

1. Name of the medicinal product

Torvastatin 10 mg Film-coated Tablets

2. Qualitative and quantitative composition

Each film-coated tablet contains 10 mg of Torvastatin as Torvastatin calcium trihydrate.

Excipient with known effect:

Contains 38.3 mg lactose monohydrate, 2.8 mg sodium.

For the full list of excipients, see section 6.1.

3. Pharmaceutical form

Film-coated tablet.

White to off white, film-coated oval tablets about 6.1 mm wide and about 8.6 mm long, debossed with 'A30' on one side and plain on other side

4. Clinical particulars

4.1 Therapeutic indications

Hypercholesterolaemia:

Torvastatin is indicated as an adjunct to diet for reduction of elevated total cholesterol (total-C), LDL-cholesterol (LDL-C), apolipoprotein B, and triglycerides in adults, adolescents and children aged 10 years or older with primary hypercholesterolaemia including familial hypercholesterolaemia (heterozygous variant) or combined (mixed) hyperlipidaemia (Corresponding to Types IIa and IIb of the Fredrickson classification) when response to diet and other nonpharmacological measures is inadequate.

Torvastatin is also indicated to reduce total-C and LDL-C in adults with homozygous familial hypercholesterolaemia as an adjunct to other lipid-lowering treatments (e.g. LDL apheresis) or if such treatments are unavailable.

Prevention of cardiovascular disease

Prevention of cardiovascular events in adult patients estimated to have a high risk for a first cardiovascular event (see section 5.1), as an adjunct to correction of other risk factors.

4.2 Posology and method of administration

Posology

The patient should be placed on a standard cholesterol-lowering diet before receiving Torvastatin and should continue on this diet during treatment with Torvastatin.

The dose should be individualised according to baseline LDL-C levels, the goal of therapy, and patient response.

The usual starting dose is 10 mg once a day. Adjustment of dose should be made at intervals of 4 weeks or more. The maximum dose is 80 mg once a day.

Primary Hypercholesterolaemia and Combined (Mixed) Hyperlipidaemia

The majority of patients are controlled with 10 mg Torvastatin once a day. A therapeutic response is evident within 2 weeks, and the maximum therapeutic response is usually achieved within 4 weeks. The response is maintained during chronic therapy.

Heterozygous Familial Hypercholesterolaemia

Patients should be started with Torvastatin 10 mg daily. Doses should be individualised and adjusted every 4 weeks to 40 mg daily. Thereafter, either the dose may be increased to a maximum of 80 mg daily or a bile acid sequestrant may be combined with 40 mg Torvastatin once daily.

Homozygous Familial Hypercholesterolaemia

Only limited data are available (see section 5.1).

The dose of Torvastatin in patients with homozygous familial hypercholesterolemia is 10 to 80 mg daily (see section 5.1). Torvastatin should be used as an adjunct to other lipid-lowering treatments (e.g. LDL apheresis) in these patients or if such treatments are unavailable.

Prevention of Cardiovascular disease

In the primary prevention trials, the dose was 10mg/day. Higher doses may be necessary in order to attain (LDL-) cholesterol levels according to current guidelines.

Renal impairment

No adjustment of dose is required (see section 4.4).

Hepatic impairment

Torvastatin should be used with caution in patients with hepatic impairment (see sections 4.4 and 5.2). Torvastatin is contraindicated in patients with active liver disease (see section 4.3).

Co-administration with other medicines

In patients taking hepatitis C antiviral agents elbasvir/grazoprevir concomitantly with Torvastatin, the dose of Torvastatin should not exceed 20 mg/day (see sections 4.4 and 4.5).

Use of Torvastatin is not recommended in patients taking letermovir co-administered with ciclosporin (see sections 4.4 and 4.5).

Elderly

Efficacy and safety in patients older than 70 using recommended doses are similar to those seen in the general population.

Paediatric population

Hypercholesterolaemia:

Paediatric use should only be carried out by physicians experienced in the treatment of paediatric hyperlipidaemia and patients should be re-evaluated on a regular basis to assess progress.

For patients with Heterozygous Familial Hypercholesterolemia aged 10 years and above, the recommended starting dose of Torvastatin is 10 mg per day (see section 5.1). The dose may be increased to 80 mg daily, according to the response and tolerability. Doses should be individualised according to the recommended goal of therapy. Adjustments should be made at intervals of 4 weeks or more. The dose titration to 80 mg daily is supported by study data in adults and by limited clinical data from studies in children with Heterozygous Familial Hypercholesterolemia (see sections 4.8 and 5.1).

There are limited safety and efficacy data available in children with Heterozygous Familial Hypercholesterolemia between 6 to 10 years of age derived from open-label studies. Torvastatin is not indicated in the treatment of patients below the age of 10 years. Currently available data are described in sections 4.8, 5.1 and 5.2 but no recommendation on a posology can be made.

Other pharmaceutical forms/strengths may be more appropriate for this population.

Method of administration

Torvastatin is for oral administration. Each daily dose of Torvastatin is given all at once and may be given at any time of day with or without food.

4.3 Contraindications

Torvastatin is contraindicated in patients:

- with hypersensitivity to the active substance or to any of the excipients listed in section 6.1
- with active liver disease or unexplained persistent elevations of serum transaminases exceeding 3 times the upper limit of normal
- during pregnancy, while breast-feeding and in women of child-bearing potential not using appropriate contraceptive measures (see section 4.6)
- treated with the hepatitis C antivirals glecaprevir/pibrentasvir

4.4 Special warnings and precautions for use

Hepatic impairment

Liver function tests should be performed before the initiation of treatment and periodically thereafter. Patients who develop any signs or symptoms suggestive of liver injury should have liver function tests performed. Patients who develop increased transaminase levels should be monitored until the abnormality (ies) resolve. Should an increase in transaminases of greater than 3 times the upper limit of normal (ULN) persist, reduction of dose or withdrawal of Torvastatin is recommended (see section 4.8).

Torvastatin should be used with caution in patients who consume substantial quantities of alcohol and/or have a history of liver disease.

Stroke Prevention by Aggressive Reduction in Cholesterol Levels (SPARCL)

In a post-hoc analysis of stroke subtypes in patients without coronary heart disease (CHD) who had a recent stroke or transient ischemic attack (TIA) there was a higher incidence of haemorrhagic stroke in patients initiated on Torvastatin 80 mg compared to placebo. The increased risk was particularly noted in patients with prior haemorrhagic stroke or lacunar infarct at study entry. For patients with prior haemorrhagic stroke or lacunar infarct, the balance of risks and benefits of Torvastatin 80 mg is uncertain and the potential risk of haemorrhagic stroke should be carefully considered before initiating treatment (see Section 5.1).

Skeletal muscle effects

Torvastatin, like other HMG-CoA reductase inhibitors, may in rare occasions affect the skeletal muscle and cause myalgia, myositis, and myopathy that may progress to rhabdomyolysis, a potentially life-threatening condition characterised by markedly elevated creatine kinase (CK) levels (> 10 times ULN), myoglobinaemia and myoglobinuria which may lead to renal failure.

