1.3.1 Summary of Product Characteristics (SmPC)

1. NAME OF THE MEDICINAL PRODUCT

UPXIN (Softgels of Dihydroartemisinin and Piperaquine Phosphate)

1.1 STRENGTH

Each Soft Gelatin Capsule Contains:

Dihydroartemisinin	40 mg
Piperaquine Phosphate	320 mg
Excipients	q.s.

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

ASOJ SOFT CAPS PVT. LTD

Asoj, Baroda-Halol Highway, Dist - Baroda - 391 510.

Product Brand Name	**: UPXIN**	
Product Generic Name	**: Softgels of Dihydroartemisinin and Piperaquine Phosphate**	
Title :	**COMPOSITION SHEET OF RAW MATERIAL**	
		Sheet : D
Date :	Mfg. For :	Product Code : CSG2047
Batch No. :	Mfg. Date :	Die : Oval
Batch Size : 550000	Exp. Date :	Colour : Orange Opaque
Revision No. : New	Shelf life : 2 Years	Fill weight : 700 mg +/- 52 mg (R.L)

Sr. No.	Name of Raw Material	Specification	Wt.per cap. (mg)	O.A. % Per capsule	Qty. per caps.with O.A. % (mg)	Total Qty per Batch kg	Purity	Actual Qty.req per Batch
[A]	**Active ingredients**							
1	Dihydroartemisinin		40.00	7.5	43.00	23.65		
2	Piperaquine Phosphate		320.00	7.5	344.00	189.2		
[B]	**Excipients**							
3	Refined Corn Oil	U.S.P.	12.74	0	12.74	7.007		*
4	White Bees Wax	B.P.	140.00	0	140.00	77		
5	Hydrogenated Vegetable Oil	B.P.	140.00	0	140.00	77		
6	Butylated Hydroxy Anisole	B.P.	0.10	0	0.10	0.055		
7	Butylated Hydroxy Toluene	B.P.	0.05	0	0.05	0.0275		
8	Methyl Paraben	B.P.	0.10	0	0.10	0.055		
9	Propyl Paraben	B.P.	0.01	0	0.01	0.0055		
10	Soya Lecithin	U.S.P.	20.00	0	20.00	11		
	Total Fill Weight Per Capsule:				**700.00**			
	Total Fill Weight Per Kg:					**385**		

*= A (3) - [Total of B (1 to 2) - Total of A (1 to 2) =

Note : Quantity of Refined Corn Oil (U.S.P.) adjusted increased quantity of active raw material as on 100% purity basis so as to make total quantity as per batch size i.e._____ kg

Prepared By :	Checked By :	Approved By :

ASOJ SOFT CAPS PVT. LTD. BARODA

3. PHARMACEUTICAL FORM

Soft Gelatin Capsules

4. CLINICAL PARTICULARS

4.1 Therapeutic indications

UPXIN is indicated for the treatment of uncomplicated malaria in adults,children and infants. UPXIN is active against all *Plasmodium* parasites that cause malaria in humans.

Consideration should be given to official guidance on the appropriate use of antimalarialmedicinalproducts.

4.2 Posology and method of administration

Posology

UPXIN should be administered over three consecutive days for a total of three doses taken at the same time each day.

Dosing should be based on body weight as shown in the following table:

Body weight	**Number of Capsules**	**Daily dose**	
		Piperaquine	**Dihydroartemisinin**
25 kg to less than 36 kg	2 Capsules per day for 3 days	640 mg	80 mg
36 kg to less than 60 kg	3 Capsules per day for 3 days	960 mg	120 mg
60 kg to less than 80 kg	4 Capsules per day for 3 days	1280 mg	160 mg
80 kg or more	5 Capsules per day for 3 days	1600 mg	200 mg

No more than two courses of UPXIN may be given within a 12-month period.

A second course of UPXIN should not be given within 2 months after the first course due to the long elimination half-life of piperaquine

Special populations

Elderly

Clinical studies of UPXIN did not include patients aged 65 years and over, therefore no dosing recommendation can be made. Considering the possibility of age-associated decrease in hepatic and renal function, as well as a potential for heart disorders, caution should be exercised when administering the product to the elderly.

