AUSTRALIAN PRODUCT INFORMATION

OMACOR®

Omega-3-acid ethyl esters

1 NAME OF THE MEDICINE

omega-3-acid ethyl esters 90

2 QUALITATIVE AND QUANTITATIVE COMPOSITION

Each capsule is comprised of about 900 mg of the omega-3-acid ethyl esters; the main components are eicosapentaenoic acid (EPA) ethyl ester of about 460mg and docosahexaenoic acid (DHA) ethyl esters of about 380mg. Omega-3 acid ethyl esters are obtained by the transesterification of the body oil of fat fish species.

Excipient with known effect: soya bean products and trace amounts of sulfites and fish products. OMACOR capsules are gluten-free.

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

3 PHARMACEUTICAL FORM

Capsule appearance: Soft, oblong, transparent capsule containing 1000 mg pale yellow oil.

4 CLINICAL PARTICULARS

4.1 THERAPEUTIC INDICATIONS

Hypertriglyceridaemia: Endogenous hypertriglyceridaemia as a supplement to diet when dietary measures alone are insufficient to produce an adequate response. Treatment is indicated for the following types of dyslipidaemia (Fredrickson classification) only:

- Type IV & V as monotherapy and with close monitoring of LDL-C levels.
- Type IIb as add-on therapy to statins, when control of triglycerides with statins has been shown to be insufficient.

Patients with higher baseline levels of triglycerides are more likely to exhibit a better response to OMACOR. OMACOR is not indicated in exogenous hypertriglyceridaemia (Type 1 hyperchylomicronaemia). There are insufficient data to support the use in patients with secondary endogenous hypertriglyceridaemia including patients with diabetes mellitus).

4.2 DOSE AND METHOD OF ADMINISTRATION

Adults:

Hypertriglyceridaemia: Four capsules per day taken with a glass of water.

OMACOR must be taken with food to avoid gastrointestinal disturbances.

OMACOR has been given in clinical trials in doses of up to 8 g per day and has been found to be well tolerated.

4.3 CONTRAINDICATIONS

Hypersensitivity to the active substance, to peanut, to soya (including soya milk, soya beans) or to any of the excipients.

4.4 SPECIAL WARNINGS AND PRECAUTIONS FOR USE

During treatment with OMACOR there is a fall in thromboxane A2 production. No significant effect has been observed on the other coagulation factors. Some studies with omega-3-acids demonstrated a prolongation of bleeding time, but the bleeding time reported in these studies has not exceeded normal limits and did not produce clinically significant bleeding episodes.

Clinical studies have not been done to thoroughly examine the combined effect of OMACOR and concomitant anticoagulants. Patients receiving treatment with OMACOR and an anticoagulant or other drug affecting coagulation (e.g. aspirin, warfarin and coumarin) should be monitored periodically, and the dosage of anticoagulant therapy adjusted if necessary (see Section 4.5 INTERACTIONS WITH OTHER MEDICINES AND OTHER FORMS OF INTERACTIONS).

It is recommended that routine monitoring of the entire lipid profile is undertaken.

As a possible rise in LDL-C has been shown in some studies with intake of OMACOR 4 g/day (see Section 5.1 PHARMACODYNAMIC PROPERTIES), LDL-C should therefore be monitored on a regular basis, especially in patients with type IV and V dyslipidaemia.

OMACOR is not recommended as monotherapy in Type IIb dyslipidaemia. Statins are to be used as first line treatment with OMACOR indicated as add-on therapy when control of the triglyceride levels is required.

OMACOR should be used with caution in patients with known sensitivity or allergy to fish.

Use in hepatic impairment

In some patients, a small but significant increase (within normal values) in ASAT and ALAT have been reported (see Section 4.8 ADVERSE EFFECTS (UNDESIRABLE EFFECTS)). ALAT and ASAT levels should be monitored in patients with hepatic impairment, in particular with the higher dosage of 4 capsules.

Use in the elderly

There is no information regarding the use of OMACOR in elderly patients over 70 years of age.