There have been very rare reports of an immune-mediated necrotizing myopathy (IMNM) during or after treatment with some statins. IMNM is clinically characterised by persistent proximal muscle weakness and elevated serum creatine kinase, which persist despite discontinuation of statin treatment, positive anti-HMG CoA reductase antibody and improvement with immunosuppressive agents.

Before the treatment

Torvastatin should be prescribed with caution in patients with pre-disposing factors for rhabdomyolysis. A CK level should be measured before starting statin treatment in the following situations:

- Renal impairment
- Hypothyroidism
- Personal or familial history of hereditary muscular disorders
- Previous history of muscular toxicity with a statin or fibrate
- Previous history of liver disease and/or where substantial quantities of alcohol are consumed
- In elderly (age > 70 years), the necessity of such measurement should be considered, according to the presence of other predisposing factors for rhabdomyolysis
- Situations where an increase in plasma levels may occur, such as interactions (see section 4.5) and special populations including genetic subpopulations (see section 5.2)

In such situations, the risk of treatment should be considered in relation to possible benefit, and clinical monitoring is recommended.

If CK levels are significantly elevated (> 5 times ULN) at baseline, treatment should not be started.

Creatine kinase measurement

Creatine kinase (CK) should not be measured following strenuous exercise or in the presence of any plausible alternative cause of CK increase as this makes value interpretation difficult. If CK levels are significantly elevated at baseline (> 5 times ULN), levels should be remeasured within 5 to 7 days later to confirm the results.

Whilst on treatment

- Patients must be asked to promptly report muscle pain, cramps, or weakness especially if accompanied by malaise or fever.
- If such symptoms occur whilst a patient is receiving treatment with Torvastatin, their CK levels should be measured. If these levels are found to be significantly elevated (> 5 times ULN), treatment should be stopped.
- If muscular symptoms are severe and cause daily discomfort, even if the CK levels are elevated to ≤ 5 x ULN, treatment discontinuation should be considered.
- If symptoms resolve and CK levels return to normal, then re-introduction of Torvastatin or introduction of an alternative statin may be considered at the lowest dose and with close monitoring.
- Torvastatin must be discontinued if clinically significant elevation of CK levels (> 10 x ULN) occur, or if rhabdomyolysis is diagnosed or suspected.

Concomitant treatment with other medicinal products

Risk of rhabdomyolysis is increased when Torvastatin is administered concomitantly with certain medicinal products that may increase the plasma concentration of Torvastatin such as potent inhibitors of CYP3A4 or transport proteins (e.g. ciclosporin, telithromycin, clarithromycin, delavirdine, stiripentol, ketoconazole, voriconazole, itraconazole, posaconazole, letermovir and HIV protease inhibitors including ritonavir, lopinavir, atazanavir, indinavir, darunavir, tipranavir/ritonavir etc).

The risk of myopathy may also be increased with the concomitant use of gemfibrozil and other fibric acid derivatives, antivirals for the treatment of hepatitis C (HCV) (e.g. boceprevir, telaprevir, elbasvir/grazoprevir, ledipasvir/sofosbuvir), erythromycin, niacin or ezetimibe. If possible, alternative (non-interacting) therapies should be considered instead of these medicinal products.

In cases where co-administration of these medicinal products with Torvastatin is necessary, the benefit and the risk of concurrent treatment should be carefully considered. When patients are receiving medicinal products that increase the plasma concentration of Torvastatin, a lower maximum dose of Torvastatin is recommended. In addition, in the case of potent CYP3A4 inhibitors, a lower starting dose of Torvastatin should be considered and appropriate clinical monitoring of these patients is recommended (see section 4.5).

Torvastatin must not be co-administered with systemic formulations of fusidic acid or within 7 days of stopping fusidic acid treatment. In patients where the use of systemic fusidic acid is considered essential, statin treatment should be discontinued throughout the duration of fusidic acid treatment. There have been reports of rhabdomyolysis (including some fatalities) in patients receiving fusidic acid and statins in combination (see section 4.5). The patient should be advised to seek medical advice immediately if they experience any symptoms of muscle weakness, pain or tenderness.

Statin therapy may be re-introduced seven days after the last dose of fusidic acid.

In exceptional circumstances, where prolonged systemic fusidic acid is needed, e.g., for the treatment of severe infections, the need for co-administration of Torvastatin and fusidic acid should only be considered on a case by case basis and under close medical supervision.

Paediatric population

No clinically significant effect on growth and sexual maturation was observed in a 3-year study based on the assessment of overall maturation and development, assessment of Tanner Stage, and measurement of height and weight (see section 4.8).

Interstitial lung disease

Exceptional cases of interstitial lung disease have been reported with some statins, especially with long term therapy (see section 4.8). Presenting features can include dyspnoea, non-productive cough and deterioration in general health (fatigue, weight loss and fever). If it is suspected a patient has developed interstitial lung disease, statin therapy should be discontinued.

Diabetes Mellitus

Some evidence suggests that statins as a class raise blood glucose and in some patients, at high risk of future diabetes, may produce a level of hyperglycaemia where formal diabetes care is appropriate. This risk, however, is outweighed by the reduction in vascular risk with statins and therefore should not be a reason for stopping statin treatment. Patients at risk (fasting glucose 5.6 to 6.9 mmol/L, BMI >30 kg/m², raised triglycerides, hypertension) should be monitored both clinically and biochemically according to national guidelines.

Excipients

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

Torvastatin contains less than 1 mmol sodium (23 mg) per tablet, that is to say essentially 'sodium-free'.

4.5 Interaction with other medicinal products and other forms of interaction

Effect of co-administered medicinal products on Torvastatin

Torvastatin is metabolised by cytochrome P450 3A4 (CYP3A4) and is a substrate of the hepatic transporters, organic anion-transporting polypeptide 1B1 (OATP1B1) and 1B3 (OATP1B3) transporter. Metabolites of Torvastatin are substrates of OATP1B1. Torvastatin is also identified as a substrate of the efflux transporters P-glycoprotein (P-gp) and breast cancer resistance protein (BCRP), which may limit the intestinal absorption and biliary clearance of Torvastatin (see section 5.2). Concomitant administration of medicinal products that are inhibitors of CYP3A4 or transport proteins may lead to increased plasma concentrations of Torvastatin and an increased risk of myopathy. The risk might also be increased at concomitant administration of Torvastatin with other medicinal products that have a potential to induce myopathy, such as fibric acid derivatives and ezetimibe (see sections 4.3 and 4.4).

CYP3A4 inhibitors

Potent CYP3A4 inhibitors have been shown to lead to markedly increased concentrations of Torvastatin (see Table 1 and specific information below). Co-administration of potent CYP3A4 inhibitors (e.g. ciclosporin, telithromycin, clarithromycin, delavirdine, stiripentol, ketoconazole, voriconazole, itraconazole, posaconazole, some antivirals used in the treatment of HCV (e.g. elbasvir/grazoprevir) and HIV protease inhibitors including ritonavir, lopinavir, atazanavir, indinavir, darunavir, etc.) should be avoided if possible. In cases where co-administration of these medicinal products with Torvastatin cannot be avoided lower starting and maximum doses of Torvastatin should be considered and appropriate clinical monitoring of the patient is recommended (see Table 1).

