Front

To be sold by retail on the prescription of an Oncologist only

1. GENERIC NAME & BRAND NAME

Abiraterone Acetate Tablets IP 250mg

ABIRAGEN-250

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

Each Uncoated Tablet Contains:

Abiraterone Acetate I.P.	250mg
Excipients	q.s.

3. Dosage Form & Strength

250 mg tablets for oral use.

4. CLINICAL PARTICULARS

4.1 THERAPEUTIC INDICATIONS

Abiraterone acetate tablets is indicated:

- In combination with prednisone for the treatment of patients with metastatic castration-resistant prostate cancer (mCRPC) who have received prior chemotherapy containing docetaxel.
- For the treatment of mCRPC in adult men who are asymptomatic or mildly symptomatic after failure of androgen deprivation therapy in whom chemotherapy is not yet clinically indicated, with prednisone or prednisolone.

4.2 POSOLOGY AND METHOD OF ADMINISTRATION

The recommended dose is 1,000 mg (two 500 mg tablets) as a single daily dose that must not be taken with food. Taking the tablets with food increase systemic exposure to abiraterone.Dosage of prednisone or prednisolone. For mCRPC, abiraterone is used with 10 mg prednisone or prednisolone daily.

Recommended monitoring

Serum transaminases should be measured prior to starting treatment, every two weeks for the first three months of treatment and monthly thereafter. Blood pressure, serum potassium and fluid retention should be monitored monthly. However, patients with a significant risk for congestive heart failure should be monitored every 2 weeks for the first three months of treatment and monthly thereafter.

In patients with pre-existing hypokalaemia or those that develop hypokalaemia whilst being treated with abiraterone, consider maintaining the patient's potassium level at ≥ 4.0 mM. For patients who develop Grade ≥ 3 toxicities including hypertension, hypokalaemia, oedema and other non-mineralocorticoid toxicities, treatment should be with held and appropriate medical management should be instituted. Treatment with abiraterone should not be reinitiated until symptoms of the toxicity have resolved to Grade 1 or baseline.

In the event of a missed daily dose of either abiraterone, prednisone or prednisolone, treatment should be resumed the following day with the usual daily dose.

Hepatotoxicity

For patients who develop hepatotoxicity during treatment (alanine aminotransferase [ALT] increases or aspartate aminotransferase [AST] increases above 5 times the upper limit of normal [ULN]), treatment should be ithheld immediately. Re-treatment following return of liver function tests to the patient's baseline may be given at a reduced dose of 500 mg (one tablet) once daily. For patients being re-treated, serum transaminases should be monitored at a minimum of every two weeks for three months and monthly thereafter. If hepatotoxicity recurs at the reduced dose of 500 mg daily, treatment should be discontinued. If patients develop severe hepatotoxicity (ALT or AST 20 times the ULN) anytime while on therapy, treatment should be discontinued, and patients should not be re-treated.

Hepatic impairment

No dose adjustment is necessary for patients with pre-existing mild hepatic impairment, Child-Pugh Class A. Moderate hepatic impairment (Child-Pugh Class B) has been shown to increase the systemic exposure to abiraterone by approximately four-fold following single oral doses of abiraterone acetate 1,000 mg. There are no data on the clinical safety and efficacy of multiple doses of abiraterone acetate when administered to patients with moderate or severe hepatic impairment (Child-Pugh Class B or C). No dose adjustment can be predicted. The use of abiraterone should be cautiously assessed in patients with moderate hepatic impairment, in whom the benefit clearly should outweigh the possible risk. Abiraterone should not be used in patients with severe hepatic impairment.

Renal impairment

No dose adjustment is necessary for patients with renal impairment. However, there is no clinical experience in patients with prostate cancer and severe renal impairment. Caution is advised in these patients.

Paediatric population

There is no relevant use of abiraterone in the paediatric population.

Method of administration

- Abiraterone is for oral use.
- The tablets should be taken at least one hour before or at least two hours after eating. These should be swallowed whole with water.