Paediatric use

In the absence of efficacy and safety data, the use of this medication in children is not recommended.

Effects on Laboratory Tests

Refer to Section 4.8 ADVERSE EFFECTS (UNDESIRABLE EFFECTS).

4.5 INTERACTIONS WITH OTHER MEDICINES AND OTHER FORMS OF INTERACTIONS

Drugs affecting coagulation

Increased bleeding time has been seen when OMACOR is given in conjunction with NSAIDs, aspirin and warfarin, but without haemorrhagic complications (see Section 4.4 SPECIAL WARNINGS AND PRECAUTIONS FOR USE). Patients should be informed about potential increased bleeding time.

When used with warfarin and coumarin, the prothrombin time/international normalised ratio (PT/INR) must be monitored during combination treatment with OMACOR among patients receiving blood-thinning therapy, and when treatment with OMACOR is discontinued.

Statins

OMACOR 4 g has been administered with simvastatin 80 mg under fasting conditions to 24 healthy volunteers in a two 14-days period drug-drug interaction study. Results of this study demonstrated that at steady state, the co-administration of OMACOR capsules with simvastatin did not appear to affect the pharmacokinetics of simvastatin tablets. The combination appeared to be well tolerated.

4.6 FERTILITY, PREGNANCY AND LACTATION

Effects on fertility

No adverse effects on fertility were observed in a rat fertility study at oral doses of up to 2,000 mg/kg/day (35 times the human dose of 4 g/day on a mg/kg basis).

Use in pregnancy- Category B1

There are no adequate data from the use of OMACOR in pregnant women. The potential risk for humans is unknown. Therefore, OMACOR should not be used during pregnancy unless clearly necessary.

In female rats given oral gavage doses of up to 2,000 mg/kg/day (35 times the human dose of 4 g/day on a mg/kg basis) beginning two weeks prior to mating and continuing during gestation and lactation, no adverse effects were observed). In pregnant rats given oral gavage doses of up to 6,000 mg/kg/day (105 times the human dose of 4 g/day on a mg/kg basis) over gestation days 6 to 15, no adverse effects were observed. In pregnant rats given oral gavage doses of up to 2,000 mg/kg/day (35 times the human dose of 4 g/day on a mg/kg basis), from gestation day 14 to the end of lactation, no adverse effects were observed.

In rabbits given oral gavage doses over gestation days 7 to 19, no adverse effects were observed at 375 mg/kg/day (ca. 7 times the human dose of 4 g/day on a mg/kg basis), but reduced foetal weights were observed at ≥750 mg/kg/day (ca.13 times the human dose of 4 g/day on a mg/kg basis) and increased post implantation loss was observed at 1500 mg/kg/day (ca. 26 times the human dose of 4 g/day on a mg/kg basis). Doses of ≥ 750 mg/kg/day were maternotoxic. Overall there is no preclinical evidence for a potential risk in pregnant humans.

Use in lactation

There are no data on the excretion of OMACOR components in human milk. Because many drugs are excreted in human milk, caution should be exercised when OMACOR is administered to a woman who is breastfeeding.

4.7 EFFECTS ON ABILITY TO DRIVE AND USE MACHINES

The effects of OMACOR on a person's ability to drive and use machines were not assessed as part of its registration. Nevertheless, OMACOR is expected to have no or negligible influence on the ability to drive and use machines.

4.8 ADVERSE EFFECTS (UNDESIRABLE EFFECTS)

Hypertriglyceridaemia:

In all subjects (655) treated with OMACOR for hypertriglyceridaemia, the following results were seen:

- Adverse events (AEs) occurred in approximately 30% of subjects,
- Only 11 specific AEs occurred at a rate greater than 1%,
- The most common treatment-emergent AEs were eructation (4.4%) and taste perversion (4.1%),
- Treatment emergent serious adverse events occurred in 2.4% of subjects,
- Four subjects (0.6%) died.

The 8 pivotal trials showed similar safety profiles.

