPD study

4 See section 4.4

5 See section 5.1.

#### Description of selected adverse reactions

The pharmacological side effects of  $\beta_2$  agonist treatment, such as tremor, palpitations and headache, have been reported, but tend to be transient and reduce with regular therapy.

As with other inhalation therapy paradoxical bronchospasm may occur with an immediate increase in wheezing and shortness of breath after dosing. Paradoxical bronchospasm responds to a rapid-acting bronchodilator and should be treated straightaway. AirFluSal<sup>®</sup> Forspiro<sup>®</sup> should be discontinued immediately, the patient assessed and alternative therapy instituted if necessary.

Due to the fluticasone propionate component, hoarseness and candidiasis (thrush) of the mouth and throat and, rarely, of the oesophagus can occur in some patients. Both hoarseness and incidence of candidiasis may be relieved by rinsing the mouth with water and/or brushing the teeth after using the product. Symptomatic mouth and throat candidiasis can be treated with topical anti-fungal therapy whilst still continuing with Salmeterol/Fluticasone.

#### Paediatric population

Possible systemic effects include Cushing's syndrome, Cushingoid features, adrenal suppression and growth retardation in children and adolescents (see section 4.4). Children may also experience anxiety, sleep disorders and behavioural changes, including hyperactivity and irritability.

#### Reporting of suspected adverse reactions

Reporting suspected adverse reactions after authorisation of the medicinal product is important. It allows continued monitoring of the benefit/risk balance of the medicinal product. Healthcare professionals are asked to report any suspected adverse reactions via HPRC Pharmacovigilance, Earlsfort Terrace, IRL - Dublin 2; Tel: +353 1 6764971; Fax: +353 1 6762517. Website: [www.hpra.ie](http://www.hpra.ie); E-mail: [medsafety@hpra.ie](mailto:medsafety@hpra.ie).

#### **4.9 Overdose**

There are no data available from clinical trials on overdose with AirFluSal<sup>®</sup> Forspiro<sup>®</sup>, however data on overdose with both drugs are given below:

The signs and symptoms of salmeterol overdose are dizziness, increases in systolic blood pressure, tremor, headache and tachycardia. If AirFluSal® Forspiro® therapy has to be withdrawn due to overdose of the beta agonist component of the drug, provision of appropriate replacement steroid therapy should be considered. Additionally, hypokalaemia can occur and therefore serum potassium levels should be monitored. Potassium replacement should be considered.

**Acute:** Acute inhalation of fluticasone propionate doses in excess of those recommended may lead to temporary suppression of adrenal function. This does not need emergency action as adrenal function is recovered in a few days, as verified by plasma cortisol measurements.

**Chronic overdose of inhaled fluticasone propionate:** Adrenal reserve should be monitored and treatment with a systemic corticosteroid may be necessary. When stabilised, treatment should be continued with an inhaled corticosteroid at the recommended dose. Refer to section 4.4: risk of adrenal suppression.

In cases of both acute and chronic fluticasone propionate overdose AirFluSal® Forspiro® therapy should be continued at a suitable dosage for symptom control.

## 5 PHARMACOLOGICAL PROPERTIES

### 5.1 Pharmacodynamic properties

Pharmacotherapeutic group: Adrenergics and other anti-asthmatics

ATC code: R03AK06

#### Mechanism of action:

AirFluSal® Forspiro® contains salmeterol and fluticasone propionate which have differing modes of action. The respective mechanisms of action of both drugs are discussed below:

#### **Salmeterol:**

Salmeterol is a selective long-acting (12 hour)  $\beta_2$  adrenoceptor agonist with a long side chain which binds to the exo-site of the receptor.

Salmeterol produces a longer duration of bronchodilation, lasting for at least 12 hours, than recommended doses of conventional short-acting  $\beta_2$  agonists.

#### **Fluticasone propionate:**

Fluticasone propionate given by inhalation at recommended doses has a glucocorticoid anti-inflammatory action within the lungs, resulting in reduced symptoms and exacerbations of asthma, with less adverse effects than when corticosteroids are administered systemically.