Hepatic and renal impairment

UPXIN has not been evaluated in subjects with moderate or severe renal or hepatic insufficiency. Therefore, caution is advised when administering UPXIN to these patients .

Method of administration

UPXIN should be taken orally with water and without food:

- Each dose should be taken no less than three hours after the last food intake.
- No food should be taken within 3 hours after each dose.

Fill a cup (Approximately 10ml per Capsule) with water. Place the Capsule in the liquid. As soon as the Capsule has dispersed completely swallow all the mixture. Afterwards, immediately rinse the cup with as additional small amount of water (approximately 10ml) and drink the water completely.

4.3 Contraindications

- Hypersensitivity to the active substances or to any of the excipients listed in section 6.1.
- Severe malaria according to WHO definition.
- Family history of sudden death or of congenital prolongation of the QTc interval.
- Known congenital prolongation of the QTcinterval or any clinical condition known to prolong the QTc interval.
- History of symptomatic cardiac arrhythmias or with clinically relevant bradycardia.
- Any predisposing cardiac conditions for arrhythmia such as severe hypertension, left ventricular hypertrophy (including hypertrophic cardiomyopathy) or congestive cardiac failure accompanied by reduced left ventricle ejection fraction.
- Electrolyte disturbances, particularly hypokalaemia, hypocalcaemia or hypomagnesaemia.
- Taking medicinal products that are known to prolong the QTc interval. These include (but are not limited to):
  - Antiarrhythmics (e.g. amiodarone, disopyramide, dofetilide, ibutilide, procainamide,quinidine, hydroquinidine, sotalol).
  - Neuroleptics (e.g. phenothiazines, sertindole, sultopride, chlorpromazine, haloperidol,mesoridazine, pimozide, or thioridazine), antidepressivemedicinal products.
  - Certain antimicrobialmedicinal products, including medicinal products of the followingclasses:
    - macrolides (e.g. erythromycin, clarithromycin),
    - fluoroquinolones (e.g. moxifloxacin, sparfloxacin),
    - imidazole and triazole antifungal medicinal products,
    - pentamidine and saquinavir.
  - Certain non-sedating antihistamines (e.g. terfenadine, astemizole, mizolastine). Cisapride, droperidol, domperidone, bepridil, diphemanil, probucol, levomethadyl, methadone, vinca alkaloids, arsenic trioxide.

- Recent treatment with medicinal products known to prolong the QTc interval that may still be circulating at the time that Eurartesim is started (e.g. mefloquine, halofantrine, lumefantrine, chloroquine, quinine and other antimalarialmedicinal products) taking intoaccount their elimination half-life.
-

4.4 Special warnings and precautions for use

UPXIN should not be used to treat complicated malaria.

The long half-life of piperaquine (about 22 days) should be kept in mind in the event that another antimalarial agent is started due to treatment failure or a new malaria .

Piperaquine is a mild inhibitor of CYP3A4. Caution is recommended when co-administering UPXIN with medicinal products exhibiting variable patterns of inhibition, induction or competition for CYP3A4 as the therapeutic and/or toxic effects of some coadministered medicinal products could be altered.

Piperaquine is also a substrate of CYP3A4. A moderate increase of piperaquine plasma concentrations (<2-fold) was observed when co-administered with strong CYP3A4 inhibitors, resulting in a potential exacerbation of the effect on QTc prolongation.

Exposure to piperaquine may also be increased when co-administered with mild or moderate CYP3A4-inhibitors (e.g. oral contraceptives). Therefore, caution should be applied when coadministering UPXIN with any CYP3A4-inhibitor and ECG monitoring should be considered.

Due to the lack of multiple dose PK data for piperaquine, administration of any strong CYP3A4-inhibitors should be discouraged after initiation (i.e. the first dose) of UPXIN.