The only potentially drug-related laboratory abnormality was mild elevation in alanine aminotransferase (ALT) levels, without concurrent elevation in aspartate aminotransferase (AST) levels.

A slight, but significant, prolongation of bleeding time has been observed without any reports of bleeding problems during clinical trials with OMACOR alone.

The following table summarises the treatment-emergent adverse events experienced by subjects from the 8 double-blind, parallel group, placebo-controlled studies in hypertriglyceridaemia, using OMACOR 4 g per day (see Section 5.1 PHARMACODYNAMIC PROPERTIES).

Table 1: Summary of treatment-emergent adverse events that were experienced by at least 1% of subjects in either treatment group by system organ class and preferred term (all subjects from the 8 pivotal studies)

SOC/Preferred Term	OMACOR 4 g per day (N = 226)		Placebo (N = 228)		P-Value[b]
	n	(%)	n	(%)	
Subjects with at least 1 adverse event	80	(35.4)	63	(27.6)	0.0859
Infections and infestations					
Infection	10	(4.4)	5	(2.2)	0.2010
Influenza	8	(3.5)	3	(1.3)	0.1398
Nervous system disorders					
Dysgeusia	6	(2.7)	0	(0.0)	0.0147
Headache	3	(1.3)	3	(1.3)	1.0000
Cardiac disorders					
Angina pectoris	3	(1.3)	2	(0.9)	0.6847
Gastrointestinal disorders					
Eructation	11	(4.9)	5	(2.2)	0.1351
Diarrhoea	8	(3.5)	8	(3.5)	1.0000
Nausea	7	(3.1)	7	(3.1)	1.0000
Dyspepsia	7	(3.1)	6	(2.6)	0.7868
Flatulence	4	(1.8)	9	(3.9)	0.2599
Abdominal pain	2	(0.9)	3	(1.3)	1.0000
Skin and subcutaneous tissue disorders					
Rash	4	(1.8)	1	(0.4)	0.2146
Musculoskeletal and connective tissue disorders					
Back pain	5	(2.2)	3	(1.3)	0.5025
General disorders and administration site conditions					
Pain	4	(1.8)	3	(1.3)	0.7235

Adverse events were coded using MedDRA version 13.0. Subjects were counted only once for each body system and for each preferred term.

b: P-values were computed using Fisher's exact test.

Adverse events according to System Organ Class:

The following list presents the frequencies of study related adverse events, observed both in post-myocardial infarction and in hypertriglyceridaemia.

The frequencies of adverse reactions are ranked according to the following: Very common (≥1/10); common (≥ 1/100 to < 1/10); uncommon (≥1/1000 to < 1/100); rare (≥1/10000 to < 1/1000); very rare (< 1/10000)

Immune system disorders

Uncommon: hypersensitivity

Metabolism and nutrition disorders

Uncommon: hyperglycaemia, gout

Nervous System disorders:

Uncommon: dizziness, dysgeusia, headache

Vascular disorders:

Uncommon: hypotension

Respiratory, thoracic and mediastinal disorders

Uncommon: epistaxis

Very rare: nasal dryness

Gastrointestinal disorders:

Common: gastrointestinal disorders (including abdominal pain, dyspepsia, gastro-oesophageal reflux disease, eructation, nausea or vomiting, abdominal distension, flatulence, diarrhoea or constipation)

Uncommon: gastrointestinal haemorrhage

Hepatobiliary disorders:

Uncommon: liver disorders – including transaminases increased (alanine aminotransferase increased and aspartate aminotransferase increased)

Skin and subcutaneous tissue disorders:

Uncommon: rash

Rare: urticaria, acne

Investigations:

Very rare: white blood cell count increased, blood lactate dehydrogenase increased.

The following adverse events have been reported spontaneously during post-marketing use of OMACOR (frequency unknown):

Blood and lymphatic system disorders:

Haemorrhagic diathesis

Skin and subcutaneous tissue disorders:

Pruritus

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 http://www.tga.gov.au/reporting-problems.

