

1 NAME OF THE MEDICINE

Naproxen

2 QUALITATIVE AND QUANTITATIVE COMPOSITION

Each tablet contains 250 mg or 500 mg of naproxen as the active ingredient.

Excipients of known effect: sugars as lactose and trace quantities of sulfites.

For the full list of excipients, see Section 6.1 LIST OF EXCIPIENTS.

3 PHARMACEUTICAL FORM

INZA 250 mg tablets: white, flat bevelled edged, marked NP/250 on one side, G on reverse.

INZA 500 mg tablets: white, oblong shaped, marked NP500 on one side, G on reverse.

4 CLINICAL PARTICULARS

4.1 THERAPEUTIC INDICATIONS

INZA is indicated for the treatment of rheumatoid arthritis, osteoarthritis, juvenile rheumatoid arthritis and ankylosing spondylitis, for the symptomatic treatment of primary dysmenorrhoea, for the relief of acute and/or chronic pain states in which there is an inflammatory component and as an analgesic in acute migraine attack.

4.2 DOSE AND METHOD OF ADMINISTRATION

After assessing the risk/benefit ratio in each individual patient, the lowest effective dose for the shortest possible duration should be used.

Chronic Conditions

Rheumatoid arthritis/osteoarthritis/ankylosing spondylitis/chronic pain states in which there is an inflammatory component

The dosage range of INZA is 375 mg to 1000 mg daily in two divided doses. The starting dose should not be less than 500 mg daily and may be varied stepwise within the range of 375 mg to 1000 mg daily maintaining twice daily administration for long term maintenance, depending on the needs of the patient.

Acute Conditions

Acute pain states in which there is an inflammatory component

The recommended dose of INZA tablets is 500 mg initially followed by 250 mg every six to eight hours as required. The total daily dose should not exceed 1250 mg.

Dysmenorrhoea

In the symptomatic treatment of primary dysmenorrhoea, the recommended dose of INZA is 500 mg initially, at the first sign of dysmenorrhoea or menstrual bleeding (whichever occurs first), followed by 250 mg every six to eight hours as required. The total daily dose should not exceed 1250 mg.

Migraine

For the treatment of acute migraine headache, the recommended dose of INZA tablets is 750 mg at the first symptom of an impending headache. An additional dose of 250 mg to 500 mg can be given throughout the day, if necessary, at least an hour after the initial dose. The total daily dose should not exceed 1250 mg.

Children

Juvenile Rheumatoid Arthritis

The recommended daily dose for children 5 years and above is 10 mg/kg daily in two equal divided doses (i.e. 5 mg/kg twice a day).

Patients on long term treatment should be reviewed regularly with regards to efficacy, risk factors and ongoing need for treatment.

Pregnancy

See Section 4.6 FERTILITY, PREGNANCY AND LACTATION and Section 4.3 CONTRAINDICATIONS.

4.3 CONTRAINDICATIONS

INZA is contraindicated in patients:

- Who are hypersensitive to naproxen or naproxen sodium or in whom acetylsalicylic acid (aspirin) or other non-steroidal anti-inflammatory/analgesic agents induce allergic manifestations, e.g. asthma, nasal polyps, rhinitis and urticaria. Severe anaphylactic-like reactions to naproxen have been reported in such patients
- with either active, or a history of peptic or gastrointestinal ulceration, chronic dyspepsia. or active gastrointestinal bleeding or perforation, related to previous NSAID therapy
- with active, or history of recurrent peptic ulcer/haemorrhage (two or more distinct episodes of proven ulceration or bleeding) unrelated to previous NSAIDs therapy
- under 2 years of age since safety in this age group has not been established
- with severe heart failure
- undergoing treatment of perioperative pain in setting of coronary artery surgery (CABG)
- with severe hepatic impairment
- in the 3rd trimester of pregnancy

4.4 SPECIAL WARNINGS AND PRECAUTIONS FOR USE

Cardiovascular Thrombotic Events

Observational studies have indicated that non-selective NSAIDs may be associated with an increased risk of serious cardiovascular events, including myocardial infarction and stroke, which may increase with dose or duration of use. Patients with cardiovascular disease, history of atherosclerotic cardiovascular disease or cardiovascular risk factors may also be at greater risk. To minimise the potential risk of an adverse cardiovascular event in patients taking an NSAID, especially in those with cardiovascular risk factors, the lowest-effective dose should be used for the shortest possible duration (see Section 4.2 DOSE AND METHOD OF ADMINISTRATION).

Physicians and patients should remain alert for such CV events even in the absence of previous CV symptoms. Patients should be informed about the signs and/or symptoms of serious CV toxicity and the steps to take if they occur.