#### Clinical efficacy and safety:

#### **Asthma clinical trials**

A twelve month study (Gaining Optimal Asthma Control, GOAL), in 3416 adult and adolescent patients with persistent asthma, compared the safety and efficacy of salmeterol/fluticasone propionate (FP) versus inhaled corticosteroid (FP) alone to determine whether the goals of asthma management were achievable. Treatment was stepped up every 12 weeks until **\*\*total control** was achieved or the highest dose of study drug was reached. GOAL showed more patients treated with salmeterol/FP achieved asthma control than patients treated with ICS alone and this control was attained at a lower corticosteroid dose.

\**Well controlled* asthma was achieved more rapidly with salmeterol/FP than with ICS alone. The time on treatment for 50% of subjects to achieve a first individual *well controlled* week was 16 days for salmeterol/FP compared to 37 days for the ICS group. In the subset of steroid naive asthmatics the time to an individual *well controlled* week was 16 days in the salmeterol/FP treatment compared to 23 days following treatment with ICS.

The overall study results showed:

Percentage of Patients Attaining *Well Controlled (WC) and **Totally Controlled (TC) Asthma over 12 months				
Pre-Study Treatment	Salmetero I/FP		FP	
	WC	TC	WC	TC
No ICS (SABA alone)	78%	50%	70%	40%
Low dose ICS ( $\leq 500$ mcg BDP or equivalent/day)	75%	44%	60%	28%

<b>Medium dose ICS (&gt;500-1000mcg BDP or equivalent/day)</b>	62%	29%	47%	16%
<b>Pooled results across the 3 treatment levels</b>	71%	41%	59%	28%

\*Well controlled asthma: less than or equal to 2 days with symptom score greater than 1 (symptom score 1 defined as 'symptoms for one short period during the day'), SABA use on less than or equal to 2 days and less than or equal to 4 occasions/week, greater than or equal to 80% predicted morning peak expiratory flow, no night-time awakenings, no exacerbations and no side effects enforcing a change in therapy

\*\*Total control of asthma: no symptoms, no SABA use, greater than or equal to 80% predicted morning peak expiratory flow, no night-time awakenings, no exacerbations and no side effects enforcing a change in therapy

The results of this study suggest that salmeterol/fluticasone 50/100 microgram bd may be considered as initial maintenance therapy in patients with moderate persistent asthma for whom rapid control of asthma is deemed essential (see section 4.2). A double-blind, randomised, parallel group study in 318 patients with persistent asthma aged  $\geq 18$  years evaluated the safety and tolerability of administering two inhalations twice daily (double dose) of salmeterol/FP for two weeks. The study showed that doubling the inhalations of each strength of salmeterol/FP for up to 14 days resulted in a small increase in  $\beta$ agonist-related adverse events (tremor; 1 patient [1%] vs 0, palpitations; 6 [3%] vs 1 [ $<1\%$ ], muscle cramps; 6[3%] vs 1 [ $<1\%$ ]) and a similar incidence of inhaled corticosteroid related adverse events (e.g. oral candidiasis; 6 [6%] vs 16 [8%], hoarseness; 2 [2%] vs 4 [2%]) compared to one inhalation twice daily. The small increase in  $\beta$ agonist-related adverse events should be taken into account if doubling the dose of AirFluSal<sup>®</sup> Forspiro<sup>®</sup> is considered by the physician in adult patients requiring additional short-term (up to 14 days) inhaled corticosteroid therapy.

In trial SAM101667, in 158 children aged 6-16 years with symptomatic asthma, the combination of salmeterol/fluticasone propionate is equally efficacious to doubling the dose of fluticasone propionate regarding symptom control and lung function. This study was not designed to investigate the effect on exacerbations.

### COPD clinical trials

TORCH was a 3-year study to assess the effect of treatment with salmeterol/FP 50/500mcg bd, salmeterol 50mcg bd, FP 500mcg bd or placebo on all-cause mortality in patients with COPD. COPD patients with a baseline (pre-bronchodilator) FEV<sub>1</sub>  $<60\%$  of predicted normal were randomised to double-blind medication. During the study, patients were permitted usual COPD therapy with the exception of other inhaled corticosteroids, long-acting bronchodilators and long-term systemic corticosteroids. Survival status at 3 years was determined for all patients regardless of withdrawal from study medication. The primary endpoint was reduction in all cause mortality at 3 years for salmeterol/FP vs Placebo.