UPXIN should not be used during pregnancy in situations where other suitable and effective antimalarials are available.

In the absence of carcinogenicity study data, and due to lack of clinical experience with repeated courses of treatment in humans, no more than two courses of UPXIN should be given in a 12-month period.

Effects on cardiac repolarization

In clinical trials with piperaquine/dihydroartemisinin limited ECGs were obtained during treatment. These showed that QTc prolongation occurred more frequently and to a larger extent in association with piperaquine/dihydroartemisinin therapy than with the comparators. Analysis of cardiac adverse events in clinical trials showed that these were reported more frequently in piperaquine/dihydroartemisinin-treated patients than in those treated with comparator antimalaria. Before the third dose of piperaquine/dihydroartemisinin, in one of the two Phase III studies 3/767

patients (0.4%) were reported to have a QTcF value of >500 milliseconds (ms) versus none in the comparator group.

The WHO guidelines no longer recommend performing an ECG before prescribing piperaquine/dihydroartemisinin. However, piperaquine/dihydroartemisinin should not be used in patients with known congenital long QT interval syndromes or those who have a clinical condition or are taking a medication that prolongs the QT interval.

There has been no evidence of piperaquine-related cardiotoxicity in large randomized trials or in extensive deployment in the field.

Delayed Haemolytic Anaemia
Delayed haemolytic anaemia has been observed up to one month following use of IV artesunate and oral artemisinin-based combination treatment (ACT) including reports involving piperaquine/dihydroartemisinin. Risk factors may include young age (children under 5 years old) and previous treatment with IV artesunate.

Patients and caregivers should be advised to be vigilant for signs and symptoms of post-treatment haemolysis such as pallor, jaundice, dark-coloured urine, fever, fatigue, shortness of breath, dizziness and confusion.

Paediatric population
Special precaution is advised in young children when vomiting, as they are likely to develop electrolyte disturbances. These may increase the QTc-prolonging effect of UPXIN.

Hepatic and renal impairment
Piperaquine/dihydroartemisinin has not been evaluated in patients with moderate or severe renal or hepatic insufficiency. Due to the potential for higher plasma concentrations of piperaquine to occur, caution is advised if UPXIN is administered to patients with jaundice and/or with moderate or severe renal or hepatic insufficiency, and ECG and blood potassium monitoring are advised.

4.5 Interaction with other medicinal products and other forms of interaction

UPXIN is contraindicated in patients already taking other medicinal products that are known to prolong the QTc interval due to the risk of a pharmacodynamic interaction leading to an additive effect on the QTc interval.
A limited number of drug-drug pharmacokinetic interaction studies with UPXIN have been performed in healthy adult subjects. The assessment of the potential for drug-drug interactions to occur is therefore based on either *in vivo* or *in vitro* studies.

Effect of UPXIN on co-administered medicinal products

Piperaquine is metabolised by, and is an inhibitor of, CYP3A4. The concurrent administration of oral UPXIN with 7.5 mg oral midazolam, a CYP3A4 probe substrate, led to a modest increase (≤2-fold) in midazolam and its metabolites exposure in healthy adult subjects. This inhibitory effect was no longer evident one week after last administration of UPXIN. Therefore, particular attention should be paid when medicinal products that have a narrow therapeutic index (e.g. antiretroviral medicinal products and cyclosporine) are co-administered with UPXIN.

From *in vitro* data, piperaquine undergoes a low level of metabolism by CYP2C19, and is also an inhibitor of this enzyme. There is the potential for reducing the rate of metabolism of other substrates of this enzyme, such as omeprazole, with consequent increase of their plasma concentration, and therefore, of their toxicity.

Piperaquine has the potential to increase the rate of metabolism for CYP2E1 substrates resulting in a decrease in the plasma concentrations of substrates such as paracetamol or theophylline, and the anaesthetic gases enflurane, halothane and isoflurane. The main consequence of this interaction could be a reduction of efficacy of the co-administered medicinal products.