There is no consistent evidence to suggest that the concurrent use of aspirin mitigates the possible increased risk of serious cardiovascular thrombotic events associated with NSAID use.

Clinical trial and epidemiological data suggest that use of coxibs and some NSAIDs (particularly at high doses and long-term treatment) may be associated with a small increased risk of arterial thrombotic events (e.g. myocardial infarction or stroke).

Hypertension

NSAIDs may lead to the onset of new hypertension or worsening of pre-existing hypertension and patients taking anti-hypertensives with NSAIDs may have an impaired anti-hypertensive response. Caution is advised when prescribing NSAIDs to patients with hypertension. Blood pressure should be monitored closely during initiation of NSAID treatment and at regular intervals thereafter.

Heart Failure

Fluid retention and oedema have been observed in some patients taking NSAIDs, therefore, caution is advised in patients with fluid retention or heart failure.

Gastrointestinal Events

All NSAIDs can cause gastrointestinal discomfort and rarely serious, potentially fatal, gastrointestinal effects such as ulcers, irritation, bleeding and perforation which may increase with dose or duration of use; but can occur at any time without warning. Upper gastrointestinal ulcers, gross bleeding or perforation caused by NSAIDs occur in approximately 1% of patients treated for 3-6 months and in about 2-4% of patients treated for one year. These trends continue with longer duration of use, increasing the likelihood of developing a serious gastrointestinal event at some time during the course of therapy. However, even short-term therapy is not without risk.

Caution is advised in patients with risk factors for gastrointestinal events who may be at greater risk of developing serious gastrointestinal events e.g. the elderly, debilitated patients, those with a history of serious gastrointestinal events, smoking and alcoholism.

NSAIDs should be given with care to patients with a history of inflammatory bowel disease (ulcerative colitis; Crohn's disease) as their condition may be exacerbated. Patients with a history of gastrointestinal toxicity, particularly when elderly, should report any unusual abdominal symptoms (especially gastrointestinal bleeding) particularly in the initial stages of treatment. When gastrointestinal bleeding or ulceration occurs in patients receiving NSAIDs, treatment should be withdrawn immediately. Physicians should warn patients about the signs and symptoms of serious gastrointestinal toxicity.

Studies to date have not identified any subset of patients not at risk of developing peptic ulcer and bleeding. However, the elderly have an increased frequency of adverse effects to NSAIDs, especially gastrointestinal bleeding and perforation which may be fatal. Debilitated patients do not seem to tolerate ulceration or bleeding as well as others. Most of the fatal gastrointestinal events associated with NSAIDs occurred with the elderly and/or debilitated patients.

In patients with active peptic ulcer or active inflammatory disease of the gastrointestinal tract and active rheumatoid arthritis, an attempt might be made to treat the arthritis with a non-ulcerogenic drug.

Patients with risk factors should commence treatment on the lowest dose available. Caution is advised in patients receiving concomitant medications which could increase the risk of ulceration or bleeding (see Section 4.5 INTERACTIONS WITH OTHER MEDICINES AND OTHER FORMS OF INTERACTIONS). The concurrent use of aspirin and NSAIDs also increases the risk of serious gastrointestinal adverse events.

Patients with risk factors should commence treatment on the lowest dose available.

Haematological

Naproxen decreases platelet aggregation and prolongs bleeding time. This effect should be kept in mind when bleeding times are being determined. (see Section 4.4 SPECIAL WARNINGS AND PRECAUTIONS FOR USE – EFFECTS ON LABORATORY TESTS).

Patients who have coagulation disorders or are receiving drug therapy that interferes with haemostasis should be carefully observed if INZA is administered. Patients at high risk of bleeding and those on full anticoagulation therapy (e.g. heparin or dicoumarol derivatives) may be at increased risk of bleeding if given INZA concurrently. Therefore, the benefits of prescribing INZA should be weighed against these risks.

Patients with initial haemoglobin values of 10 grams or less, and who are to receive long-term therapy should have their haemoglobin values determined frequently.

Patients on other drugs such as hydantoin, sulfonamides, sulfonylureas or methotrexate should be observed for increased effect or toxicity (see Section 4.5 INTERACTIONS WITH OTHER MEDICINES AND OTHER FORMS OF INTERACTIONS).

Severe Skin Reactions

NSAIDs may very rarely cause serious cutaneous adverse events such as exfoliative dermatitis, Stevens-Johnson Syndrome (SJS), Drug Reaction with Eosinophilia with Systemic Symptoms (DRESS) and toxic epidermal necrolysis (TEN), which can be fatal and occur without warning. These serious adverse events are idiosyncratic and are independent of dose or duration of use. Patients should be advised of the signs and symptoms of serious skin reactions and to consult their physician at the first appearance of a skin rash or any other sign of hypersensitivity.