4.3 CONTRAINDICATIONS

- Hypersensitivity to the active substance or to any of the excipients.
- Women who are or may potentially be pregnant
- Severe hepatic impairment (Child-Pugh Class C)
- Abiraterone with prednisone or prednisolone is contraindicated in combination with Ra-223.

4.4 SPECIAL WARNINGS AND PRECAUTIONS FOR USE

Hypertension, hypokalaemia, fluid retention and cardiac failure due to mineralocorticoid excess. Abiraterone may cause hypertension, hypokalaemia and fluid retention as aconsequence of increased mineralocorticoid levels resulting from CYP17 inhibition. Co-administration of a corticosteroid suppresses adrenocorticotropic hormone (ACTH) drive,resulting in a reduction in incidence and severity of these adverse reactions. Caution is required in treating patients whose underlying medical conditions might be compromised by increases in blood pressure, hypokalaemia (e.g., those on cardiac glycosides), or fluid retention (e.g., those with heart failure, severe or unstable angina pectoris, recentmyocardial infarction or ventricular arrhythmia and those with severe renal impairment).

Abiraterone should be used with caution in patients with a history of cardiovascular disease. The Phase 3 studies conducted with Abiraterone excluded patients with uncontrolledhypertension, clinically significant heart disease as evidenced by myocardial infarction, or arterial thrombotic events in the past 6 months, severe or unstable angina, or New York Heart Association Class (NYHA) III or IV heart failure (study 301) or Class II to IV heart failure (studies 3011 and 302) or cardiac ejection fraction measurement of < 50%. In studies 3011 and 302, patients with atrial fibrillation, or other cardiac arrhythmia requiring medical therapy were excluded. Safety in patients with left ventricular ejection fraction (LVEF) <50% or NYHA Class III or IV heart failure (in study 301) or NYHA Class II to IV heart failure (in studies 3011 and 302) was not established. Before treating patients with a significant risk for congestive heart failure (e.g. a history of cardiac failure, uncontrolled hypertension, or cardiac events such as ischaemic heart disease), consider obtaining an assessment of cardiac function (e.g. echocardiogram). Before treatment with Abiraterone, cardiac failure should be treated, and cardiac function optimised. Hypertension, hypokalaemia and fluid retention should be corrected and controlled. During treatment, blood pressure, serum potassium, fluid retention (weight gain, peripheral oedema), and other signs and symptoms of congestive heart failure should be monitored every 2 weeks for 3 months, then monthly thereafter and abnormalities corrected. QT prolongation has been observed in patients experiencing hypokalaemia in association with Abiraterone treatment. Assess cardiac function as clinically indicated,

institute appropriate management and consider discontinuation of this treatment if there is a clinically significant decrease in cardiac function.

Hepatotoxicity and hepatic impairment

Marked increases in liver enzymes leading to treatment discontinuation or dose modification occurred in controlled clinical studies. Serum transaminase levels should be measured prior to starting treatment, every two weeks for the first three months of treatment, and monthly thereafter. If clinical symptoms or signs suggestive of hepatotoxicity develop, serum transaminases should be measured immediately. If at any time the ALT or AST rises above 5 times the ULN, treatment should be interrupted immediately, and liver function closely monitored. Re-treatment may take place only after return of liver function tests to the patient's baseline and at a reduced dose level.

If patients develop severe hepatotoxicity (ALT or AST 20 times the ULN) anytime while on therapy, treatment should be discontinued, and patients should not be re-treated. Patients with active or symptomatic viral hepatitis were excluded from clinical trials; thus, there are no data to support the use of Abiraterone in this population. There are no data on the clinical safety and efficacy of multiple doses of abiraterone acetate when administered to patients with moderate or severe hepatic impairment (Child Pugh Class B or C). The use of Abiraterone should be cautiously assessed in patients with moderate hepatic impairment, in whom the benefit clearly should utweigh the possible

risk. Abiraterone should not be used in patients with severe hepatic impairment.

There have been rare post-marketing reports of acute liver failure and hepatitis fulminant, some with fatal outcome.

Corticosteroid withdrawal and coverage of stress situations

Caution is advised and monitoring for adrenocortical insufficiency should occur if patients are withdrawn from prednisone or prednisolone. If Abiraterone is continued after corticosteroids are withdrawn, patients should be monitored for symptoms of mineralocorticoid excess.