Dihydroartemisinin administration may result in a slight decrease in CYP1A2 activity. Caution is therefore, advised when UPXIN is administered concomitantly with medicinal products metabolised by this enzyme that have a narrow therapeutic index, such as theophylline. Any effects are unlikely to persist beyond 24 hours after the last intake of dihydroartemisinin.

Effect of co-administered medicinal products on UPXIN

Piperaquine is metabolised by CYP3A4 *in vitro.* The concurrent administration of a single dose of oral clarithromycin, (a strong CYP3A4 inhibitor probe) with a single dose of oral UPXIN led to a modest increase (≤2-fold) in piperaquine exposure in healthy adult subjects. This increase in exposure to the antimalarial combination may result in an exacerbation of the effect on QTc. Therefore, particular caution is required if UPXIN is administered to patients taking potent CYP3A4 inhibitors (e.g. some protease inhibitors [amprenavir, atazanavir, indinavir, nelfinavir, ritonavir], nefazodone or verapamil), and ECG monitoring should be considered due to the risk of higher plasma concentrations of piperaquine.

Enzyme-inducing medicinal products such as rifampicin, carbamazepine, phenytoin, phenobarbital, St. John's wort (Hypericumperforatum) are likely to lead to reduced piperaquine plasma concentrations. The concentration of dihydroartemisinin may also be reduced. Concomitant treatment with such medicinal products is not recommended.

Paediatric population

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

Oral contraceptives

When co-administered to healthy women, UPXIN exerted only a minimum effect on an estrogen/progestinic combination oral contraceptive treatment, increasing the ethynilestradiol rate of absorption (expressed by geometric mean Cmax) by about 28% but not significantly changing the exposure to ethynilestradiol and levonorgestrel and not influencing contraception activity as demonstrated by the similar plasma concentrations of follicle stimulating hormone (FSH), luteinizing hormone (LH) and progesterone observed after oral contraceptive treatment with or without concomitant UPXIN administration.

Food interaction

Absorption of piperaquine is increased in the presence of fatty food which may increase its effect on QTc interval. Therefore, UPXIN should be taken with water only, as described in section 4.2. UPXIN should not be taken with grapefruit juice as it is likely to lead to increased piperaquine plasma concentrations.

4.6 Fertility, pregnancy and breastfeeding

Pregnancy

There are insufficient data on the use of dihydroartemisinin and piperaquine in pregnant women. Based on animal data, piperaquine/dihydroartemisinin is suspected to cause serious birth defects when administered during the first trimester of pregnancy. Reproductive studies with artemisinin derivatives have demonstrated teratogenic potential with an increased risk during early gestation. Piperaquine was not teratogenic in the rat or rabbit. In perinatal and postnatal studies in rats, piperaquine was associated with delivery complications. However, there was no delay in neonatal development following exposure *in utero* or via milk.

UPXIN should not be used during pregnancy in situations where other suitable and effective antimalarials are available.

Breast-feeding

Animal data suggest excretion of piperaquine into breast milk, but no data are available in humans. Women taking UPXIN should not breast-feed during their treatment.

Fertility

There are no specific data relating to the effects of piperaquine on fertility, however, to date no adverse events have been reported during clinical use. Moreover, data obtained in animal studies show that fertility is unaffected by dihydroartemisinin in both females and males.

4.7 Effects on ability to drive and use machines

Adverse event data collected in clinical trials suggest that UPXIN has no influence on the ability to drive and operate machines once the patient has recovered from the acute infection.

4.8 Undesirable effects

Summary of the safety profile
The safety of piperaquine/dihydroartemisinin has been evaluated in two phase III open-label studies involving 1,239 paediatric patients up to 18 years and 566 adult patients >18 years treated with piperaquine/dihydroartemisinin.