DRESS has been reported in patients taking NSAIDs. Some of these events have been fatal or life-threatening. DRESS typically, although not exclusively, presents with fever, rash, lymphadenopathy, and/or facial swelling. Other clinical manifestations may include hepatitis, nephritis, haematological abnormalities, myocarditis, or myositis. Sometimes symptoms of DRESS may resemble an acute viral infection. Eosinophilia is often present. Because this disorder is variable in its presentation, other organ systems not noted here may be involved. It is important to note that early manifestations of hypersensitivity, such as fever or lymphadenopathy, may be present even though rash is not evident. If such signs or symptoms are present, discontinue NSAID and evaluate the patient immediately.

Anaphylactic Reactions

Hypersensitivity reactions may occur in susceptible individuals. Anaphylactic (anaphylactoid) reactions may occur both in patients with, and without a history of hypersensitivity or exposure to aspirin; or other NSAIDs or naproxen-containing products. They may also occur in individuals with a history of angioedema, bronchospastic reactivity (e.g. asthma), rhinitis and nasal polyps. Anaphylactoid reactions, like anaphylaxis, may have a fatal outcome.

Bronchospasm may be precipitated in patients suffering from, or with a history of, asthma or allergic disease or aspirin sensitivity.

Infection

The antipyretic, anti-inflammatory and analgesic effects of naproxen may mask the usual signs or symptoms of infection.

Ocular Events

Adverse ophthalmological effects have been observed with NSAIDs. In rare cases, adverse ocular disorders including papillitis, retrobulbar optic neuritis and papilloedema have been reported in users of NSAIDs

including INZA, although a cause-and-effect relationship cannot be established; accordingly, patients who develop visual disturbances during treatment with INZA should have an ophthalmological examination.

Fluid Retention and Oedema

Peripheral oedema has been observed in some patients taking INZA or other NSAIDs. Although sodium retention has not been reported in metabolic studies, it is possible that patients with compromised cardiac function may be at greater risk when taking naproxen. For this reason, naproxen should be used with caution in patients with fluid retention, hypertension or heart failure.

Use in Hepatic Impairment

As with other NSAIDs, elevations of one or more liver function tests may occur in up to 15% of patients. These abnormalities may progress, may remain essentially unchanged, or may resolve with continued therapy. The ALT test is probably the most sensitive indicator of liver dysfunction. Meaningful elevations (three times the upper limit of normal) of ALT or AST occurred in controlled clinical trials in less than 1% of patients. Physicians and patients should remain alert for hepatotoxicity. Patients should be informed about the signs and/or symptoms of hepatotoxicity. A patient with symptoms and/or signs suggesting hepatic dysfunction (e.g. nausea, fatigue, lethargy, pruritis, jaundice, abdominal tenderness in the right upper quadrant and “flu-like” symptoms), or in whom an abnormal hepatic test has occurred, should be evaluated for evidence of the development of more severe hepatic reaction while on therapy with INZA.

Hepatic abnormalities may be the result of hypersensitivity or direct toxicity.

Severe hepatic reactions, including jaundice and cases of fatal hepatitis, have been reported with naproxen as with other NSAIDs. Cross reactivity has been reported. Although such reactions are rare, if abnormal hepatic tests persist or worsen, if clinical signs and symptoms consistent with hepatic disease develop, or if systemic manifestations occur (e.g. eosinophilia, rash, etc.), this drug should be discontinued.

Chronic alcoholic hepatic disease and potentially other forms of cirrhosis reduce the total plasma concentration of naproxen; however, the plasma concentration of unbound naproxen is increased. The implication of this finding for naproxen dosing is unknown.

In patients with impaired hepatic function, the lowest effective dose is recommended.

Use in Renal Impairment

There have been reported cases of impaired renal function, renal failure, acute interstitial nephritis, haematuria, proteinuria, renal papillary necrosis, and occasionally nephritic syndrome associated with naproxen.

INZA should not be given to patients with creatinine clearance less than 30 mL/minute because accumulation of naproxen metabolites has been seen in such patients.