Moderate CYP3A4 inhibitors (e.g. erythromycin, diltiazem, verapamil and fluconazole) may increase plasma concentrations of Torvastatin (see Table 1). An increased risk of myopathy has been observed with the use of erythromycin in combination with statins. Interaction studies evaluating the effects of amiodarone or verapamil on Torvastatin have not been conducted. Both amiodarone and verapamil are known to inhibit CYP3A4 activity and co-administration with Torvastatin may result in increased exposure to Torvastatin. Therefore, a lower maximum dose of Torvastatin should be considered and appropriate clinical monitoring of the patient is recommended when concomitantly used with moderate CYP3A4 inhibitors. Appropriate clinical monitoring is recommended after initiation or following dose adjustments of the inhibitor.

CYP3A4 inducers

Concomitant administration of Torvastatin with inducers of cytochrome P450 3A (e.g. efavirenz, rifampin, St. John's Wort) can lead to variable reductions in plasma concentrations of Torvastatin. Due to the dual interaction mechanism of rifampin, (cytochrome P450 3A induction and inhibition of hepatocyte uptake transporter OATP1B1), simultaneous co-administration of Torvastatin with rifampin is recommended, as delayed administration of Torvastatin after administration of rifampin has been associated with a significant reduction in Torvastatin plasma concentrations. The effect of rifampin on Torvastatin concentrations in hepatocytes is, however, unknown and if concomitant administration cannot be avoided, patients should be carefully monitored for efficacy.

Transporter inhibitors

Inhibitors of transport proteins can increase the systemic exposure of Torvastatin. Ciclosporin and letermovir are both inhibitors of transporters involved in the disposition of Torvastatin, i.e. OATP1B1/1B3, P-gp, and BCRP leading to an increased systemic exposure of Torvastatin (see Table 1). The effect of inhibition of hepatic uptake transporters on Torvastatin exposure in hepatocytes is unknown. If concomitant administration cannot be avoided, a dose reduction and clinical monitoring for efficacy is recommended (see Table 1).

Use of Torvastatin is not recommended in patients taking letermovir co-administered with ciclosporin (see section 4.4).

Gemfibrozil / fibric acid derivatives

The use of fibrates alone is occasionally associated with muscle related events, including rhabdomyolysis. The risk of these events may be increased with the concomitant use of fibric acid derivatives and Torvastatin. If concomitant administration cannot be avoided, the lowest dose of Torvastatin to achieve the therapeutic objective should be used and the patients should be appropriately monitored (see section 4.4).

Ezetimibe

The use of ezetimibe alone is associated with muscle related events, including rhabdomyolysis. The risk of these events may therefore be increased with concomitant use of ezetimibe and Torvastatin. Appropriate clinical monitoring of these patients is recommended.

Colestipol

Plasma concentrations of Torvastatin and its active metabolites were lower (ratio of Torvastatin concentration: 0.74) when colestipol was co-administered with Torvastatin. However, lipid effects were greater when Torvastatin and colestipol were co-administered than when either medicinal product was given alone.

Fusidic acid

The risk of myopathy including rhabdomyolysis may be increased by the concomitant administration of systemic fusidic acid with statins. The mechanism of this interaction (whether it is pharmacodynamic or pharmacokinetic, or both) is yet unknown. There have been reports of rhabdomyolysis (including some fatalities) in patients receiving this combination.

If treatment with systemic fusidic acid is necessary, Torvastatin treatment should be discontinued throughout the duration of the fusidic acid treatment. **See also section 4.4.**

Colchicine

Although interaction studies with Torvastatin and colchicine have not been conducted, cases of myopathy have been reported with Torvastatin co-administered with colchicine, and caution should be exercised when prescribing Torvastatin with colchicine.

Effect of Torvastatin on co-administered medicinal products

Digoxin

When multiple doses of digoxin and 10 mg Torvastatin were co-administered, steady-state digoxin concentrations increased slightly. Patients taking digoxin should be monitored appropriately.

Oral contraceptives

Co-administration of Torvastatin with an oral contraceptive produced increases in plasma concentrations of norethindrone and ethinyl oestradiol.

Warfarin

In a clinical study in patients receiving chronic warfarin therapy, coadministration of Torvastatin 80 mg daily with warfarin caused a small decrease of about 1.7 seconds in prothrombin time during the first 4 days of dosing which returned to normal within 15 days of Torvastatin treatment. Although only very rare cases of clinically significant anticoagulant interactions have been reported, prothrombin time should be determined before starting Torvastatin in patients taking coumarin anticoagulants and frequently enough during early therapy to ensure that no significant alteration of prothrombin time occurs. Once a stable prothrombin time has been documented, prothrombin times can be monitored at the intervals usually recommended for patients on coumarin anticoagulants. If the dose of Torvastatin is changed or discontinued, the same procedure should be repeated. Torvastatin therapy has not been associated with bleeding or with changes in prothrombin time in patients not taking anticoagulants.

Paediatric population

Drug-drug interaction studies have only been performed in adults. The extent of interactions in the paediatric population is not known. The above mentioned interactions for adults and the warnings in section 4.4 should be taken into account for the paediatric population.

Drug interactions

Table 1: Effect of co-administered medicinal products on the pharmacokinetics of Torvastatin

Co-administered medicinal product and dosing regimen	Torvastatin		
	Dose (mg)	Ratio of AUC*	Clinical Recommendation*
Glecaprevir 400 mg OD/ Pibrentasvir 120 mg OD, 7 days	10 mg OD for 7 days	8.3	Co-administration with products containing glecaprevir or pibrentasvir is contraindicated (see section 4.3).
Tipranavir 500 mg BID/ Ritonavir 200 mg BID, 8 days (days 14 to 21)	40 mg on day 1, 10 mg on day 20	9.4	In cases where co-administration with Torvastatin is necessary, do not exceed 10 mg Torvastatin daily. Clinical monitoring of these patients is recommended.
Telaprevir 750 mg q8h, 10 days	20 mg, SD	7.9	
Ciclosporin 5.2 mg/kg/day, stable dose	10 mg OD for 28 days	8.7	
Lopinavir 400 mg BID/ Ritonavir 100 mg BID, 14 days	20 mg OD for 4 days	5.9	In cases where co-administration with Torvastatin is necessary, lower maintenance doses of Torvastatin are recommended. At Torvastatin doses exceeding 20 mg, clinical monitoring of these patients is recommended.
Clarithromycin 500 mg BID, 9 days	80 mg OD for 8 days	4.5	
Saquinavir 400 mg BID/ Ritonavir (300 mg BID from days 5-7, increased to 400 mg BID on day 8), days 4-18, 30 min after Torvastatin dosing	40 mg OD for 4 days	3.9	In cases where co-administration with Torvastatin is necessary, lower maintenance doses of Torvastatin are recommended. At Torvastatin doses exceeding 40 mg, clinical monitoring of these patients is recommended.
Darunavir 300 mg BID/ Ritonavir 100 mg BID, 9 days	10 mg OD for 4 days	3.4	
Itraconazole 200 mg OD, 4 days	40 mg SD	3.3	
Fosamprenavir 700 mg BID/ Ritonavir 100 mg BID, 14 days	10 mg OD for 4 days	2.5	
Fosamprenavir 1400 mg BID, 14 days	10 mg OD for 4 days	2.3	
Elbasvir 50 mg OD/ Grazoprevir 200 mg OD, 13 days	10 mg SD	1.95	The dose of Torvastatin should not exceed a daily dose of 20 mg during co-administration with products containing elbasvir or grazoprevir.
Letermovir 480 mg OD, 10 days	20 mg SD	3.29	The dose of Torvastatin should not exceed a daily dose of 20 mg during co-administration with products containing letermovir.
Nelfinavir 1250 mg BID, 14 days	10 mg OD for 28 days	1.74	No specific recommendation.
Grapefruit Juice, 240 mL OD*	40 mg, SD	1.37	Concomitant intake of large quantities of grapefruit juice and Torvastatin is not recommended.
Diltiazem 240 mg OD, 28 days	40 mg, SD	1.51	After initiation or following dose adjustments of diltiazem,