In a randomized trial in which 767 adults and children with uncomplicated *P. falciparum* malaria were exposed to piperaquine/dihydroartemisinin, 25% of subjects were judged to have experienced an adverse drug reaction (ADR). No single type of ADR occurred at an incidence of ≥5%. The most frequent ADRs observed at an incidence ≥1.0% were: headache (3.9%), electrocardiogram QTcprolonged (3.4%), *P. falciparum* infection (3.0%), anaemia (2.8%), eosinophilia (1.7%), haemoglobin decreased (1.7%), sinus tachycardia (1.7%), asthenia (1.6%), haematocrit [decreased] (1.6%), pyrexia (1.5%), red blood cell count decreased (1.4%). A total of 6 (0.8%) subjects had serious ADRs in the study.

In a second randomized trial, 1,038 children, aged between 6 months and 5 years, were exposed to piperaquine/dihydroartemisinin and 71% were judged to have experienced an ADR. The following ADRs were observed at an incidence of ≥5.0%: cough (32%), pyrexia (22.4%), influenza (16.0%), *P. falciparum* infection (14.1%), diarrhoea (9.4%), vomiting (5.5%) and anorexia (5.2%). A total of 15 (1.5%) subjects had serious ADRs in the study.

Tabulated list of adverse reactions
In the tables below, ADRs are listed under system organ class (SOC) and ranked by headings of frequency. Within each frequency grouping, adverse reactions are presented in the order of decreasing seriousness, using the following convention: 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), not known (cannot be estimated from the available data). The table in this section is for adult patients only. A corresponding table for paediatric patients is presented in the specific section below.

Frequency of ADRs in adult patients participating in clinical studies with	**Very common**	**Common**	**Uncommon**

UPXIN: SOC			
Infections and infestations	*P. falciparum* infection		Respiratory tract infection; influenza
Blood and lymphatic system disorders		Anaemia	
Metabolism and nutrition disorders		Anorexia	
Nervous system disorders	Headache		Convulsion; dizziness
Cardiac disorders	QTc interval prolongation; tachycardia		Cardiac conduction disorders; sinus arrhythmia; bradycardia
Respiratory, thoracic and mediastinal disorders		Cough	
Gastrointestinal disorders		Vomiting; diarrhoea; nausea; abdominal pain	
Hepatobiliary disorders		Hepatitis; hepatomegaly; abnormal liver function tests	
Skin and subcutaneous tissue disorders		Pruritis	
Musculoskeletal and connective tissue disorders		Arthralgia; myalgia	
General disorders and administration site conditions		Asthenia; pyrexia	

Description of selected adverse reactions

The ADRs noted for piperaquine/dihydroartemisinin were generally mild in severity, and the majority were non-serious.Reactions such as cough, pyrexia, headache, *P. falciparum* infection, anaemia, asthenia, anorexia andthe observed changes in blood cell parameters are consistent with those expected in patients with acutemalaria. The effect on prolongation of the QTc interval was observed on Day 2 and had resolved byDay 7 (the next time point at which ECGs were performed).

Paediatric population

A tabular overview of the frequency of the ADRs in paediatric patients is given below. The majorityof paediatric experience is derived from African children aged 6 months to 5 years.

Frequency of ADRs in paediatric patients participating in clinical studies with UPXIN: SOC	**Very common**	**Common**	**Uncommon**
Infections and infestations	Influenza; *P. falciparum*		Respiratory tract infection;

	infection	ear infection
Blood and lymphatic system disorders	Thrombocytopenia; leukopenia/neutropenia; leukocytosis; anaemia	Thrombocytosis; splenomegaly; lymphadenopathy; hypochromasia
Metabolism and nutrition disorders	Anorexia	
Nervous system disorders	Convulsion; headache	
Eye disorders	Conjunctivitis	
Cardiac disorders	QTc interval prolongation; heart rate irregular	Cardiac conduction disorders; cardiac murmur
Respiratory, thoracic and mediastinal disorders	Cough	Rhinorrhoea; epistaxis
Gastrointestinal disorders	Vomiting; diarrhoea; abdominal pain	Stomatitis; nausea
Hepatobiliary disorders	Hepatitis; hepatomegaly; abnormal liver function tests; jaundice	
Skin and subcutaneous tissue disorders	Dermatitis; rash	Acanthosis; pruritis
Musculoskeletal and connective tissue disorders	Arthralgia	
General disorders and administration site conditions	Pyrexia	Asthenia

Reporting of suspected adverse reactions

Reporting suspected adverse reactions after authorisation of the medicinal product is important. Itallows continued monitoring of the benefit/risk balance of the medicinal product. Healthcareprofessionals are asked to report any suspected adverse reactions via the national reporting systemlisted in Appendix V.