In patients on prednisone or prednisolone who are subjected to unusual stress, an increased dose of corticosteroids maybe indicated before, during and after the stressful situation.

Bone density

Decreased bone density may occur in men with metastatic advanced prostate cancer. The use of Abiraterone in combination with a glucocorticoid could increase this effect. Prior use of ketoconazole. Lower rates of response might be expected in patients previously treated with ketoconazole for prostate cancer.

Hyperglycaemia

The use of glucocorticoids could increase hyperglycaemic; therefore, blood sugar should be measured frequently in patients with diabetes.

Hypoglycaemia

Cases of hypoglycaemia have been reported when Abiraterone plus prednisone/prednisolone was administered to patients with pre-existing diabetes receiving pioglitazone or repaglinide; therefore, blood sugar should be monitored in patients with diabetes.

Use with chemotherapy

The safety and efficacy of concomitant use of abiraterone with cytotoxic chemotherapy has not been established.

Intolerance to excipients

This medicinal product contains lactose. Patients with rare hereditary problems of galactose intolerance, the Lapp lactase deficiency or glucose-galactose malabsorption should not take this medicine. This medicinal product also contains more than 1.18 mmol (or 27 mg) sodium per dose of two tablets. To be taken into consideration by patients on a controlled sodium diet.

Potential risks

Anaemia and sexual dysfunction may occur in men with metastatic prostate cancer including those undergoing treatment with Abiraterone.

Skeletal muscle effects

Cases of myopathy and rhabdomyalysis have been reported in patients treated with Abiraterone. Most cases developed within the first 6 months of treatment and recovered after Abiraterone withdrawal. Caution is ecommended in patients concomitantly treated with medicinal products known to be associated with myopathy/rhabdomyolysis.

Interactions with other medicinal products.

Strong inducers of CYP3A4 during treatment are to be avoided unless there is no therapeutic alternative, due to risk of decreased exposure to abiraterone.

Combination of abiraterone and prednisone/prednisolone with Ra-223

Treatment with abiraterone and prednisone/prednisolone in combination with Ra-223 is contraindicated due to an increased risk of fractures and a trend for increased mortality among asymptomatic or mildly symptomatic prostate cancer patients as observed in clinical trials.

It is recommended that subsequent treatment with Ra-223 is not initiated for at least 5 days after the last administration of abiraterone in combination with prednisone/prednisolone.

4.5 DRUG INTERACTIONS

Effect of food on abiraterone acetate

Administration with food significantly increases the absorption of abiraterone acetate. The efficacy and safety when given with food have not been established therefore this medicinal product must not be taken with food.

Interactions with other medicinal products

Potential for other medicinal products to affect abiraterone exposures

In a clinical pharmacokinetic interaction study of healthy subjects pre-treated with a strong CYP3A4 inducer rifampicin,600 mg daily for 6 days followed by a single dose of abiraterone acetate 1,000 mg, the mean plasma AUC∞ of abiraterone was decreased by 55%.

Strong inducers of CYP3A4 (e.g., phenytoin, carbamazepine, rifampicin, rifabutin, rifapentine, phenobarbital, St John's wort (Hypericum perforatum)) during treatment are to be avoided, unless there is no therapeutic alternative.

In a separate clinical pharmacokinetic interaction study of healthy subjects, co-administration of ketoconazole, a strong inhibitor of CYP3A4, had no clinically meaningful effect on the pharmacokinetics of abiraterone.

Potential to affect exposures to other medicinal products

Abiraterone is an inhibitor of the hepatic drug-metabolising enzymes CYP2D6 and CYP2C8.

In a study to determine the effects of abiraterone acetate (plus prednisone) on a single dose of the CYP2D6 substrate dextromethorphan, the systemic exposure (AUC) of dextromethorphan was increased approximately 2.9-fold. The AUC24 for dextrorphan, the active metabolite of dextromethorphan, increased approximately 33%.