			appropriate clinical monitoring of these patients is recommended.
Erythromycin 500 mg QID, 7 days	10 mg, SD	1.33	Lower maximum dose and clinical monitoring of these patients is recommended.
Amlodipine 10 mg, single dose	80 mg, SD	1.18	No specific recommendation.
Cimetidine 300 mg QID, 2 weeks	10 mg OD for 2 weeks	1.00	No specific recommendation.
Colestipol 10 g BID, 24 weeks	40 mg OD for 8 weeks	0.74**	No specific recommendation
Antacid suspension of magnesium and aluminium hydroxides, 30 mL QID, 17 days	10 mg OD for 15 days	0.66	No specific recommendation.
Efavirenz 600 mg OD, 14 days	10 mg for 3 days	0.59	No specific recommendation.
Rifampin 600 mg OD, 7 days (co-administered)	40 mg SD	1.12	If co-administration cannot be avoided, simultaneous co-administration of Torvastatin with rifampin is recommended, with clinical monitoring.
Rifampin 600 mg OD, 5 days (doses separated)	40 mg SD	0.20	
Gemfibrozil 600 mg BID, 7 days	40 mg SD	1.35	Lower starting dose and clinical monitoring of these patients is recommended.
Fenofibrate 160 mg OD, 7 days	40 mg SD	1.03	Lower starting dose and clinical monitoring of these patients is recommended.
Boceprevir 800 mg TID, 7 days	40 mg SD	2.3	Lower starting dose and clinical monitoring of these patients is recommended. The dose of Torvastatin should not exceed a daily dose of 20 mg during co-administration with boceprevir.

* Represents ratio of treatments (co-administered drug plus Torvastatin versus Torvastatin alone).

See sections 4.4 and 4.5 for clinical significance.

* Contains one or more components that inhibit CYP3A4 and can increase plasma concentrations of medicinal products metabolised by CYP3A4. Intake of one 240 ml glass of grapefruit juice also resulted in a decreased AUC of 20.4% for the active orthohydroxy metabolite. Large quantities of grapefruit juice (over 1.2 l daily for 5 days) increased AUC of Torvastatin 2.5 fold and AUC of active (Torvastatin and metabolites) HMG-CoA reductase inhibitors 1.3 fold.

** Ratio based on a single sample taken 8-16 h post dose.

OD = once daily; SD = single dose; BID = twice daily; TID = three times daily; QID = four times daily.

Table 2: Effect of Torvastatin on the pharmacokinetics of co-administered medicinal products

Torvastatin and dosing regimen	Co-administered medicinal product		
	Medicinal product/Dose (mg)	Ratio of AUC*	Clinical Recommendation
80 mg OD for 10 days	Digoxin 0.25 mg OD, 20 days	1.15	Patients taking digoxin should be monitored appropriately.
40 mg OD for 22 days	Oral contraceptive OD, 2 months - norethindrone 1 mg - ethinyl estradiol 35 µg	1.28 1.19	No specific recommendation.
80 mg OD for 15 days	* Phenazone, 600 mg SD	1.03	No specific recommendation.
10 mg, SD	Tipranavir 500 mg BID/ritonavir 200 mg BID, 7 days	1.08	No specific recommendation.
10 mg, OD for 4 days	Fosamprenavir 1400 mg BID, 14 days	0.73	No specific recommendation.
10 mg OD for 4 days	Fosamprenavir 700 mg BID/ritonavir 100 mg BID, 14 days	0.99	No specific recommendation.

* Represents ratio of treatments (co-administered drug plus Torvastatin versus Torvastatin alone).

* Co-administration of multiple doses of Torvastatin and phenazone showed little or no detectable effect in the clearance of phenazone.

OD = once daily; SD = single dose; BID = twice daily.

4.6 Fertility, pregnancy and lactation

Women of childbearing potential

Women of child-bearing potential should use appropriate contraceptive measures during treatment (see section 4.3).

Pregnancy

Torvastatin is contraindicated during pregnancy (see section 4.3). Safety in pregnant women has not been established. No controlled clinical trials with Torvastatin have been conducted in pregnant women. Rare reports of congenital anomalies following intrauterine exposure to HMG-CoA reductase inhibitors have been received. Studies in animals have shown toxicity to reproduction (see section 5.3).

Maternal treatment with Torvastatin may reduce the fetal levels of mevalonate which is a precursor of cholesterol biosynthesis. Atherosclerosis is a chronic process, and ordinarily discontinuation of lipid-lowering medicinal products during pregnancy should have little impact on the long-term risk associated with primary hypercholesterolaemia.

For these reasons, Torvastatin should not be used in women who are pregnant, trying to become pregnant or suspect they are pregnant. Treatment with Torvastatin should be suspended for the duration of pregnancy or until it has been determined that the woman is not pregnant (see section 4.3.)

Breast-feeding

It is unknown whether Torvastatin or its metabolites are excreted in human milk. In rats, plasma concentrations of Torvastatin and its active metabolites are similar to those in milk (see section 5.3). Because of the potential for serious adverse reactions, women taking Torvastatin should not breast-feed their infants (see section 4.3). Torvastatin is contraindicated during breastfeeding (see section 4.3).

Fertility

In animal studies Torvastatin had no effect on male or female fertility (see section 5.3).

4.7 Effects on ability to drive and use machines

Torvastatin has negligible influence on the ability to drive and use machines.

4.8 Undesirable effects

In the Torvastatin placebo-controlled clinical trial database of 16,066 (8755 Torvastatin vs. 7311 placebo) patients treated for a median period of 53 weeks, 5.2% of patients on Torvastatin discontinued due to adverse reactions compared to 4.0% of the patients on placebo.

Based on data from clinical studies and extensive post-marketing experience, the following table presents the adverse reaction profile for Torvastatin.

Estimated frequencies of reactions are ranked according to the following convention: 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 ($\leq 1/10,000$); Not known (cannot be estimated from the available data)

Infections and infestations

Common: nasopharyngitis.

Blood and lymphatic system disorders

Rare: thrombocytopenia.

Immune system disorders

Common: allergic reactions.

Very rare: anaphylaxis.

Metabolism and nutrition disorders

Common: hyperglycaemia.

Uncommon: hypoglycaemia, weight gain, anorexia

Psychiatric disorders

Uncommon: nightmare, insomnia.

Nervous system disorders

Common: headache.