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 to the marketing authorisation holder, or, if available, via the national reporting system.

4.9 Overdose

In clinical trials, nine patients received double the cumulative intended dose of piperaquine/dihydroartemisinin. The safety profile of these patients did not differ from that of patients receiving the recommended dose, with no patient reporting SAEs.

In cases of suspected overdose, symptomatic and supportive therapy should be given as appropriate, including ECG monitoring because of the possibility of QTc interval prolongation.

5. PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: Antiprotozoals, antimalarials, artemisinin and derivatives, combinations, ATC code: P01BF05

Pharmacodynamic effects

Dihydroartemisinin is able to reach high concentrations within the parasitized erythrocytes. Its endoperoxide bridge is thought to be essential for its antimalarial activity, causing free-radical damage to parasite membrane systems including:

- Inhibition of *falciparum* sarcoplasmic-endoplasmic reticulum calcium ATPase
- Interference with mitochondrial electron transport
- Interference with parasite transport proteins
- Disruption of parasite mitochondrial function

The exact mechanism of action of piperaquine is unknown, but it likely mirrors that of chloroquine, aclose structural analogue. Chloroquine binds to toxic haem (derived from the patient's haemoglobin)within the malaria parasite, preventing its detoxification via a polymerisation step.

Piperaquine is a bisquinolone, and this class has shown good antimalarial activity against chloroquine-resistant*Plasmodium* strains *in vitro*. The bulky bisquinolone structure may be important for activityagainst chloroquine-resistant strains, and may act through the following mechanisms:

- Inhibition of the transporters that efflux chloroquine from the parasite food vacuole
- Inhibition of haem-digestion pathway in the parasite food vacuole.

Resistance to piperaquine (when used as monotherapy) has been reported.

The efficacy and safety of piperaquine/dihydroartemisinin have been assessed in two large randomised, open-label clinicaltrials:

Study DM040010 was conducted in Asian adult and paediatric patients with uncomplicated*P. falciparum* malaria. Piperaquine/dihydroartemisinin(PPQ/DHA) treatment was compared with

Artesunate + Mefloquine (AS + MQ).The primary endpoint was the PCR-corrected cure rate at Day 63.

Study DM040011 was conducted in African paediatric patients with uncomplicated *P. falciparum* malaria. Piperaquine/dihydroartemisinin(PPQ/DHA) treatment was compared with Artemether + Lumefantrine (A + L). The primaryendpoint was PCR-corrected cure rate at Day 28.

The results for the primary endpoint in the modified intent to treat (m-ITT) populations (defined as allrandomised patients who received at least one dose of the study treatment, with the exclusion of thosepatients lost to follow up for unknown reasons) were as follows:

Study				**PCR-corrected cure rate (m-ITT)**	
PPQ/DHA		**AS+MQ**		**A+L**	**95 % two-sided CI onthe treatment difference (PPQ/DHA-Comparator)**
DM040010 (n=1087)	97.0%	95.3%		-	(-0.84, 4.19) %; p=0.161
DM040011 (n=1524)	92.7%	-		94.8%	(-4.59, 0.45) %; p=0.128

In each case the results confirmed that PPQ/DHA was not inferior to the comparator medicinalproduct. In both studies, the true treatment failure rate was below the 5% efficacy threshold set byWHO.