Caution is advised when administering with medicinal products activated by or metabolised by CYP2D6, particularly with medicinal products that have a narrow therapeutic index. Dose reduction of medicinal products with a narrow therapeutic index that are metabolised by CYP2D6 should be considered. Examples of medicinal products metabolised by CYP2D6include metoprolol, propranolol, desipramine, venlafaxine, haloperidol, risperidone, propafenone, fleceinide, codeine, oxycodone and tramadol (the latter three medicinal products requiring CYP2D6 to form their active analgesic metabolites).

In a CYP2C8 drug drug interaction trial in healthy subjects, the AUC of pioglitazone was increased by 46% and the AUCs for M III and M IV, the active metabolites of pioglitazone, each decreased by 10% when pioglitazone was given together with a single dose of 1,000 mg abiraterone acetate. Patients should be monitored for signs of toxicity related to a CYP2C8 substrate with a narrow therapeutic index if used concomitantly. Examples of medicinal products metabolised by CYP2C8 include pioglitazone and repaglinide.

In vitro, the major metabolites abiraterone sulphate and N-oxide abiraterone sulphate were shown to inhibit the hepatic

Use with products known to prolong QT interval

Since androgen deprivation treatment may prolong the QT interval, caution is advised when administering Abiraterone with medicinal products known to prolong the QT interval or medicinal products able to induce torsades de pointes such as class IA (e.g. quinidine, disopyramide) or class III (e.g. amiodarone, sotalol, dofetilide, ibutilide) antiarrhythmic medicinal products, methadone, moxifloxacin, antipsychotics, etc.

Use with Spironolactone

Spironolatone binds to the androgen receptor and may increase prostate specific antigen (PSA) levels. Use with Abiraterone is not recommended

4.6 USE IN SPECIAL POPULATIONS (SUCH AS PREGNANT WOMEN, LACTATING WOMEN, PAEDIATRIC PATIENTS, GERIATRIC PATIENTS ETC.)

Women of childbearing potential

There are no human data on the use of Abiraterone in pregnancy and this medicinal product is not for use in women of childbearing potential.

Contraception in males and females

It is not known whether abiraterone or its metabolites are present in semen. A condom is required if the patient is engaged in sexual activity with a pregnant woman. If the patient is engaged in sex with a woman of childbearing potential, a condom is required along with another effective contraceptive method. Studies in animals have shown reproductive toxicity.

Pregnancy

Abiraterone is not for use in women and is contraindicated in women who are or may potentially be pregnant.

Breast-feeding

Abiraterone is not for use in women.

Fertility

Abiraterone affected fertility in male and female rats, but these effects were fully reversible.

4.7 EFFECTS ON ABILITY TO DRIVE AND USE MACHINES

Abiraterone has no or negligible influence on the ability to drive and use machines

4.8 UNDESIRABLE EFFECTS

Adverse reactions observed during clinical studies and post-marketing experience are listed below by frequency category. Frequency categories are defined as follows: very common (≥ 1/10); common (≥ 1/100 to < 1/10); uncommon (≥ 1/1,000 to < 1/100); rare (≥ 1/10,000 to < 1/1,000); very rare (< 1/10,000) and not known (frequency cannot be estimated from the available data).

Within each frequency grouping, undesirable effects are presented in order of decreasing seriousness. uptake transporter OATP1B1 and as a consequence it may increase the concentrations of medicinal products eliminated by OATP1B1. There are no clinical data available to confirm transporter-based interaction.

System Organ Class	Adverse reaction and frequency
Infections and infestations	very common: urinary tract infection common: sepsis
Endocrine disorders	uncommon: adrenal insufficiency
Metabolism and nutrition disorders	very common: hypokalaemia common: hyper triglyceridaemia
Cardiac disorders	common: cardiac failure*, angina pectoris, atrial fibrillation, tachycardia uncommon: other arrhythmias not known: myocardial infarction, QT prolongation
Vascular disorders	very common: hypertension
Respiratory, thoracic and mediastinal disorders	rare: allergic alveolitisa
Gastrointestinal disorders	very common: diarrhoea common: dyspepsiavery
Hepatobiliary disorders	common: alanine aminotransferase increased and/or aspartate aminotransferase increasedb rare: hepatitis fulminant, acute hepatic failure
Skin and subcutaneous tissue disorders	common: rash
Musculoskeletal and connective tissue disorders	uncommon: myopathy, rhabdomyolysis
Renal and urinary disorders	common: haematuria
General disorders and administration site conditions	very common: oedema peripheral
Injury, poisoning and procedural complications	common: fractures**