As with other NSAIDs, INZA should be used with caution in patients with impaired renal function or a history of kidney disease because naproxen is an inhibitor of prostaglandin synthesis. Caution should be observed in patients with conditions leading to a reduction in blood volume and/or renal blood flow as prostaglandins have a supportive role in the maintenance of renal perfusion. In these patients, administration of INZA or other NSAIDs may cause a dose-dependent reduction in renal prostaglandin formation and may precipitate overt renal decompensation or failure. Patients at greatest risk are those with impaired renal function, hypovolaemia, heart failure, liver dysfunction, salt depletion, those taking diuretics, angiotensin converting enzyme inhibitors or angiotensin receptor blockers and the elderly. Discontinuation of INZA is usually followed by recovery to the pre-treatment state; however, serious adverse events may persist. INZA should be used with great caution in such patients and the monitoring of serum creatinine and/or creatinine clearance is advised and patients should be adequately hydrated. A reduction of daily dosage should be considered to avoid the possibility of excessive accumulation of naproxen metabolites in these patients.

Haemodialysis does not decrease the plasma concentration of naproxen because of the high degree of its protein binding.

Use in the Elderly

The lowest effective dose is recommended in elderly patients.

Studies indicate that although the total plasma concentration of naproxen is unchanged, the unbound plasma fraction of naproxen is increased in the elderly.

Paediatric Use

INZA is not recommended in children under 5 years of age as the safety and efficacy in this population has not been established.

Effects on Laboratory Tests

Naproxen decreases platelet aggregation and prolongs bleeding time. This effect should be considered when bleeding times are determined.

INZA may result in artefactual interference with some tests for 17-ketogenic steroid and may interfere with some urinary assays for 5-hydroxy-indoleacetic acid (5HIAA). 17-hydroxycorticosteroid measurements (Porter/Silber test) do not appear to be altered.

Naproxen therapy should be temporarily discontinued for at least 72 hours before testing adrenal function.

4.5 INTERACTIONS WITH OTHER MEDICINES AND OTHER FORMS OF INTERACTIONS

Concomitant administration of sucralfate or colestyramine can delay the absorption of naproxen; but does not affect its extent. Antacids have a variable effect on absorption.

Other NSAIDs

Combination of naproxen-containing products and other NSAIDs, including cyclooxygenase-2 (COX-2) selective inhibitors, is not recommended, because of the cumulative risks of inducing serious NSAID-related adverse events.

Protein Binding

Naproxen is highly bound to plasma albumin; thus, naproxen has a theoretical potential for interaction with other albumin-bound drugs; for example, warfarin, or bishydroxycoumarin may be displaced and induce excessively prolonged prothrombin times. Similarly, patients receiving hydantoins, sulfonamides or sulfonylureas should be observed for increased effect or toxicity (see Section 4.4 SPECIAL WARNINGS AND PRECAUTIONS FOR USE - HAEMATOLOGICAL).

Warfarin

The concurrent use of NSAIDs and warfarin has been associated with severe, sometimes fatal, haemorrhage. The exact mechanism of the interaction between NSAIDs and warfarin is unknown; but may involve enhanced bleeding from NSAID-induced gastrointestinal ulceration, or an additive effect of anticoagulation by warfarin and inhibition of platelet function by NSAIDs. INZA should be used in combination with warfarin only if absolutely necessary, and patients taking this combination of drugs should be closely monitored.

Anticoagulants / Antiplatelet Agents

Patients who have coagulation disorders or are receiving drug therapy that interferes with haemostasis should be carefully observed if naproxen is administered. Patients on full anticoagulation therapy (e.g. heparin or dicoumarol derivatives) may be at increased risk of bleeding if given naproxen concurrently. Thus, the benefits should be weighed against these risks.

There is an increased risk of gastrointestinal bleeding when anti-platelet agents are combined with NSAIDs.

Selective Serotonin Reuptake Inhibitors (SSRIs)

There is an increased risk of gastrointestinal bleeding when SSRIs are combined with NSAIDs.

Steroids

If steroid dosage is reduced or eliminated during INZA therapy, the steroid dosage should be reduced slowly, and the patients must be observed closely for any evidence of adverse effects, including adrenal insufficiency and exacerbation of symptoms of underlying disease.

Probenecid

Probenecid significantly prolongs the half-life of naproxen (from 14 to 37 hours). This is associated with a decrease in conjugated metabolites and an increase in 6-O-desmethyl naproxen.

Methotrexate

Concomitant administration of naproxen and methotrexate should be done with caution, because naproxen has been reported among other NSAIDs to reduce the tubular secretion of methotrexate in an animal models and have been reported to reduce the clearance of methotrexate; and thus, possibly increasing the toxicity of methotrexate.

Beta-blockers

Naproxen and other NSAIDs can reduce the anti-hypertensive effect of beta-blockers, angiotensin converting enzyme inhibitors (ACE inhibitors), and angiotensin receptor blockers (ARBs).

Diuretics

As with other NSAIDs, naproxen may inhibit the natriuretic effect of furosemide .