4.9 OVERDOSE

There are no special recommendations for over dosage with OMACOR. Treatment should be symptomatic.

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

5 PHARMACOLOGICAL PROPERTIES

5.1 PHARMACODYNAMIC PROPERTIES

Mechanism of action

The omega-3 series polyunsaturated fatty acids (OFA), eicosapentaenoic acid (EPA) and docosahexaenoic acid (DHA) are essential fatty acids. They are essential nutrients that cannot be synthesised by the human body in sufficient amounts and have to be obtained in the diet. Like all fatty acids, omega-3 fatty acids are used to provide energy and are stored in adipose tissue; small amounts are incorporated into cell membranes as well.

OMACOR is active on the plasma lipids by lowering triglyceride levels as a result of a fall in VLDL (very low density lipoprotein), and the substance is also active on haemostasis and blood pressure.

The mechanism of action of OMACOR in lowering plasma triglycerides (TG) is not completely understood. Potential mechanisms of action include inhibition of acyl CoA:1,2-diacylglycerol acyltransferase, increased mitochondrial and peroxisomal β-oxidation of fatty acids in the liver and decreased lipogenesis in the liver. OMACOR may reduce the synthesis of TG in the liver because EPA and DHA are poor substrates for the enzymes responsible for TG synthesis, and EPA and DHA inhibit esterification of other fatty acids.

OMACOR increases low density lipoproteins (LDL) cholesterol in some patients with hypertriglyceridaemia. A small rise in high- density lipoproteins (HDL) cholesterol has also been observed however it is significantly smaller than seen after fibrates, and is not consistent across this population subset.

There is no strong evidence that lowering the triglycerides reduces the risk of ischaemic heart disease.

During treatment with OMACOR a decrease in thromboxane A2 production has been observed and a slight increase in bleeding time (particularly with the higher doses 4 g per day). No significant effect has been observed on the other coagulation factors (see Section 4.4 SPECIAL WARNINGS AND PRECAUTIONS FOR USE).

OMACOR has been shown to cause a significant reduction in blood pressure.

Clinical trials

Hypertriglyceridaemia:

There have been eight double-blind, parallel group, placebo-controlled studies in hypertriglyceridaemia, using OMACOR 4 g per day. These eight studies are the pivotal studies. These studies included seven individual studies and one part of a study that evaluated OMACOR 2 g, 4 g, 8 g, and placebo treatment arms.

The duration of the eight pivotal studies was short term (maximum 12 weeks).

Numerous studies in patients with hypertriglyceridemia have been conducted with OMACOR, with variable designs: double-blind studies, placebo-controlled studies, randomised studies, open studies and long-term studies (up to 24 months). OMACOR at doses of 4 g per day consistently and significantly reduced triglycerides levels compared to placebo. The studies have shown that the reductions were maintained for up to 24 months after treatment.

Table 2: OMACOR has been documented to have the following effects on the lipid profile.

Lipid	Effect
TG levels	OMACOR 2–4 g per day consistently and significantly reduced TG levels compared with placebo. These reductions were maintained for up to 20 months after treatment. Reductions in TG levels were observed across age, gender, and baseline TG. When OMACOR was used in conjunction with statins, an additive effect was observed.
Very-low-density lipoprotein (VLDL) cholesterol (VLDL-C) levels	OMACOR 2–4 g daily produced reductions in VLDL-C levels that were consistent with reductions in TG levels.
TC levels	OMACOR 2–4 g daily had no effect on TC levels in patients with hyperlipidaemia type IIb.
HDL-C levels	OMACOR 2–4 g daily produced small, significant increases in HDL-C levels, especially in patients with low HDL-C at baseline.
LDL-C levels	OMACOR 2–4 g daily increased LDL-C levels, especially in patients with low LDL-C at baseline (HTG type IV). The increase was probably due to cholesterol enrichment of LDL particles with a shift from small, dense LDL particles to larger, more buoyant LDL particles.