* Cardiac failure also includes congestive heart failure, left ventricular dysfunction and ejection fraction decreased

** Fractures includes osteoporosis and all fractures with the exception of pathological fractures

a Spontaneous report from post-marketing experience

b Alanine aminotransferase increased and/or aspartate aminotransferase increased includes ALT increased, AST increased, and hepatic function abnormal.

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Spec.: 54 ± 15% Gsm Maplitho Paper

Folding Size: 54x77 mm

Reason for change: Change in brand name design and artwork code revised

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Reporting of suspected adverse reactions
Health care professionals, patients/consumers are advised to closely monitor the possibility of the above ADRs associated with the use of the above drugs. If such reactions are encountered, please report to the Hetero either by filling of Suspect Adverse Drug Reactions Reporting Form (form.heteroworld.com) or by Hetero Helpline No.1800-120-8689 and for all India safety cases and complaints, please write to drugsatetyinda@heterodrugs.com.
For Product Complaints/Adverse events or Queries please write to
webmasterindia@abbott.com

4.9 OVERDOSAGE
Human experience of overdose with abiraterone is limited.
There is no specific antidote. In the event of an overdose, administration should be withheld and general supportive measures undertaken, including monitoring for arrhythmias, hypokalaemia and for signs and symptoms of fluid retention. Liver function also should be assessed.

5.0 PHARMACOLOGICAL PROPERTIES

5.1 MECHANISM OF ACTION
Abiraterone acetate is converted in vivo to abiraterone, an androgen biosynthesis inhibitor. Specifically, abiraterone selectively inhibits the enzyme 17α-hydroxylase/C17,20-lyase (CYP17). This enzyme is expressed in and is required for androgen biosynthesis in testicular, adrenal and prostatic tumour tissues. CYP17 catalyses the conversion of pregnenolone and progesterone into testosterone precursors, DHEA and androstenedione, respectively, by 17α-hydroxylation and cleavage of the C17,20 bond. CYP17 inhibition also results in increased mineralocorticoid production by the adrenals.
Androgen-sensitive prostatic carcinoma responds to treatment that decreases androgen levels. Androgen deprivation therapies, such as treatment with LHRH analogues or orchiectomy, decrease androgen production in the testes but do not affect androgen production by the adrenals or in the tumour. Treatment with abiraterone decreases serum testosterone to undetectable levels (using commercial assays) when given with LHRH analogues (or orchiectomy).

5.2 PHARMACODYNAMIC PROPERTIES
Abiraterone decreases serum testosterone and other androgens to levels lower than those achieved by the use of LHRH analogues alone or by orchiectomy. This results from the selective inhibition of the CYP17 enzyme required for androgen biosynthesis. PSA serves as a biomarker in patients with prostate cancer. In a Phase 3 clinical study of patients who failed prior chemotherapy with taxanes, 38% of patients treated with abiraterone acetate, versus 10% of patients treated with placebo, had at least a 50% decline from baseline in PSA levels.

5.3 PHARMACOKINETIC PROPERTIES
Following administration of abiraterone acetate, the pharmacokinetics of abiraterone and abiraterone acetate have been studied in healthy subjects, patients with metastatic advanced prostate cancer and subjects without cancer with hepatic or renal impairment. Abiraterone acetate is rapidly converted in vivo to abiraterone, an androgen biosynthesis inhibitor.

Absorption
Following oral administration of abiraterone acetate in the fasting state, the time to reach maximum plasma abiraterone concentration is approximately 2 hours.
Administration of abiraterone acetate with food, compared with administration in a fasted state, results in up to a 10-fold (AUC) and up to a 17-fold (Cmax) increase in mean systemic exposure of abiraterone, depending on the fat content of the meal. Given the normal variation in the content and composition of meals, taking abiraterone with meals has the potential to result in highly variable exposures. Therefore, abiraterone must not be taken with food. It should be taken at least one hour before or at least two hours after eating. The tablets should be swallowed whole with water.