	<b>Placebo N = 1524</b>	<b>Salmeterol 50 N = 1521</b>	<b>FP 500 N = 1534</b>	<b>Salmeterol/FP 50/500 N = 1533</b>
All cause mortality at 3 years				
Number of deaths (%)	231 (15.2%)	205 (13.5%)	246 (16.0%)	193 (12.6%)
Hazard Ratio vs Placebo (CIs) p value	N/A	0.879 (0.73, 1.06) 0.180	1.060 (0.89, 1.27) 0.525	0.825 (0.68, 1.00 ) 0.052 <sup>1</sup>
Hazard Ratio salmeterol/FP 50/500 vs components (CIs) p value	N/A	0.932 (0.77, 1.13) 0.481	0.774 (0.64, 0.93) 0.007	N/A

<sup>1</sup> Non significant P value after adjustment for 2 interim analyses on the primary efficacy comparison from a log-rank analysis stratified by smoking status

There was a trend towards improved survival in subjects treated with salmeterol/FP compared with placebo over 3 years however this did not achieve the statistical significance level  $p \leq 0.05$ .

The percentage of patients who died within 3 years due to COPD-related causes was 6.0% for placebo, 6.1% for salmeterol, 6.9% for FP and 4.7% for salmeterol/FP.

The mean number of moderate to severe exacerbations per year was significantly reduced with salmeterol/FP as compared with treatment with salmeterol, FP and placebo (mean rate in the salmeterol/FP group 0.85 compared with 0.97 in the salmeterol group, 0.93 in the FP group and 1.13 in the placebo). This translates to a reduction in the rate of moderate to severe exacerbations of 25% (95% CI: 19% to 31%;  $p < 0.001$ ) compared with placebo, 12% compared with salmeterol (95% CI: 5% to 19%,  $p = 0.002$ ) and 9% compared with FP (95% CI: 1% to 16%,  $p = 0.024$ ). Salmeterol and FP significantly reduced exacerbation rates compared with placebo by 15% (95% CI: 7% to 22%;  $p < 0.001$ ) and 18% (95% CI: 11% to 24%;  $p < 0.001$ ) respectively.

Health Related Quality of Life, as measured by the St George's Respiratory Questionnaire (SGRQ) was improved by all active treatments in comparison with placebo. The average improvement over three years for salmeterol/fluticasone compared with placebo was -3.1 units (95% CI: -4.1 to -2.1;  $p < 0.001$ ), compared with salmeterol was -2.2 units ( $p < 0.001$ ) and compared with FP was -1.2 units ( $p = 0.017$ ). A 4-unit decrease is considered clinically relevant.

The estimated 3-year probability of having pneumonia reported as an adverse event was 12.3% for placebo, 13.3% for salmeterol, 18.3% for FP and 19.6% for salmeterol/FP (Hazard ratio for salmeterol/FP vs placebo: 1.64, 95% CI: 1.33 to 2.01,  $p < 0.001$ ). There was no increase in pneumonia related deaths; deaths while on treatment that were adjudicated as primarily

due to pneumonia were 7 for placebo, 9 for salmeterol, 13 for FP and 8 for salmeterol/FP. There was no significant difference in probability of bone fracture (5.1% placebo, 5.1% salmeterol, 5.4% FP and 6.3% salmeterol/FP; Hazard ratio for salmeterol/FP vs placebo: 1.22, 95% CI: 0.87 to 1.72, p=0.248).

Placebo-controlled clinical trials, over 6 and 12 months, have shown that regular use of salmeterol/FP 50/500 micrograms improves lung function and reduces breathlessness and the use of relief medication.

Studies SCO40043 and SCO100250 were randomised, double-blind, parallel-group, replicate studies comparing the effect of salmeterol/FP 50/250 micrograms bd (a dose not licensed for COPD treatment in the European Union) with salmeterol 50 micrograms bd on the annual rate of moderate/severe exacerbations in subjects with COPD with FEV1 less than 50% predicted and a history of exacerbations. Moderate/ severe exacerbations were defined as worsening symptoms that required treatment with oral corticosteroids and/or antibiotics or in-patient hospitalisation.