The age-specific PCR-corrected cure rates in the m-ITT populations are tabulated below for the Asianand African studies, respectively:

Study			**PCR-corrected cure rate (m-ITT)**	
PPQ/DHA	**AS+MQ**		**A+L**	**95 % two-sided CI onthe treatment difference(**PPQ/DHA **-Comparator)**
DM04010	100.0%	100.0%	-	-
(n=1087)	98.2%	96.5%	-	(-3.67, 7.09) %; p=0.605
≤5 years	97.3%	100.0%	-	
>5 to ≤12 years	96.6%	94.4%	-	(-6.40, 0.99) %; p=1.000

>12 to ≤ 18 years >18 to ≤ 64 years				(-0.98, 5.30) %; p=0.146
DM04011 (n=1524) ≤1 year >1 to ≤2 years >2 to ≤5 years	91.5% 92.6% 93.0%	- - -	98.5% 94.6% 94.0%	(-12.66, -1.32) %(1); p=0.064 (-6.76, 2.63) %; p=0.413 (-4.41, 2.47) %; p=0.590

(1) This CI is asymptotic because the exact CI could not be computed.

5.2 Pharmacokinetic properties

The absorption characteristics of UPXIN have been determined after administrationof Dihydroartemisinin/ PiperaquineTetraphosphate 40/320 mg FDC dispersibleCapsules in healthy volunteers in the fasting state as follows:

Pharmacokinetic variable'	**Mean value ± standard deviation (*)**	
	Dihydroartemisinin	**Piperaquine**
Maximum concentration (Cmax) ng/ml	107 ± 54 (93)	28 ± 12 (25)
Area under the curve (AUC0–∞), a measure of the extent of absorptionng.hour/ml	236 ± 122 --	1474 ± 912 --
Time to attain maximum concentration (tmax) hour	1.27 ± 0.58	3.65 ± 1.97

*geometric mean

	Dihydroartemisinin	**Piperaquine**
General		
Bioavailability is higher in patients with malaria compared to healthy volunteers.		
Absorption		
Absolute bioavailability	NA	NA
Oral Bioavailability	NA	NA
Food effect	Exposure increased by 43% with a high fat/high calorie	Exposure increased approximately 3-fold with a

	meal	high fat/high calorie meal
Distribution		
Volume of distribution (mean)	0.8 L/kg	730 L/kg
Plasma protein binding *in vitro*	44–93%	> 99%
Tissue distribution	Accumulates in red blood cells	Accumulates in red blood cells
Metabolism		
Hepatic glucuronidation to α- artenimol-β-glucuronide	Hepatic: major metabolites are a carboxyl acid cleavage product and a mono-N-oxidated product	
Elimination		
Mean elimination half-life	1 hour	22 days
Mean oral clearance	1.34 L/h/kg	2.1 L/h/kg
% of dose excreted in urine	Negligible as intact drug	NA
% of dose excreted in faeces	Negligible as intact drug	NA
Pharmacokinetic linearity	NA	NA
Drug interactions *(in vitro)*		
Transporters	NA	NA
Metabolising enzymes	UGT1A9 and UGT2B7	CYP3A4 (mainly), CYP2C9 and CYP2C19
Inhibitor of CYP1A2	Mild inhibitor of CYP3A4 and CYP2C19 Inducer of CYP2E1	
Special populations		
Renal impairment	NA	NA
Hepatic impairment	NA	NA
Elderly patients	NA	NA

Patients with hepatic or renal insufficiency

No specific pharmacokinetic studies have been performed in patients with hepatic or renalinsufficiency, or in elderly people.

Paediatrics

In a paediatric pharmacokinetic study, and based on very limited sampling, minor differences wereobserved for dihydroartemisinin pharmacokinetics between the paediatric and adult populations. The meanclearance (1.45 L/h/kg) was slightly faster in the paediatric patients than in the adult

patients(1.34 L/h/kg), while the mean volume of distribution in the paediatric patients (0.705 L/kg) was lowerthan in the adults (0.801 L/kg).

The same comparison showed that piperaquine absorption rate constant and terminal half-life inchildren were predominantly similar to those seen in adults. However, the apparent clearance wasfaster (1.30 versus 1.14 L/h/kg) and the apparent total volume of distribution was lower in thepaediatric population (623 versus 730 L/kg).