Distribution
The plasma protein binding of 14C-abiraterone in human plasma is 99.8%. The apparent volume of distribution is approximately 5,630 L, suggesting that abiraterone extensively distributes to peripheral tissues.

Biotransformation
Following oral administration of 14C-abiraterone acetate as capsules, abiraterone acetate is hydrolysed to abiraterone, which then undergoes metabolism including sulphation, hydroxylation and oxidation primarily in the liver. The majority of circulating radioactivity (approximately 92%) is found in the form of metabolites of abiraterone. Of 15 detectable metabolites, 2 main metabolites, abiraterone sulphate and N-oxide abiraterone sulphate, each represents approximately43% of total radioactivity.

Elimination
The mean half-life of abiraterone in plasma is approximately 15 hours based on data from healthy subjects. Following oral administration of 14C-abiraterone acetate 1,000 mg, approximately 88% of the radioactive dose is recovered in faeces and approximately 5% in urine. The major compounds present in faeces are unchanged abiraterone acetate and abiraterone (approximately 55% and 22% of the administered dose, respectively).

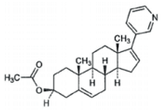
Hepatic impairment
The pharmacokinetics of abiraterone acetate was examined in subjects with pre-existing mild or moderate hepatic impairment (Child-Pugh Class A and B, respectively) and in healthy control subjects. Systemic exposure to abiraterone after a single oral 1,000 mg dose increased by approximately 11% and 260% in subjects with mild and moderate pre-existing hepatic impairment, respectively. The mean half-life of abiraterone is prolonged to approximately 18 hours in subjects with mild hepatic impairment and to approximately 19 hours in subjects with moderate hepatic impairment.
In another trial, the pharmacokinetics of abiraterone were examined in subjects with pre-existing severe (n = 8) hepatic impairment (Child-Pugh Class C) and in 8 healthy control subjects with normal hepatic function. The AUC to abiraterone increased by approximately 600% and the fraction of free drug increased by 80% in subjects with severe hepatic impairment compared to subjects with normal hepatic function.
No dose adjustment is necessary for patients with pre-existing mild hepatic impairment.
The use of abiraterone acetate should be cautiously assessed in patients with moderate hepatic impairment in whom the benefit clearly should outweigh the possible risk. Abiraterone acetate should not be used in patients with severe hepatic impairment.
For patients who develop hepatotoxicity during treatment, suspension of treatment and dose adjustment may be required.

Renal impairment
The pharmacokinetics of abiraterone acetate was compared in patients with end-stage renal disease on a stable haemodialysis schedule versus matched control subjects with normal renal function. Systemic exposure to abiraterone after a single oral 1,000 mg dose did not increase in subjects with end-stage renal disease on dialysis. Administration inpatients with renal impairment, including severe renal impairment, does not require dose reduction. However, there is no clinical experience in patients with prostate cancer and severe renal impairment. Caution is advised in these patients.

6.0 NONCLINICAL PROPERTIES

6.1 ANIMAL TOXICOLOGY OR PHARMACOLOGY
In all animal toxicity studies, circulating testosterone levels were significantly reduced. As a result, reduction in organ weights and morphological and/or histopathological changes in the reproductive organs, and the adrenal, pituitary and mammary glands were observed. All changes showed complete or partial reversibility. The changes in the reproductive organs and androgen-sensitive organs are consistent with the pharmacology of abiraterone. All treatment-related hormonal changes reversed or were shown to be resolving after a 4-week recovery period.
In fertility studies in both male and female rats, abiraterone acetate reduced fertility, which was completely reversible in 4to 16 weeks after abiraterone acetate was stopped. In a developmental toxicity study in the rat, abiraterone acetate affected pregnancy including reduced foetal weight and survival. Effects on the external genitalia were observed though abiraterone acetate was not teratogenic.
In these fertility and developmental toxicity studies performed in the rat, all effects were related to the pharmacological activity of abiraterone. Aside from reproductive organ changes seen in all animal toxicology studies, non-clinical data reveal no special hazard for humans based on conventional studies of safety pharmacology, repeated dose toxicity, genotoxicity and carcinogenic potential. Abiraterone acetate was not carcinogenic in a 6-month study in the transgenic (Tg.rasH2) mouse. In a 24-month carcinogenicity study in the rat, abiraterone acetate increased the incidence of interstitial cell neoplasms in the testes. This finding is considered related to the pharmacological action of abiraterone and rat specific. Abiraterone acetate was not carcinogenic in female rats.The active substance, abiraterone, shows an environmental risk for the aquatic environment, especially to fish.