Uncommon: dizziness, paraesthesia, hypoesthesia, dysgeusia, amnesia.

Rare: peripheral neuropathy.

Eye disorders

Uncommon: vision blurred.

Rare: visual disturbance.

Ear and labyrinth disorders

Uncommon: tinnitus

Very rare: hearing loss.

Respiratory, thoracic and mediastinal disorders

Common: pharyngolaryngeal pain, epistaxis.

Gastrointestinal disorders

Common: constipation, flatulence, dyspepsia, nausea, diarrhoea.

Uncommon: vomiting, abdominal pain upper and lower, eructation, pancreatitis.

Hepatobiliary disorders

Uncommon: hepatitis.

Rare: cholestasis.

Very rare: hepatic failure.

Skin and subcutaneous tissue disorders

Uncommon: urticaria, skin rash, pruritus, alopecia.

Rare: angioneurotic oedema, dermatitis bullous including erythema multiforme, Stevens-Johnson syndrome and toxic epidermal necrolysis.

Musculoskeletal and connective tissue disorders

Common: myalgia, arthralgia, pain in extremity, muscle spasms, joint swelling, back pain.

Uncommon: neck pain, muscle fatigue.

Rare: myopathy, myositis, rhabdomyolysis, muscle rupture, tendonopathy, sometimes complicated by rupture. Very rare: lupus-like syndrome

Not known: immune-mediated necrotizing myopathy (see section 4.4)

Reproductive system and breast disorders

Very rare: gynecomastia.

General disorders and administration site conditions

Uncommon: malaise, asthenia, chest pain, peripheral oedema, fatigue, pyrexia.

Investigations

Common: liver function test abnormal, blood creatine kinase increased.

Uncommon: white blood cells urine positive.

As with other HMG-CoA reductase inhibitors elevated serum transaminases have been reported in patients receiving Torvastatin. These changes were usually mild, transient, and did not require interruption of treatment. Clinically important (> 3 times upper normal limit) elevations in serum transaminases occurred in 0.8% patients on Torvastatin. These elevations were dose related and were reversible in all patients.

Elevated serum creatine kinase (CK) levels greater than 3 times upper limit of normal occurred in 2.5% of patients on Torvastatin, similar to other HMG-CoA reductase inhibitors in clinical trials. Levels above 10 times the normal upper range occurred in 0.4% Torvastatin-treated patients (see section 4.4).

Paediatric Population

Paediatric patients aged from 10 to 17 years of age treated with Torvastatin had an adverse experience profile generally similar to that of patients treated with placebo, the most common adverse experiences observed in both groups, regardless of causality assessment, were infections. No clinically significant effect on growth and sexual maturation was observed in a 3-year study based on the assessment of overall maturation and development, assessment of Tanner Stage, and measurement of height and weight. The safety and tolerability profile in paediatric patients was similar to the known safety profile of Torvastatin in adult patients.

The clinical safety database includes safety data for 520 paediatric patients who received Torvastatin, among which 7 patients were < 6 years old, 121 patients were in the age range of 6 to 9, and 392 patients were in the age range of 10 to 17. Based on the data available, the frequency, type and severity of adverse reactions in children is similar to adults.

The following adverse events have been reported with some statins:

- Sexual dysfunction
- Depression
- Exceptional cases of interstitial lung disease, especially with long term therapy (see section 4.4)
- Diabetes Mellitus: Frequency will depend on the presence or absence of risk factors (fasting blood glucose ≥ 5.6 mmol/L, BMI > 30 kg/m², raised triglycerides, history of hypertension).

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 the Yellow Card Scheme, website www.mhra.gov.uk/yellowcard or search for MHRA Yellow Card in the Google Play or Apple App store.

4.9 Overdose

Specific treatment is not available for Torvastatin over dosage. Should an overdose occur, the patient should be treated symptomatically and supportive measures instituted, as required. Liver function tests should be performed and serum CK levels should be monitored. Due to extensive Torvastatin binding to plasma proteins, haemodialysis is not expected to significantly enhance Torvastatin clearance.

5. Pharmacological properties

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: Lipid modifying agents, HMG-CoA-reductase inhibitors, ATC code: C10AA05

Torvastatin is a selective, competitive inhibitor of HMG-CoA reductase, the rate-limiting enzyme responsible for the conversion of 3-hydroxy-3-methyl-glutaryl-coenzyme A to mevalonate, a precursor of sterols, including cholesterol. Triglycerides and cholesterol in the liver are incorporated into very low-density lipoproteins (VLDL) and released into the plasma for delivery to peripheral tissues. Low-density lipoprotein (LDL) is formed from VLDL and is catabolised primarily through the receptor with high affinity to LDL (LDL receptor).

Torvastatin lowers plasma cholesterol and lipoprotein serum concentrations by inhibiting HMG-CoA reductase and subsequently cholesterol biosynthesis in the liver and increases the number of hepatic LDL receptors on the cell surface for enhanced uptake and catabolism of LDL.

Torvastatin reduces LDL production and the number of LDL particles. Torvastatin produces a profound and sustained increase in LDL receptor activity coupled with a beneficial change in the quality of circulating LDL particles. Torvastatin is effective in reducing LDL-C in patients with homozygous familial hypercholesterolaemia, a population that has not usually responded to lipid-lowering medicinal products.

Torvastatin has been shown to reduce concentrations of total-C (30% - 46%), LDL-C (41% - 61%), apolipoprotein B (34% - 50%), and triglycerides (14% - 33%) while producing variable increases in HDL-C and apolipoprotein A1 in a dose response study. These results are consistent in patients with heterozygous familial hypercholesterolaemia, nonfamilial forms of hypercholesterolaemia, and mixed hyperlipidaemia, including patients with noninsulin-dependent diabetes mellitus.

Reductions in total-C, LDL-C, and apolipoprotein B have been proven to reduce risk for cardiovascular events and cardiovascular mortality.

Homozygous familial hypercholesterolaemia

In a multicenter 8 week open-label compassionate-use study with an optional extension phase of variable length, 335 patients were enrolled, 89 of which were identified as homozygous familial hypercholesterolaemia patients. From these 89 patients, the mean percent reduction in LDL-C was approximately 20%. Torvastatin was administered at doses up to 80 mg/day.

Atherosclerosis

In the Reversing Atherosclerosis with Aggressive Lipid-Lowering Study (REVERSAL), the effect of intensive lipid lowering with Torvastatin 80 mg and standard degree of lipid lowering with pravastatin 40 mg on coronary atherosclerosis was assessed by intravascular ultrasound (IVUS), during angiography, in patients with coronary heart disease. In this randomised, double-blind, multicenter, controlled clinical trial, IVUS was performed at baseline and at 18 months in 502 patients. In the Torvastatin group (n=253), there was no progression of atherosclerosis.

The median percent change, from baseline, in total atheroma volume (the primary study criteria) was -0.4% (p=0.98) in the Torvastatin group and +2.7% (p=0.001) in the pravastatin group (n=249). When compared to pravastatin the effects of Torvastatin were statistically significant (p=0.02). The effect of intensive lipid lowering on cardiovascular endpoints (e.g. need for revascularisation, non fatal myocardial infarction, coronary death) was not investigated in this study.