Lithium

Inhibition of renal lithium clearance leading to increases in plasma lithium concentrations has been reported.

Sodium Bicarbonate

Sodium bicarbonate may enhance the rate of naproxen absorption.

Zidovudine

In vitro studies have shown that naproxen may interfere with the metabolism of zidovudine, resulting in higher zidovudine plasma levels. Therefore, to avoid the potential side effects associated with increased zidovudine plasma levels, dose reduction should be considered.

ACE-Inhibitors

Concomitant use of NSAIDs with ACE inhibitors or angiotensin receptor blockers may increase the risk of renal dysfunction, especially in patients with pre-existing poor renal function (see Section 4.4 SPECIAL WARNINGS AND PRECAUTIONS FOR USE).

Combination use of ACE inhibitors or angiotensin receptor antagonists, anti-inflammatory drugs and thiazide diuretics

The use of an ACE inhibiting drug (ACE-inhibitor or angiotensin receptor antagonist), an anti-inflammatory drug (NSAID or COX-2 inhibitor) and a thiazide diuretic at the same time (triple whammy) increases the risk of renal impairment. This includes use in fixed-combination products containing more than one class of drug. Combined use of these medications should be accompanied by increased monitoring of serum creatinine, particularly at the initiation of the combination. The combination of drugs from these three classes should be used with caution particularly in elderly patients or those with pre-existing renal impairment.

4.6 FERTILITY, PREGNANCY AND LACTATION

Effects on Fertility

The use of naproxen, as with any drug known to inhibit cyclooxygenase/prostaglandin synthesis, may impair fertility and is not recommended in women attempting to conceive. In women who have difficulty conceiving or are undergoing investigation of infertility, withdrawal of naproxen should be considered.

Use in Pregnancy

Pregnancy category: C

Naproxen is contraindicated in the 3rd trimester of pregnancy.

Naproxen should not be used during the first two trimesters of pregnancy, unless the expected benefits to the mother outweigh the risks to the foetus. If there is a compelling need for NSAID treatment during the first or second trimester, limit use to the lowest effective dose and shortest duration possible.

Data from epidemiological studies suggest an increased risk of miscarriage and congenital malformation associated with NSAID use in early pregnancy.

NSAIDs inhibit prostaglandin synthesis and data from epidemiological studies suggest an increased risk of miscarriage and congenital malformation associated with NSAID use in early pregnancy. In animals, administration of prostaglandin synthesis inhibitors has been shown to result in increased pre- and post-implantation loss.

Use of NSAIDs in the second or third trimester may cause foetal renal dysfunction leading to oligohydramnios and, in some cases, neonatal renal impairment. Oligohydramnios is generally seen after days to weeks of treatment, although it has been reported as soon as 48 hours after NSAID initiation. Oligohydramnios is usually, but not always, reversible after treatment discontinuation. Consider ultrasound monitoring of amniotic fluid if treatment extends beyond 48 hours. Discontinue treatment with naproxen if oligohydramnios occurs.

NSAIDs inhibit prostaglandin synthesis and, when given during the 3rd trimester of pregnancy, may cause premature closure of the foetal ductus arteriosus (see Premature Closure of Foetal Ductus Arteriosus), foetal renal dysfunction leading to oligohydramnios and neonatal renal impairment (see Oligohydramnios and Neonatal Renal Impairment), inhibition of platelet aggregation, prolong labour and delay labour and birth. NSAID use in the 3rd trimester of pregnancy is therefore contraindicated.

INZA should only be administered during pregnancy if the benefit justifies the potential risk.

Data from epidemiological studies suggest an increased risk of miscarriage after the use of a prostaglandin synthesis inhibitor in early pregnancy.

Premature Closure of Foetal Ductus Arteriosus

Naproxen may cause premature closure of the foetal ductus arteriosus. Avoid use of naproxen in pregnant women starting at about 30 weeks of gestation (third trimester) and later. Naproxen increases the risk of premature closure of the foetal ductus arteriosus at approximately this gestational age.

Oligohydramnios and Neonatal Renal Impairment

Use of NSAIDs from about 20 weeks gestation or later in pregnancy may cause foetal renal dysfunction leading to oligohydramnios and, in some cases, neonatal renal impairment. These adverse outcomes are seen, on average, after days to weeks of treatment, although oligohydramnios has been infrequently reported as soon as 48 hours after NSAID initiation. Oligohydramnios is often, but not always, reversible with treatment discontinuation. Complications of prolonged oligohydramnios may, for example, include limb contractures and delayed lung maturation. In some post marketing cases of impaired neonatal renal function, invasive procedures such as exchange transfusion or dialysis were required.