5.3 Preclinical safety data

General toxicity
Literature data concerning chronic toxicity of piperaquine in dogs and monkeys indicate some hepatotoxicity and mild reversible depression of total white cell and neutrophil counts.

The most important nonclinical safety findings after repeated dosing were the infiltration of macrophages with intracytoplasmic basophilic granular material consistent with phospholipidosis and degenerative lesions in numerous organs and tissues. These adverse reactions were seen in animals at exposure levels similar to clinical exposure levels, and with possible relevance to clinical use. It is not known whether these toxic effects are reversible.

Dihydroartemisinin and piperaquine were not genotoxic/clastogenic based on *in vitro* and *in vivo* testing.

No carcinogenicity studies have been performed.

Dihydroartemisinin causes embryolethality and teratogenicity in rats and rabbits.

Piperaquine did not induce malformation in rats and rabbits. In a perinatal and postnatal development study (segment III) in female rats treated with 80 mg/kg, some animals had a delay of delivery inducing mortality of the neonates. In females delivering normally, the development, behaviour and growth of the surviving progeny was normal following exposure *in utero* or via milk.

No reproduction toxicity studies have been performed with the combination of dihydroartemisinin and piperaquine.

Central nervous system (CNS) toxicity
There is potential for neurotoxicity of artemisinin derivatives in man and animals, which is strongly related to the dose, route and formulations of the different dihydroartemisinin pro-drugs. In humans, the potential neurotoxicity of orally administered dihydroartemisinin can be considered highly unlikely, given the rapid clearance ofdihydroartemisinin, and its short exposure (3 days of treatment

for malaria patients). There was no evidence of dihydroartemisinin-induced lesions in the specific nuclei in rats or dogs, even at lethal dose.

Cardiovascular toxicity

Effects on blood pressure and on PR and QRS duration were observed at high piperaquine doses. Themost important potential cardiac effect was related to cardiac conduction.

In the hERG test, the IC50 was 0.15 µmol for piperaquine and 7.7 µmol fordihydroartemisinin. The associationof dihydroartemisinin and piperaquine does not produce hERG inhibition greater than that of the singlecompounds.

Phototoxicity

There are no phototoxicity concerns withdihydroartemisinin, as it does not absorb in the range of 290–700 nm.Piperaquine has an absorption maximum at 352 nm. Since piperaquine is present in the skin (about 9%in the non-pigmented rat and only 3% in the pigmented rat), slight phototoxic reactions (swelling anderythema) were observed 24 hours after oral treatment in mice exposed to UV radiation.

6. PHARMACEUTICAL PARTICULARS

6.1 List of excipients

S. No.	Ingredients	Specification
1.	Refined Corn Oil	USP
2.	Hydrogenated Vegetable Oil	BP
3.	White Bees Wax	BP
4.	Butylated Hydroxy Anisole	BP
5.	Butylated Hydroxy Toluene	BP
6.	Soyalecithin	USP
7.	Methyl Paraben	BP
8.	Propyl Paraben	BP

6.2 Incompatibilities

None known.

6.3 Shelf – life:

24 months from the date of manufacturing.

6.4 Special precautions for storage:

Store below 30°C in a cool & dry place,
Protect from direct light, heat & moisture.
Keep out of reach of children.

6.5 Nature and contents of container :

9 or 12 Capsules packed in Alu-PVC Blister Pack, 1 Blisters packed in mono carton along with package insert and 10 Mono Cartons are packed in 1 Outer Carton.

6.6 Special precautions for disposal and other handling

Not applicable

7. MARKETING AUTHORIZATION HOLDER: NA

8. MANUFACTURER:

ASOJ SOFT CAPS PVT. LTD.
Asoj, Baroda – Halol Highway,
Dist. Baroda – 391 510. Gujarat.

9. AWARD GLOBAL COMPANY LIMITED,
13 OLAWALE DAUDA STREET,IFAKO,
GBAGADA. LAGOS