The following table summarises the median percent changes in lipid parameters from baseline in the overall population, and in patients with Types IIb, IV and V dyslipidaemia.

Table 3: Summary of median percent changes from baseline for lipids parameters by dyslipidaemia classification

	TG		TC		HDL-C		LDL-C		VLDL-C		Non-HDL-C	
	Omacor	Pbo	Omacor	Pbo	Omacor	Pbo	Omacor	Pbo	Omacor	Pbo	Omacor	Pbo
Overall (%)	-28.0	+2.5	-2.9	-0.5	+8.9	+3.5	+16.8	+0.7	-25.2	+8.0	-3.9	-1.0
Type IIb (%)	-26.3	+0.8	-2.3	-1.5	+5.5	+4.6	+1.4	-3.9	-10.9	+13.7	-3.2	-2.1
Type IV (%)	-25.5	+4.5	+2.0	+1.1	+11.1	+2.9	+33.8	+2.2	-34.3	+6.7	+1.4	+1.0
Type V (%)	-39.4	+2.8	-16.5	+0.5	+18.1	-4.6	+42.8	+19.9	-31.9	+2.2	-18.9	+0.7

The documented number of patients enrolled in clinical trials with Type III dyslipidaemia is very limited, and no studies were designed to especially investigate the effect of OMACOR in these patients. Type III dyslipidaemic patients are homozygotes for ApoE, and genotyping of patients was only performed in one study (K85-95011). More Type III dyslipidaemic patients may have been therefore enrolled in clinical studies without being verified as such. There is no reason to believe that Type III dyslipidaemic patients do not respond to OMACOR.

One of the pivotal clinical trials in patients with type IV and V dyslipidaemia (K85-95009 study) demonstrated a mean LDL-C increase of 42.6% with OMACOR 4 g/day. 67% of the patients in the study experienced increases in LDL-C, and the increases observed were in the range of 6%-110%. However, mean LDL-C concentrations at the end of the study were still only equal to 2.69 mmol/L (104 mg/dL). For the majority of these patients (40 of 42 with no history of coronary disease) this is still below their target LDL-C levels.

In clinical trials on patients with Type IIb dyslipidaemia mean LDL-C is unchanged or slightly increased (maximum 8.6%) with OMACOR treatment. In studies with concomitant treatment of OMACOR and a statin no significant increase in LDL-C has been observed with OMACOR.

The cholesterol enrichment of LDL particles appears to happen in conjunction with a marked reduction in VLDL-C. Studies also demonstrate a shift from small, dense LDL particles to larger, more buoyant LDL particles, indicating a shift towards less atherogenic lipoprotein particles.

Consistent with the overall population (see Table 4 hereafter), subjects in each baseline triglycerides level category in the OMACOR 4 g treatment group had significantly larger mean absolute and relative changes in triglycerides levels compared with those in the placebo treatment group.

For the subjects who received OMACOR 4 g per day, those with higher baseline levels (TG = 500-749 mg/dL and ≥750 mg/dL [5.65‑8.46 mmol/L, and ≥8.47 mmol/L])) had greater reductions in triglycerides levels, and therefore were more likely to exhibit a better response to OMACOR.

Table 4. Mean change from baseline in TG levels at endpoint, overall and by baseline TG level - Integrated analysis of the 8 Category I studies.