If, after careful consideration of alternative treatment options for pain management, naproxen treatment is necessary from about 20 weeks, limit naproxen use to the lowest effective dose and shortest duration possible. Consider ultrasound monitoring of amniotic fluid if naproxen treatment extends beyond 48 hours. Discontinue treatment with naproxen if oligohydramnios occurs and follow up according to clinical practice.

Use in Lactation

INZA has been found in the milk of lactating mothers at a concentration approximately 1% of that found in plasma. As the effect of naproxen in the newborn is not known, the use of INZA in lactating mothers is not recommended.

4.7 EFFECTS ON ABILITY TO DRIVE AND USE MACHINES

Some patients may experience drowsiness, dizziness, vertigo, insomnia or depression with the use of INZA. If patients experience these or similar undesirable effects, they should exercise caution in carrying out activities that require alertness.

4.8 ADVERSE EFFECTS (UNDESIRABLE EFFECTS)

Clinical Trial Experience

Adverse effects reported in controlled clinical trials in 960 patients treated for rheumatoid arthritis and osteoarthritis are listed below. In general, these effects were reported 2 to 10 times more frequently than they were in studies in the of 962 patients treated for mild to moderate pain.

Incidence between 3% and 9%

Gastrointestinal: the most frequently reported adverse events were related to the gastrointestinal tract. These were: constipation, heartburn, abdominal pain, nausea

Central Nervous System: headache, dizziness, drowsiness

Dermatologic: itching (pruritus), skin eruption, ecchymoses

Special Senses: tinnitus

Cardiovascular: oedema, dyspnoea

Incidence between 1% and less than 3%

Gastrointestinal: dyspepsia, diarrhoea, stomatitis

Central Nervous System: light-headedness, vertigo

Dermatologic: sweating, purpura

Special Senses: hearing disturbances, visual disturbances

Cardiovascular: palpitations

General: thirst

Incidence less than 1%

Probable causal relationship

The following adverse effects were reported less frequently than 1% during controlled clinical trials and in post marketing reports. The probability of a causal relationship exists between naproxen and these adverse effects.

Gastrointestinal: abnormal liver function tests, gastrointestinal bleeding, haematemesis, jaundice, melaena, peptic ulceration with bleeding and/or perforation, non-peptic gastrointestinal ulceration, vomiting, ulcerative stomatitis, colitis, fatal hepatitis

Renal: glomerular nephritis, haematuria, interstitial nephritis, renal papillary necrosis, nephrotic syndrome, renal disease, renal papillary necrosis, hyperkalaemia, renal failure

Haematological: eosinophilia, granulocytopenia, leukopenia, thrombocytopenia

Central Nervous System: depression, dream abnormalities, inability to concentrate, insomnia, malaise, myalgia, muscle weakness, aseptic meningitis

Dermatologic: porphyria cutanea tarda, epidermolysis bullosa, alopecia, skin rashes, epidermal necrolysis, erythema multiforme, Stevens-Johnson syndrome (SJS), photosensitivity reactions including rare cases in which the skin resembles porphyria cutanea tarda (pseudoporphyria) or epidermolysis bullosa

Special Senses: hearing impairment

Cardiovascular: congestive heart failure, vasculitis

General: menstrual disorders, pyrexia (chills and fever), eosinophilic pneumonitis, anaphylactoid reactions (see Section 4.4 SPECIAL WARNINGS AND PRECAUTIONS FOR USE – ANAPHYLACTIC REACTIONS)

Causal relationship unknown

Other reactions have been reported in circumstances in which a causal relationship could not be established. Although rarely reported, the physician should be alerted to these.

Haematological: agranulocytosis, aplastic anaemia, haemolytic anaemia

Mouth and Throat: sore throat

Central and Peripheral Nervous System: cognitive dysfunction, convulsions, paraesthesia

Dermatologic: urticaria, photosensitivity

General: angioneurotic oedema, hyperglycaemia, hypoglycaemia, hyperkalaemia

Reproductive: female infertility

Post-Marketing Experience

The following adverse effects have been reported with NSAIDs and naproxen:

Gastrointestinal: inflammation, peptic ulcers, ulceration, perforation and obstruction of the upper and lower gastrointestinal tract, gastrointestinal bleeding (sometimes fatal, particularly in the elderly), heartburn, nausea, oesophagitis, vomiting, diarrhoea, flatulence, constipation, dyspepsia, abdominal pain, non-peptic gastrointestinal ulceration, melaena, haematemesis, stomatitis, ulcerative stomatitis, exacerbation of ulcerative colitis and Crohn's disease, pancreatitis, gastritis