In the Torvastatin group, LDL-C was reduced to a mean of 2.04 mmol/L \pm 0.8 (78.9 mg/dl \pm 30) from baseline 3.89 mmol/L \pm 0.7 (150 mg/dl \pm 28) and in the pravastatin group, LDL-C was reduced to a mean of 2.85 mmol/L \pm 0.7 (110 mg/dl \pm 26) from baseline 3.89 mmol/L \pm 0.7 (150 mg/dl \pm 26) (p<0.0001). Torvastatin also significantly reduced mean TC by 34.1% (pravastatin: -18.4%, p<0.0001), mean TG levels by 20% (pravastatin: -6.8%, p<0.0009), and mean apolipoprotein B by 39.1% (pravastatin: -22.0%, p<0.0001). Torvastatin increased mean HDL-C by 2.9% (pravastatin: +5.6%, p=NS). There was a 36.4% mean reduction in CRP in the Torvastatin group compared to a 5.2% reduction in the pravastatin group (p<0.0001).

Study results were obtained with the 80 mg dose strength. Therefore, they cannot be extrapolated to the lower dose strengths.

The safety and tolerability profiles of the two treatment groups were comparable.

The effect of intensive lipid lowering on major cardiovascular endpoints was not investigated in this study. Therefore, the clinical significance of these imaging results with regard to the primary and secondary prevention of cardiovascular events is unknown.

Acute coronary syndrome

In the MIRACL study, Torvastatin 80 mg has been evaluated in 3,086 patients (Torvastatin n=1,538; placebo n=1,548) with an acute coronary syndrome (non Q-wave MI or unstable angina). Treatment was initiated during the acute phase after hospital admission and lasted for a period of 16 weeks. Treatment with Torvastatin 80 mg/day increased the time to occurrence of the combined primary endpoint, defined as death from any cause, nonfatal MI, resuscitated cardiac arrest, or angina pectoris with evidence of myocardial ischaemia requiring hospitalization, indicating a risk reduction by 16% (p=0.048). This was mainly due to a 26% reduction in re-hospitalisation for angina pectoris with evidence of myocardial

ischaemia (p=0.018). The other secondary endpoints did not reach statistical significance on their own (overall: Placebo: 22.2%, Torvastatin: 22.4%).

The safety profile of Torvastatin in the MIRACL study was consistent with what is described in section 4.8.

Prevention of cardiovascular disease

The effect of Torvastatin on fatal and non-fatal coronary heart disease was assessed in a randomized, double-blind, placebo-controlled study, the Anglo-Scandinavian Cardiac Outcomes Trial Lipid Lowering Arm (ASCOT-LLA). Patients were hypertensive, 40-79 years of age, with no previous myocardial infarction or treatment for angina, and with TC levels \leq 6.5 mmol/l (251 mg/dl). All patients had at least 3 of the pre-defined cardiovascular risk factors: male gender, age \geq 55 years, smoking, diabetes, history of CHD in a first-degree relative, TC:HDL-C $>$ 6, peripheral vascular disease, left ventricular hypertrophy, prior cerebrovascular event, specific ECG abnormality, proteinuria/albuminuria. Not all included patients were estimated to have a high risk for a first cardiovascular event.

Patients were treated with anti-hypertensive therapy (either amlodipine or atenolol-based regimen) and either Torvastatin 10 mg daily (n=5,168) or placebo (n=5,137).

The absolute and relative risk reduction effect of Torvastatin was as follows:

Event	Relative Risk Reduction (%)	No. of Events (Torvastatin vs Placebo)	Absolute Risk Reduction ¹ (%)	p-value
Fatal CHD plus non-fatal MI	36%	100 vs. 154	1.1%	0.0005
Total cardiovascular events and revascularization procedures	20%	389 vs. 483	1.9%	0.0008
Total coronary events	29%	178 vs 247	1.4%	0.0006

¹Based on difference in crude events rates occurring over a median follow-up of 3.3 years.

CHD = coronary heart disease; MI = myocardial infarction.

Total mortality and cardiovascular mortality were not significantly reduced (185 vs. 212 events, p=0.17 and 74 vs. 82 events, p=0.51). In the subgroup analyses by gender (81% males, 19% females), a beneficial effect of Torvastatin was seen in males but could not be established in females possibly due to the low event rate in the female subgroup. Overall and cardiovascular mortality were numerically higher in the female patients (38 vs. 30 and 17 vs. 12), but this was not statistically significant. There was significant treatment interaction by antihypertensive baseline therapy. The primary endpoint (fatal CHD plus non-fatal MI) was significantly reduced by Torvastatin in patients treated with amlodipine (HR 0.47 (0.32-0.69), p=0.00008), but not in those treated with atenolol (HR 0.83 (0.59-1.17), p=0.287).

The effect of Torvastatin on fatal and non-fatal cardiovascular disease was also assessed in a randomized, double-blind, multicenter, placebo-controlled trial, the Collaborative Torvastatin Diabetes Study (CARDS) in patients with type 2 diabetes, 40-75 years of age, without prior history of cardiovascular disease, and with LDL-C \leq 4.14 mmol/l (160 mg/dl) and TG \leq 6.78 mmol/l (600 mg/dl). All patients had at least 1 of the following risk factors: hypertension, current smoking, retinopathy, microalbuminuria or macroalbuminuria.

Patients were treated with either Torvastatin 10 mg daily (n=1,428) or placebo (n=1,410) for a median follow-up of 3.9 years.

The absolute and relative risk reduction effect of Torvastatin was as follows:

Event	Relative Risk Reduction (%)	No. of Events (Torvastatin vs Placebo)	Absolute Risk Reduction ¹ (%)	p-value
Major cardiovascular events (fatal and non-fatal AMI, silent MI, acute CHD death, unstable angina, CABG, PTCA, revascularization, stroke)	37%	83 vs. 127	3.2%	0.0010
MI (fatal and non-fatal AMI, silent MI)	42%	38 vs 64	1.9%	0.0070
Strokes (Fatal and non-fatal)	48%	21 vs. 39	1.3%	0.0163

¹Based on difference in crude events rates occurring over a median follow-up of 3.9 years.

AMI = acute myocardial infarction; CABG = coronary artery bypass graft; CHD = coronary heart disease; MI = myocardial infarction; PTCA = percutaneous transluminal coronary angioplasty.

There was no evidence of a difference in the treatment effect by patient's gender, age, or baseline LDL-C level. A favourable trend was observed regarding the mortality rate (82 deaths in the placebo group vs. 61 deaths in the Torvastatin group, p=0.0592).

Recurrent stroke

In the Stroke Prevention by Aggressive Reduction in Cholesterol Levels (SPARCL) study, the effect of Torvastatin 80 mg daily or placebo on stroke was evaluated in 4731 patients who had a stroke or transient ischemic attack (TIA) within the preceding 6 months and no history of coronary heart disease (CHD). Patients were 60% male, 21-92 years of age (average age 63 years), and had an average baseline LDL of 133 mg/dL (3.4 mmol/L). The mean LDL-C was 73 mg/dL (1.9 mmol/L) during treatment with Torvastatin and 129 mg/dL (3.3 mmol/L) during treatment with placebo. Median follow-up was 4.9 years.