	OMACOR 4 g		**Placebo**		**P-value[a]**
	Mean Value		**Mean Value**		
Overall					
	(n = 206)		(n = 204)		
Baseline value (mg/dL, mmol/L)	422.8	4.77	404.0	4.56	
Endpoint value (mg/dL, mmol/L)	285.7	3.23	410.3	4.63	
Absolute change (mg/dL, mmol/L)	-137.0	-1.55	6.3	0.07	<0.0001
Relative change (%)	-28.0		2.5		<0.0001
≤ 250 mg/dL (≤ 2.82 mmol/L)					
	(n = 63)		(n = 67)		
Baseline value (mg/dL, mmol/L)	215.1	2.43	207.1	2.34	
Endpoint value (mg/dL, mmol/L)	172.6	1.95	216.9	2.45	
Absolute change (mg/dL, mmol/L)	-42.6	-0.48	9.8	0.11	<0.0001
Relative change (%)	-19.8		4.9		<0.0001
251-499 mg/dL (2.83-5.64 mmol/L)					
	(n = 90)		(n =88)		
Baseline value (mg/dL, mmol/L)	332.7	3.76	334.8	3.78	
Endpoint value (mg/dL, mmol/L)	243.5	2.75	338.4	3.82	
Absolute change (mg/dL, mmol/L)	-89.2	-1.01	3.6	0.04	<0.0001
Relative change (%)	-27.0		0.9		<0.0001
500-749 mg/dL (5.65-8.46 mmol/L)					
	(n = 28)		(n = 26)		
Baseline value (mg/dL, mmol/L)	599.3	6.77	597.1	6.74	
Endpoint value (mg/dL, mmol/L)	360.3	4.07	598.6	6.76	
Absolute change (mg/dL, mmol/L)	-239	-2.70	1.5	0.02	<0.0001
Relative change (%)	-39.5		1.5		<0.0001
≥ 750 mg/dL (≥ 8.47 mmol/L)					
	(n = 25)		(n = 23)		
Baseline value (mg/dL, mmol/L)	1072.4	12.11	1024.1	11.56	
Endpoint value (mg/dL, mmol/L)	638.8	7.21	1035.9	11.70	

Absolute change (mg/dL, mmol/L)	-433.6	-4.90	11.8	0.19	0.0001
Relative change (%)	-39.4		2.8		<0.0001

a P-values were computed using analysis of variance (ANOVA)

A number of studies have been conducted to evaluate the effect of concomitant use of OMACOR with widely used statins (simvastatin, atorvastatin). The studies have been carried out in patients with elevated serum triglycerides receiving statin therapy. The results of the studies demonstrate that the combined treatment increases the efficacy in lowering triglycerides. In these studies, little or no effect on LDL-C has been observed and no significant safety issues have been raised.

5.2 PHARMACOKINETIC PROPERTIES

Absorption

The absorption of OMACOR has been determined by measuring the increase of EPA and DHA in plasma or serum phospholipids after dosing. The levels of EPA and DHA do increase on ingestion of OMACOR, although in a less than dose-proportional manner.

After absorption, OFA are metabolised by multiple pathways that are not highly predictable. Animal pharmacokinetic studies have shown that there is no systemic exposure of the ethyl esters. Due to this complicated process, it is not possible to conduct standard bioavailability studies, and consequently, to measure meaningful values for C_{max}, T_{max}, AUC, etc. for OMACOR.

Concomitant ingestion of another unsaturated fatty acid, olive oil, did not affect absorption of omega-3 fatty acids from OMACOR.

Distribution

The concentration of omega-3 fatty acids, EPA and DHA, in the plasma phospholipids corresponds to the EPA and DHA incorporated into the cell membranes.

Significant, dose-dependent increases in serum phospholipid EPA content were seen, while increases in DHA incorporation were less marked and not dose dependent. Uptake of EPA and DHA into plasma/serum phospholipids in subjects treated with OMACOR was also independent of gender, age, and hypertensive status.

Metabolism and Excretion

The hydrolysis of omega-3 ethyl esters by esterases in the intestine is complete and rapid. During and after absorption there are three main pathways for the metabolism of the omega-3 fatty acids:

The fatty acids are first transported to the liver where they are incorporated into various categories of lipoproteins and then channelled to the peripheral lipids stores.

The cell membrane phospholipids are replaced by lipoprotein phospholipids and the fatty acids can then act as precursors for various eicosanoids.

The majority is oxidised to meet energy requirements.

5.3 PRECLINICAL SAFETY DATA

Genotoxicity

There was no clear evidence of a genotoxic effect of OMACOR from the genotoxicity studies conducted (Ames test in Salmonella typhinurium, gene mutation at the HGPRT locus in Chinese hamster V79 cells, chromosome aberration study in cultured human lymphocytes and in vivo mouse micronucleus test).