Infection: aseptic meningitis

Blood and Lymphatic System Disorders: agranulocytosis, aplastic anaemia, eosinophilia, haemolytic anaemia, leukopenia, thrombocytopenia

Immune System Disorders: anaphylactoid reactions

Metabolic and Nutrition Disorders: hyperkalaemia

Psychiatric Disorders: depression, dream abnormalities, insomnia

Nervous System Disorders: dizziness, drowsiness, headache, light-headedness, retrobulbar optic neuritis, convulsions, cognitive dysfunction, inability to concentrate

Eye Disorders: visual disturbances, corneal opacity, papillitis, papilloedema

Ear and Labyrinth Disorders: hearing impairment, hearing disturbances, tinnitus, vertigo

Cardiac Disorders: palpitations, cardiac failure, congestive heart failure

Vascular Disorders: hypertension, vasculitis

Respiratory, Thoracic and Mediastinal Disorders: dyspnoea, pulmonary oedema, asthma, eosinophilic pneumonitis

Hepatobiliary Disorders: hepatitis, jaundice

Skin and Subcutaneous Tissue Disorder: ecchymoses, itching (pruritus), purpura, skin eruptions, sweating, alopecia, epidermal necrolysis, very rarely toxic epidermal necrolysis (TEN), erythema multiforme, bullous reactions (including SJS, Drug Reaction with Eosinophilia and Systemic Symptoms (DRESS)), erythema nodosum, fixed drug eruption, lichen planus, pustular reaction, skin rashes, systemic lupus erythematosus (SLE), urticaria, photosensitivity reactions, including rare cases resembling porphyria cutanea tarda (“pseudoporphyria”) or epidermolysis bullosa or angioneurotic oedema.

If skin fragility, blistering or other symptoms suggestive of pseudoporphyria occur, treatment should be discontinued and patient monitored.

Musculoskeletal and Connective Tissue Disorders: myalgia, muscle weakness

Renal and Urinary Disorders: haematuria, interstitial nephritis, nephritic syndrome, renal disease, renal failure, renal papillary necrosis

Pregnancy, puerperium and perinatal conditions: oligohydramnios, neonatal renal impairment

Reproductive System and Breast Disorders: female infertility

General Disorders and Administration Site Conditions: oedema, thirst

Investigations: abnormal liver function tests, raised serum creatinine

Reporting Suspected Adverse Effects

Reporting suspected adverse reactions after registration 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 at www.tga.gov.au/reporting-problems.

4.9 OVERDOSE

Significant overdose of the medicine may be characterised by dizziness, drowsiness, epigastric pain, abdominal discomfort, indigestion, transient alterations in liver function, hypoprothrombinaemia, renal dysfunction, metabolic acidosis, apnoea, disorientation, nausea or vomiting. A few patients have experienced seizures, but it is unclear if these were casually related to naproxen. It is not known what dose of naproxen would be life-threatening.

Gastrointestinal bleeding may occur. Hypertension, acute renal failure, respiratory depression and coma may occur after the ingestion of NSAIDs and may occur following an overdose.

Anaphylactoid reactions have been reported with therapeutic ingestion of NSAIDs and may occur following an overdose.

Patients should be managed by symptomatic and supportive care following NSAIDs overdose. There are no specific antidotes. Prevention of further absorption (e.g. activated charcoal) may be indicated in symptomatic patients seen within 4 hours of ingestion or following a large overdose. Forced diuresis, alkalinisation of urine, haemodialysis, or haemoperfusion may not be useful due to high protein binding.

For information on the management of overdose, contact the Poisons Information Centre on 13 11 26 (Australia).

5 PHARMACOLOGICAL PROPERTIES

5.1 PHARMACODYNAMIC PROPERTIES

Mechanism of Action

Naproxen has been shown to have anti-inflammatory properties when tested in human clinical studies. In addition, it has analgesic and antipyretic actions. It exhibits its anti-inflammatory effects even in adrenalectomised animals, indicating that its action is not mediated through the pituitary axis. It inhibits prostaglandin synthetase, as do other NSAIDs, however, the exact mechanism of its anti-inflammatory action is not known.

Clinical Trials

No data available.

5.2 PHARMACOKINETIC PROPERTIES

Absorption

In humans, naproxen is completely absorbed from the gastrointestinal tract after oral administration. Concomitant administration of food can delay the absorption of naproxen but does not affect its extent.

After administration of INZA tablets, peak plasma levels are attained in 2 to 4 hours, depending on food intake.

Distribution

Naproxen has a relatively small volume of distribution (0.09 ± 0.03 L/kg) which corresponds to about 10% of the body weight in humans. At therapeutic levels naproxen is greater than 99% albumin-bound.