7.0 DESCRIPTION
Abiraterone acetate, the active ingredient of abiraterone tablet is the acetyl ester of abiraterone. Abiraterone is an inhibitor of CYP17 (17α-hydroxylase/C17,20-lyase). Abiraterone acetate is designated chemically as (3β)-17-(3-pyridinyl) androsta-5,16-dien-3-yl acetate and its structure is:



8.0 PHARMACEUTICAL PARTICULARS

8.1 INCOMPATIBILITIES
Not applicable.

8.2 Shelf-life
24 Months

8.3 PACKING INFORMATION
120's HDPE Container [150 cc HDPE Container (HW) with 38 mm Child Resistant Closure, Silica Gel Bags 1 gm and Absorbent Cotton]

8.4 STORAGE AND HANDLING INSTRUCTIONS
Store protected from light and moisture, at a temperature not exceeding 30°C.
Keep out of reach of children.

9.0 PATIENT COUNSELLING INFORMATION
Hypokalaemia, Fluid Retention, and cardiovascular adverse reactions
Inform patients that abiraterone is associated with hypertension, hypokalaemia, and peripheral edema that may lead to QT prolongation and Torsades de Pointes in patients who develop hypokalaemia while taking abiraterone.
Advise patients that their blood pressure, serum potassium and signs and symptoms of fluid retention will be monitored clinically at least monthly. Advise patients to adhere to corticosteroids and to report symptoms of hypertension, hypokalaemia, or edema to their healthcare provider.

Adrenocortical insufficiency
Inform patients that abiraterone with methylprednisolone is associated with adrenal insufficiency. Advise patients to report symptoms of adrenocortical insufficiency to their healthcare provider.

Hepatotoxicity
Inform patients that abiraterone is associated with severe hepatotoxicity. Inform patients that their liver function will be monitored using blood tests. Advise patients to immediately report symptoms of hepatotoxicity to their healthcare provider.

Use in Combination with Radium Ra 223 Dichloride
Advise patients that radium Ra 223 dichloride showed an increase in mortality and an increased rate of fracture when used in combination with abiraterone acetate plus a corticosteroid. Inform patients to speak with their healthcare provider about any other medications or treatment they are currently taking for prostate cancer.
Embryo-Fetal Toxicity
- Inform patients that abiraterone may harm a developing fetus and can cause loss of pregnancy.
- Advise males with female partners of reproductive potential to use effective contraception during treatment and for 3 weeks after the final dose of abiraterone
- Advise females who are pregnant or women who may be pregnant not to handle abiraterone tablets if broken, crushed, or damaged without protection, e.g., gloves.

Infertility
Advise male patients that abiraterone may impair fertility

10. DETAILS OF MANUFACTURER

MANUFACTURED BY:
Hetero Labs Limited (Unit-I)
Village: Kalyanpur, Chakkan Road,
Tehsil: Baddi, Distt.: Solan,
Himachal Pradesh-173 205.

11. DETAILS OF PERMISSION OR LICENCE NUMBER WITH DATE
MNB/06/328 Dated 21/01/2021

12. DATE OF REVISION
09-09-2024

GENYGI

Marketed by:
Genygi Life Sciences Private Limited
SS - 29, Second Floor, Aditya Mega Mall,
Plot # 9D, Delhi - 110032

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Dimension: W 108 mm x H 308 mm

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Spec.: 54 ± 15% Gsm Maplitho Paper
Folding Size: 54x77 mm
Reason for change: Change in brand name design and artwork code revised