The trials had a 4 week run-in period during which all subjects received open-label salmeterol/ FP 50/250 to standardize COPD pharmacotherapy and stabilise disease prior to randomisation to blinded study medication for 52 weeks. Subjects were randomised 1:1 to salmeterol/ FP 50/250 (total ITT n=776) or salmeterol (total ITT n=778). Prior to run-in, subjects discontinued use of previous COPD medications except short-acting bronchodilators. The use of concurrent inhaled long-acting bronchodilators ( $\beta_2$  agonist and anticholinergic), ipratropium/salbutamol combination products, oral  $\beta_2$  agonists, and theophylline preparations were not allowed during the treatment period. Oral corticosteroids and antibiotics were allowed for the acute treatment of COPD exacerbations with specific guidelines for use. Subjects used salbutamol on an as-needed basis throughout the studies.

The results of both studies showed that treatment with salmeterol/FP 50/250 resulted in a significantly lower annual rate of moderate/severe COPD exacerbations compared with salmeterol (SCO40043: 1.06 and 1.53 per subject per year, respectively, rate ratio of 0.70, 95% CI: 0.58 to 0.83, p<0.001; SCO100250: 1.10 and 1.59 per subject per year, respectively, rate ratio of 0.70, 95% CI: 0.58 to 0.83, p<0.001). Findings for the secondary efficacy measures (time to first moderate/severe exacerbation, the annual rate of exacerbations requiring oral corticosteroids, and pre-dose morning (AM) FEV1) significantly favoured salmeterol/FP 50/250 micrograms bd over salmeterol. Adverse event profiles were similar with the exception of a higher incidence of pneumonias and known local side effects (candidiasis and dysphonia) in the salmeterol/FP 50/250 micrograms bd group compared with salmeterol. Pneumonia-related events were reported for 55 (7%) subjects in the salmeterol/FP 50/250 micrograms bd group and 25 (3%) in the salmeterol group. The increased incidence of reported pneumonia with salmeterol/FP 50/250 micrograms bd appears to be of similar magnitude to the incidence reported following treatment with salmeterol/FP 50/500 micrograms bd in TORCH.

#### The Salmeterol Multi-center Asthma Research Trial (SMART)

SMART was a multi-centre, randomised, double-blind, placebo-controlled, parallel group 28-week study in the US which randomised 13,176 patients to salmeterol (50 $\mu$ g twice daily) and 13,179 patients to placebo in addition to the patients' usual asthma therapy. Patients were enrolled if  $\geq 12$  years of age, with asthma and if currently using asthma medication (but not a LABA). Baseline ICS use at study entry was recorded, but not required in the study. The primary endpoint in SMART was the combined number of respiratory-related deaths and respiratory-related life-threatening experiences.

Key findings from SMART: primary endpoint

Patient group	Number of primary endpoint events /number of patients		Relative Risk (95% confidence intervals)
	salmeterol	placebo	
All patients	50/13,176	36/13,179	1.40 (0.91, 2.14)
Patients using inhaled steroids	23/6,127	19/6,138	1.21 (0.66, 2.23)
Patients not using inhaled steroids	27/7,049	17/7,041	1.60 (0.87, 2.93)
<b>African-American patients</b>	<b>20/2,366</b>	<b>5/2,319</b>	<b>4.10 (1.54, 10.90)</b>

(Risk in bold is statistically significant at the 95% level.)

Key findings from SMART by inhaled steroid use at baseline: secondary endpoints

	Number of secondary endpoint events /number of patients		Relative Risk (95% confidence intervals)
	salmeterol	placebo	
Respiratory -related death			
Patients using inhaled steroids	10/6127	5/6138	2.01 (0.69, 5.86)
Patients not using inhaled steroids	14/7049	6/7041	2.28 (0.88, 5.94)
Combined asthma-related death or life-threatening experience			
Patients using inhaled steroids	16/6127	13/6138	1.24 (0.60, 2.58)

<b>Patients not using inhaled steroids</b>	<b>21/7049</b>	<b>9/7041</b>	<b>2.39 (1.10, 5.22)</b>
Asthma-related death			
Patients using inhaled steroids	4/6127	3/6138	1.35 (0.30, 6.04)
Patients not using inhaled steroids	9/7049	0/7041	*

(\* = could not be calculated because of no events in placebo group. Risk in bold figures is statistically significant at the 95% level. The secondary endpoints in the table above reached statistical significance in the whole population.) The secondary endpoints of combined all-cause death or life-threatening experience, all cause death, or all cause hospitalisation did not reach statistical significance in the whole population.