The plasma concentration of naproxen increases proportionally with doses up to 500 mg twice daily. Larger doses result in a less than proportional increase due to accelerated renal clearance of disproportionately increased amounts of non-protein bound drug. However, whether this effect increases or decreases the toxicity of naproxen has not been established.

Steady-state plasma levels of naproxen are reached after 4 to 5 doses.

Naproxen enters synovial fluid and crosses the placenta. It has been found in the milk of lactating mothers at a concentration approximately 1% of that found in plasma.

Metabolism

Naproxen is metabolised in the liver to 6-O-desmethyl naproxen (approximately 28% of an IV dose).

Excretion

Approximately 95% of the naproxen is excreted in the urine, primarily as naproxen (10%), 6-O-desmethyl naproxen (5%) or their conjugates. The rate of excretion of metabolites and conjugates has been found to

coincide closely with the rate of naproxen clearance from the plasma. Small amounts, 5% or less, are excreted in the faeces.

The elimination half-life of naproxen is approximately 14 hours.

Pharmacokinetics in Special Populations

Children

The pharmacokinetic profile of naproxen in children aged 5 - 16 years is similar to that in adults.

Renal Impairment

Given that naproxen and its metabolites are primarily excreted by the kidney, the potential exists for accumulation in the presence of renal insufficiency. Elimination of naproxen is decreased in patients with severe renal impairment (creatinine clearance < 20 mL/min), in whom there is higher clearance of naproxen than estimated from the degree of renal impairment alone (see Section 4.4 SPECIAL WARNINGS AND PRECAUTIONS FOR USE – USE IN RENAL IMPAIRMENT).

5.3 PRECLINICAL SAFETY DATA

Genotoxicity

No data available.

Carcinogenicity

No data available.

6 PHARMACEUTICAL PARTICULARS

6.1 LIST OF EXCIPIENTS

The tablets also contain the following inactive ingredients: lactose monohydrate, microcrystalline cellulose, maize starch, purified talc, colloidal anhydrous silica, pregelatinized maize starch, sodium starch glycollate and magnesium stearate.

6.2 INCOMPATIBILITIES

Incompatibilities were either not assessed or not identified as part of the registration of this medicine.

6.3 SHELF LIFE

In Australia, information on the shelf life can be found on the public summary of the Australian Register of Therapeutic Goods (ARTG). The expiry date can be found on the packaging.

6.4 SPECIAL PRECAUTIONS FOR STORAGE

Store below 30°C. Protect from light.

6.5 NATURE AND CONTENTS OF CONTAINER

Container type: bottle (HDPE)

Pack sizes:

250 mg tablets: 20, 30, 50, 60, 90, 100 and 120

500 mg tablets: 6, 10 and 50

Some pack sizes may not be marketed.

Australian Register of Therapeutic Goods (ARTG)

AUST R 40927 – INZA 250 naproxen 250 mg tablet bottle

AUST R 40929 - INZA 500 naproxen 500 mg tablet bottle

6.6 SPECIAL PRECAUTIONS FOR DISPOSAL

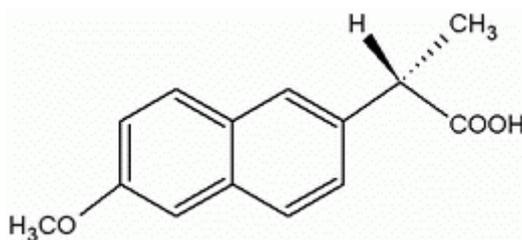
In Australia, any unused medicine or waste material should be disposed of by taking it to your local pharmacy.

6.7 PHYSICOCHEMICAL PROPERTIES

Chemical Structure

Naproxen is a non-steroidal anti-inflammatory drug (NSAID) with analgesic, anti-inflammatory and antipyretic properties.

It is a propionic acid derivative related to the arylacetic acid class of drugs. It is unrelated to salicylates and the corticosteroid hormones. Naproxen is an odourless, white to off-white crystalline substance. It is lipid soluble, practically insoluble in water at low pH and freely soluble in water at high pH.



Chemical name: (+)-6-methoxy-alpha-methyl-2-naphthaleneacetic acid

Molecular formula: C₁₄H₁₄O₃

Molecular weight: 230.3

CAS Number

22204-53-1

7 MEDICINE SCHEDULE (POISONS STANDARD)

S4 (Prescription Only Medicine)

8 SPONSOR

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9 DATE OF FIRST APPROVAL

10/08/1992

10 DATE OF REVISION

20/06/2024

Summary Table of Changes

Section Changed	Summary of New Information
2	Minor editorial update to excipient declaration

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