Carcinogenicity

There was no evidence of a carcinogenic effect of OMACOR from the carcinogenicity studies in rats and mice at oral doses of up to 2,000 mg/kg/day (35 times the human dose of 4 g/day on a mg/kg basis).

6 PHARMACEUTICAL PARTICULARS

6.1 LIST OF EXCIPIENTS

The capsules also contain d-alpha-Tocopherol: 4 mg (antioxidant), gelatin, glycerol and purified water. OMACOR capsules are gluten-free.

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. Do not refrigerate. Do not freeze.

6.5 NATURE AND CONTENTS OF CONTAINER

OMACOR capsules are packed in white tamper-evident high density polyethylene (HDPE) bottles with desiccant closed with an inner seal and a screw cap.

Pack size: 28 or 100* capsules.

* Not currently marketed

Australian Register of Therapeutic Goods (ARTG)

AUST R 155717 – OMACOR (omega-3-acid ethyl esters 90) 1000 mg soft capsule bottle

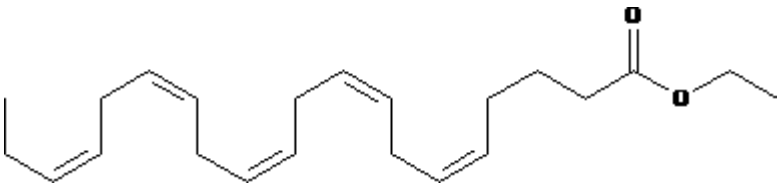
6.6 SPECIAL PRECAUTIONS FOR DISPOSAL

In Australia, any unused medicine or waste material should be disposed of in accordance with local requirements.

6.7 PHYSICOCHEMICAL PROPERTIES

Chemical structure:

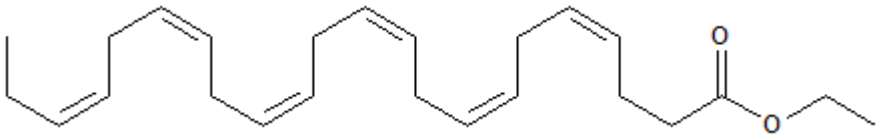
Eicosapentaenoic acid (EPA) ethyl ester



Molecular Formula: C22H34O2

Molecular Weight: 330.51

Docosahexaenoic acid (DHA) ethyl ester



Molecular formula: C24H36O2

Molecular Weight: 356.55

CAS number:

Eicosapentaenoic acid (EPA) ethyl ester: 86227-47-6

The empirical formula of EPA is $C_{22}H_{34}O_2$. MW: 330.51. It is a pale yellow liquid. Very soluble in methanol, ethanol, acetone and heptane. Practically insoluble in water. Slight smell.

Docosahexaenoic acid (DHA) ethyl ester: 81926-94-5

The empirical formula for DHA is $C_{24}H_{36}O_2$. MW: 356.55. It is a pale yellow liquid. Very soluble in ethanol, acetone, heptane, and freely soluble in methanol. Practically insoluble in water. Slight smell.

7 MEDICINE SCHEDULE (POISONS STANDARD)

S4 (Prescription Only Medicine)

8 SPONSOR

Viatris Pty Ltd

Level 1, 30 The Bond

30-34 Hickson Road

Millers Point NSW 2000

www.viatris.com.au

Phone: 1800 274 276

9 DATE OF FIRST APPROVAL

28/07/2010

10 DATE OF REVISION

26/11/2021

Summary Table of Changes

Section Changed	Summary of New Information
All	Minor editorial changes
1	Update to active ingredient name
2	Update wording to comply with TGO91
3, 6.7	Move physiochemical properties information
6.1	Remove lecithin (soy) and medium chain triglycerides
6.5	Insert AUST R numbers

8	Update sponsor's details

OMACOR® is licenced to the Viatris company group

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