Torvastatin 80 mg reduced the risk of the primary endpoint of fatal or non-fatal stroke by 15% (HR 0.85; 95% CI, 0.72-1.00; $p=0.05$ or 0.84; 95% CI, 0.71-0.99; $p=0.03$ after adjustment for baseline factors) compared to placebo. All cause mortality was 9.1% (216/2365) for Torvastatin versus 8.9% (211/2366) for placebo.

In a post-hoc analysis, Torvastatin 80 mg reduced the incidence of ischemic stroke (218/2365, 9.2% vs. 274/2366, 11.6%, $p=0.01$) and increased the incidence of hemorrhagic stroke (55/2365, 2.3% vs. 33/2366, 1.4%, $p=0.02$) compared to placebo.

- The risk of hemorrhagic stroke was increased in patients who entered the study with prior hemorrhagic stroke (7/45 for Torvastatin versus 2/48 for placebo; HR 4.06; 95% CI, 0.84-19.57), and the risk of ischemic stroke was similar between groups (3/45 for Torvastatin versus 2/48 for placebo; HR 1.64; 95% CI, 0.27-9.82).

- The risk of hemorrhagic stroke was increased in patients who entered the study with prior lacunar infarct (20/708 for Torvastatin versus 4/701 for placebo; HR 4.99; 95% CI, 1.71-14.61), but the risk of ischemic stroke was also decreased in these patients (79/708 for Torvastatin versus 102/701 for placebo; HR 0.76; 95% CI, 0.57-1.02). It is possible that the net risk of stroke is increased in patients with prior lacunar infarct who receive Torvastatin 80 mg/day.

All cause mortality was 15.6% (7/45) for Torvastatin versus 10.4% (5/48) in the subgroup of patients with prior hemorrhagic stroke. All cause mortality was 10.9% (77/708) for Torvastatin versus 9.1% (64/701) for placebo in the subgroup of patients with prior lacunar infarct.

Paediatric Population

Heterozygous Familial Hypercholesterolaemia in Paediatric Patients aged 6-17 years old

An 8-week, open-label study to evaluate pharmacokinetics, pharmacodynamics, and safety and tolerability of Torvastatin was conducted in children and adolescents with genetically confirmed heterozygous familial hypercholesterolemia and baseline LDL-C ≥ 4 mmol/L. A total of 39 children and adolescents, 6 to 17 years of age, were enrolled. Cohort A included 15 children, 6 to 12 years of age and at Tanner Stage 1. Cohort B included 24 children, 10 to 17 years of age and at Tanner Stage ≥ 2 .

The initial dose of Torvastatin was 5 mg daily of a chewable tablet in Cohort A and 10 mg daily of a tablet formulation in Cohort B. The Torvastatin dose was permitted to be doubled if a subject had not attained target LDL-C of <3.35 mmol/L at Week 4 and if Torvastatin was well tolerated.

Mean values for LDL-C, TC, VLDL-C, and Apo B decreased by Week 2 among all subjects. For subjects whose dose was doubled, additional decreases were observed as early as 2 weeks, at the first assessment, after dose escalation. The mean percent decreases in lipid parameters were similar for both cohorts, regardless of whether subjects remained at their initial dose or doubled their initial dose. At Week 8, on average, the percent change from baseline in LDL-C and TC was approximately 40% and 30%, respectively, over the range of exposures.

In a second open label, single arm study, 271 male and female HeFH children 6-15 years of age were enrolled and treated with Torvastatin for up to three years. Inclusion in the study required confirmed HeFH and a baseline LDL-C level ≥ 4 mmol/L (approximately 152 mg/dL). The study included 139 children at Tanner 1 developmental stage (generally ranging from 6-10 years of age). The dosage of Torvastatin (once daily) was initiated at 5 mg (chewable tablet) in children less than 10 years of age. Children age 10 and above were initiated at 10 mg Torvastatin (once daily). All children could titrate to higher doses to achieve a target of <3.35 mmol/L LDL-C. The mean weighted dose for children aged 6 to 9 years was 19.6 mg and the mean weighted dose for children aged 10 years and above was 23.9 mg.

The mean (\pm SD) baseline LDL-C value was 6.12 (1.26) mmol/L which was approximately 233 (48) mg/dL. See table 3 below for final results.

The data were consistent with no drug effect on any of the parameters of growth and development (i.e., height, weight, BMI, Tanner stage, Investigator assessment of Overall Maturation and Development) in paediatric and adolescent subjects with HeFH receiving Torvastatin treatment over the 3 year study. There was no Investigator-assessed drug effect noted in height, weight, BMI by age or by gender by visit.

TABLE 3. Lipid-lowering Effects of Torvastatin in Adolescent Boys and Girls with Heterozygous Familial Hypercholesterolemia (mmol/L)

Timepoint	N	TC (S.D.)	LDL-C (S.D.)	HDL-C (S.D.)	TG (S.D.)	Apo B (S.D.)#
Baseline	271	7.86(1.30)	6.12(1.26)	1.314(0.2663)	0.93(0.47)	1.42(0.28)**
Month 30	206	4.95(0.77)*	3.25(0.67)	1.327(0.2796)	0.79(0.38)*	0.90(0.17)*

Month 36/ET	240	5.12(0.86)	3.45(0.81)	1.308(0.2739)	0.78(0.41)	0.93(0.20)***
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TC= total cholesterol; LDL-C = low density lipoprotein cholesterol-C; HDL-C = high density lipoprotein cholesterol-C; TG = triglycerides; Apo B = apolipoprotein B; "Month 36/ET" included final visit data for subjects who ended participation prior to the scheduled 36 month timepoint as well as full 36 month data for subjects completing the 36 month participation; "***" = Month 30 N for this parameter was 207; "****" = Baseline N for this parameter was 270; "*****" = Month 36/ET N for this parameter was 243; "#"=g/L for Apo B.

Heterozygous Familial Hypercholesterolaemia in Paediatric Patients aged 10-17 years old

In a double-blind, placebo controlled study followed by an open-label phase, 187 boys and postmenarchal girls 10-17 years of age (mean age 14.1 years) with heterozygous familial hypercholesterolaemia (FH) or severe hypercholesterolaemia were randomised to Torvastatin (n=140) or placebo (n=47) for 26 weeks and then all received Torvastatin for 26 weeks. The dosage of Torvastatin (once daily) was 10 mg for the first 4 weeks and up-titrated to 20 mg if the LDL-C level was >3.36 mmol/l. Torvastatin significantly decreased plasma levels of total-C, LDL-C, triglycerides, and apolipoprotein B during the 26 week double-blind phase. The mean achieved LDL-C value was 3.38 mmol/l (range: 1.81-6.26 mmol/l) in the Torvastatin group compared to 5.91 mmol/l (range: 3.93-9.96 mmol/l) in the placebo group during the 26-week double-blind phase.

An additional paediatric study of Torvastatin versus colestipol in patients with hypercholesterolaemia aged 10-18 years demonstrated that Torvastatin (N=25) caused a significant reduction in LDL-C at week 26 (p<0.05) compared with colestipol (N=31).