## 5.2 Pharmacokinetic properties

For pharmacokinetic purposes each component can be considered separately.

### Salmeterol:

Salmeterol acts locally in the lung therefore plasma levels are not an indication of therapeutic effects. In addition there are only limited data available on the pharmacokinetics of salmeterol because of the technical difficulty of assaying the drug in plasma due to the low plasma concentrations at therapeutic doses (approximately 200 picograms/ml or less) achieved after inhaled dosing.

### Fluticasone propionate:

#### Absorption:

The absolute bioavailability of a single dose of inhaled fluticasone propionate in healthy subjects varies between approximately 5-11% of the nominal dose depending on the inhalation device used. In patients with asthma or COPD a lesser degree of systemic exposure to inhaled fluticasone propionate has been observed.

Systemic absorption occurs mainly through the lungs and is initially rapid then prolonged. The remainder of the inhaled dose may be swallowed but contributes minimally to systemic exposure due to the low aqueous solubility and pre-systemic metabolism, resulting in oral availability of less than 1%. There is a linear increase in systemic exposure with increasing inhaled dose.

#### Distribution:

The disposition of fluticasone propionate is characterised by high plasma clearance (1150ml/min), a large volume of distribution at steady-state (approximately 300l) and a terminal half-life of approximately 8 hours.

Plasma protein binding is 91%.

#### Biotransformation:

Fluticasone propionate is cleared very rapidly from the systemic circulation. The main pathway is metabolism to an inactive carboxylic acid metabolite, by the cytochrome P450 enzyme CYP3A4. Other unidentified metabolites are also found in the faeces.

#### Elimination:

The renal clearance of fluticasone propionate is negligible. Less than 5% of the dose is excreted in urine, mainly as metabolites. The main part of the dose is excreted in faeces as metabolites and unchanged drug.

## 5.3 Preclinical safety data

The only safety concerns for human use derived from animal studies of salmeterol xinafoate and fluticasone propionate given separately were effects associated with exaggerated pharmacological actions.

In animal reproduction studies, glucocorticosteroids have been shown to induce malformations (cleft palate, skeletal malformations). However, these animal experimental results do not seem to be relevant for man given recommended doses. Animal studies with salmeterol xinafoate have shown embryofetal toxicity only at high exposure levels. Following co-administration, increased incidences of transposed umbilical artery and incomplete ossification of occipital bone were found in rats at doses associated with known glucocorticoid-induced abnormalities.

## 6 PHARMACEUTICAL PARTICULARS

### 6.1 List of excipients

Lactose monohydrate

## **6.2 Incompatibilities**

Not applicable.

## **6.3 Shelf life**

2 years

## **6.4 Special precautions for storage**

Do not store above 25 °C.

## **6.5 Nature and contents of container**

The plastic materials of the inhaler are: acrylonitrile butadiene styrene, methyl methacrylate acrylonitrile butadiene styrene, polyoxymethylene and polybutylene teraphthalate.

Plastic inhalation device containing an OPA/Al/PVC-Al blister with 60 pre-metered doses of powder blend.

Pack sizes:

1, 2, 3, 4 or 6 devices containing 60 doses

Not all pack sizes may be marketed.

## **6.6 Special precautions for disposal and other handling**

Any unused medicinal product or waste material should be disposed of in accordance with local requirements.

## **7 MARKETING AUTHORISATION HOLDER**

Rowex Ltd  
Newtown  
Bantry  
Co. Cork  
Ireland

## **8 MARKETING AUTHORISATION NUMBER**

PA0711/237/002

## **9 DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUTHORISATION**

Date of first authorisation: 14<sup>th</sup> November 2014

Date of last renewal: 15<sup>th</sup> September 2019

## **10 DATE OF REVISION OF THE TEXT**

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