A compassionate use study in patients with severe hypercholesterolaemia (including homozygous hypercholesterolaemia) included 46 paediatric patients treated with Torvastatin titrated according to response (some subjects received 80 mg Torvastatin per day). The study lasted 3 years: LDL-cholesterol was lowered by 36%.

The long-term efficacy of Torvastatin therapy in childhood to reduce morbidity and mortality in adulthood has not been established.

The European Medicines Agency has waived the obligation to submit the results of studies with Torvastatin in children aged 0 to less than 6 years in the treatment of heterozygous hypercholesterolaemia and in children aged 0 to less than 18 years in the treatment of homozygous familial hypercholesterolaemia, combined (mixed) hypercholesterolaemia, primary hypercholesterolaemia and in the prevention of cardiovascular events (see section 4.2 for information on paediatric use).

5.2 Pharmacokinetic properties

Absorption:

Torvastatin is rapidly absorbed after oral administration; maximum plasma concentrations (C_{max}) occur within 1 to 2 hours. Extent of absorption increases in proportion to Torvastatin dose. After oral administration, Torvastatin film-coated tablets are 95% to 99% bioavailable compared to the oral solution. The absolute bioavailability of Torvastatin is approximately 12% and the systemic availability of

HMG-CoA reductase inhibitory activity is approximately 30%. The low systemic availability is attributed to presystemic clearance in gastrointestinal mucosa and/or hepatic first-pass metabolism.

Distribution:

Mean volume of distribution of Torvastatin is approximately 381 l. Torvastatin is $\geq 98\%$ bound to plasma proteins.

Biotransformation:

Torvastatin is metabolised by cytochrome P450 3A4 to ortho- and parahydroxylated derivatives and various beta-oxidation products. Apart from other pathways these products are further metabolized via glucuronidation. In vitro, inhibition of HMG-CoA reductase by ortho- and parahydroxylated metabolites is equivalent to that of Torvastatin. Approximately 70% of circulating inhibitory activity for HMG-CoA reductase is attributed to active metabolites.

Elimination:

Torvastatin is eliminated primarily in bile following hepatic and/or extrahepatic metabolism. However, the Torvastatin does not appear to undergo significant enterohepatic recirculation. Mean plasma elimination half-life of Torvastatin in humans is approximately 14 hours. The half-life of inhibitory activity for HMG-CoA reductase is approximately 20 to 30 hours due to the contribution of active metabolites.

Torvastatin is a substrate of the hepatic transporters, organic anion-transporting polypeptide 1B1 (OATP1B1) and 1B3 (OATP1B3) transporter. Metabolites of Torvastatin are substrates of OATP1B1. Torvastatin is also identified as a substrate of the efflux transporters P-glycoprotein (P-gp) and breast cancer resistance protein (BCRP), which may limit the intestinal absorption and biliary clearance of Torvastatin.

Special Populations

Elderly: Plasma concentrations of Torvastatin and its active metabolites are higher in healthy elderly subjects than in young adults while the lipid effects were comparable to those seen in younger patient populations.

Paediatric population: In an open-label, 8-week study, Tanner Stage 1 (N=15) and Tanner Stage ≥ 2 (N=24) paediatric patients (ages 6-17 years) with heterozygous familial hyper-cholesterolemia and baseline LDL-C ≥ 4 mmol/L were treated with 5 or 10 mg of chewable or 10 or 20 mg of film-coated Torvastatin tablets once daily, respectively. Body weight was the only significant covariate in Torvastatin population PK model. Apparent oral clearance of Torvastatin in paediatric subjects appeared similar to adults when scaled allometrically by body weight. Consistent decreases in LDL-C and TC were observed over the range of Torvastatin and o-hydroxyTorvastatin exposures.

Gender: Concentrations of Torvastatin and its active metabolites in women differ from those in men (women: approximately 20% higher for C_{max} and 10% lower for AUC). These differences were of no clinical significance, resulting in no clinically significant differences in lipid effects among men and women.

Renal impairment: Renal disease has no influence on the plasma concentrations or lipid effects of Torvastatin and its active metabolites.

Hepatic impairment: Plasma concentrations of Torvastatin and its active metabolites are markedly increased (approximately 16-fold in C_{max} and approx. 11-fold in AUC) in patients with chronic alcoholic liver disease (Child – Pugh B).

SLC1B1 polymorphism: Hepatic uptake of all HMG-CoA reductase inhibitors including Torvastatin, involves the OATP1B1 transporter. In patients with SLC1B1 polymorphism there is a risk of increased exposure of Torvastatin, which may lead to an increased risk of rhabdomyolysis (see section 4.4). Polymorphism in the gene encoding OATP1B1 (SLC1B1 c.521CC) is associated with a 2.4-fold higher Torvastatin exposure (AUC) than in individuals without this genotype variant (c.521TT). A genetically impaired hepatic uptake of Torvastatin is also possible in these patients. Possible consequences for the efficacy are unknown.

5.3 Preclinical safety data

Torvastatin was negative for mutagenic and clastogenic potential in a battery of 4 in vitro tests and 1 in vivo assay. Torvastatin was not found to be carcinogenic in rats, but high doses in mice (resulting in 6-11 fold the AUC_{0-24h} reached in humans at the highest recommended dose) showed hepatocellular adenomas in males and hepatocellular carcinomas in females.

There is evidence from animal experimental studies that HMG-CoA reductase inhibitors may affect the development of embryos or fetuses. In rats, rabbits and dogs Torvastatin had no effect on fertility and was not teratogenic; however, at maternally toxic doses fetal toxicity was observed in rats and rabbits. The development of the rat offspring was delayed and post-natal survival reduced during exposure of the dams to high doses of Torvastatin. In rats, there is evidence of placental transfer. In rats, plasma concentrations of Torvastatin are similar to those in milk. It is not known whether Torvastatin or its metabolites are excreted in human milk.

6. Pharmaceutical particulars

6.1 List of excipients

Tablet core:

Microcrystalline cellulose

Lactose monohydrate

Colloidal anhydrous silica

Croscarmellose sodium

Sodium hydrogen carbonate

Sodium carbonate, anhydrous

Hydroxypropylcellulose

Magnesium stearate

Butylhydroxyanisole

Butylhydroxytoluene

Tablet coating:

Opadry YS-1-7040 white

Hypromellose

Macrogol 8000

Titanium dioxide (E171)

Talc

6.2 Incompatibilities

Not applicable.

6.3 Shelf life

24 months

6.4 Special precautions for storage

Store below 25°C

6.5 Nature and contents of container

Cold form blister laminate (structure: oriented polyamide/ aluminium foil/ PVC) with the backing of hard tempered, aluminium foil coated with heat seal lacquer on inner side

Packs of 10, 14, 20, 28, 30, 50, 56, 60, 84, 90, 98, 100 film-coated tablets each

(Not all pack size may be marketed)

6.6 Special precautions for disposal and other handling

No special requirements.

7. Marketing authorisation holder

Emzor pharmaceutical industries limited

Flowergate Mixed Development Scheme, Km

1, Sagamu/Benin Expressway, Makun, Sagamu, Ogun-State.

8. Marketing authorisation number(s)

NA

9. Date of first authorisation/renewal of the authorisation

NA

10. Date of revision of the text

NA