Elapix®
Apixaban

FORMS AND PRESENTATION
Elapix® 2.5: Film Coated Tablets: Box of 60.
Elapix® 5: Film Coated Tablets: Box of 60.
COMPOSITION
Elapix® 2.5: Each film coated tablet contains Apixaban 2.5mg.
Elapix® 5: Each film coated tablet contains Apixaban 5mg.
Excipients: Lactose monohydrate, microcrystalline cellulose, croscarmellose sodium, sodium lauryl sulfate, magnesium stearate, hypromellose, titanium dioxide, triacetin, iron oxide yellow (Elapix®2.5), iron oxide red (Elapix®5).
PHARMACOLOGICAL PROPERTIES
Pharmacodynamic properties
Pharmacotherapeutic group: Antithrombotic agents, direct factor Xa inhibitors, ATC code: B01AF02.
Mechanism of action
Apixaban is a potent, oral, reversible, direct and highly selective active site inhibitor of factor Xa. It does not require antithrombin III for antithrombotic activity. Apixaban inhibits free and clot-bound factor Xa, and prothrombinase activity. Apixaban has no direct effects on platelet aggregation, but indirectly inhibits platelet aggregation induced by thrombin. By inhibiting factor Xa, apixaban prevents thrombin generation and thrombus development. Preclinical studies of apixaban in animal models have demonstrated antithrombotic efficacy in the prevention of arterial and venous thrombosis at doses that preserved haemostasis.
Pharmacodynamic effects
The pharmacodynamic effects of apixaban are reflective of the mechanism of action (FXa inhibition). As a result of FXa inhibition, apixaban prolongs clotting tests such as prothrombin time (PT), INR and activated partial thromboplastin time (aPTT). Changes observed in these clotting tests at the expected therapeutic dose are small and subject to a high degree of variability. They are not recommended to assess the pharmacodynamic effects of apixaban. In the thrombin generation assay, apixaban reduced endogenous thrombin potential, a measure of thrombin generation in human plasma. Apixaban also demonstrates anti-FXa activity as evident by reduction in Factor Xa enzyme activity in multiple commercial anti-FXa kits, however results differ across kits. Anti-FXa activity exhibits a close direct linear relationship with apixaban plasma concentration, reaching maximum values at the time of apixaban peak plasma concentrations. The relationship between apixaban plasma concentration and anti-FXa activity is approximately linear over a wide dose range of apixaban.
Pharmacokinetic properties
Absorption: The absolute bioavailability of apixaban is approximately 50% for doses up to 10 mg. Apixaban is rapidly absorbed with maximum concentrations (Cmax) appearing 3 to 4 hours after tablet intake. Intake with food does not affect apixaban AUC or Cmax at the 10 mg dose. Apixaban demonstrates linear pharmacokinetics with dose proportional increases in exposure for oral doses up to 10 mg. At doses ≥ 25 mg apixaban displays dissolution limited absorption with decreased bioavailability. Apixaban exposure parameters exhibit low to moderate variability reflected by a within-subject and inter-subject variability of ~20% CV and ~30% CV, respectively. Following oral administration of 10 mg of apixaban as 2 crushed 5 mg tablets suspended in 30 mL of water, exposure was comparable to exposure after oral administration of 2 whole 5 mg tablets. Following oral administration of 10 mg of apixaban as 2 crushed 5 mg tablets with 30 g of apple puree, the Cmax and AUC were 21% and 16% lower, respectively, when compared to administration of 2 whole 5 mg tablets. The reduction in exposure is not considered clinically relevant. Following administration of a crushed 5 mg apixaban tablet suspended in 60 mL of G5W and delivered via a nasogastric tube, exposure was similar to exposure seen in other clinical studies involving healthy subjects receiving a single oral 5 mg apixaban tablet dose. Given the predictable, dose-proportional pharmacokinetic profile of apixaban, the bioavailability results from the conducted studies are applicable to lower apixaban doses.
Distribution: Plasma protein binding in humans is approximately 87%. The volume of distribution (Vss) is approximately 21 litres.
Biotransformation and elimination: Apixaban has multiple routes of elimination. Of the administered apixaban dose in humans, approximately 25% was recovered as metabolites, with the majority recovered in faeces. Renal excretion of apixaban accounts for approximately 27% of total clearance. Additional contributions from biliary and direct intestinal excretion were observed in clinical and nonclinical studies, respectively. Apixaban has a total clearance of about 3.3 L/h and a half-life of approximately 12 hours. O-demethylation and hydroxylation at the 3-oxopiperidinyl moiety are the major sites of biotransformation. Apixaban is metabolised mainly via CYP3A4/5 with minor contributions from CYP1A2, 2C8, 2C9, 2C19, and 2J2. Unchanged apixaban is the major active substance-related component in human plasma with no active circulating metabolites present. Apixaban is a substrate of transport proteins, P-gp and breast cancer resistance protein (BCRP).
Elderly: Elderly patients (above 65 years) exhibited higher plasma concentrations than younger patients, with mean AUC values being approximately 32% higher and no difference in Cmax.
Renal impairment: There was no impact of impaired renal function on peak concentration of apixaban. There was an increase in apixaban exposure correlated to decrease in renal function, as assessed via measured creatinine clearance. In individuals with mild (creatinine clearance 51-80 mL/min), moderate (creatinine clearance 30-50 mL/min) and severe (creatinine clearance 15-29 mL/min) renal impairment, apixaban plasma concentrations (AUC) were increased 16, 29, and 44% respectively, compared to individuals with normal creatinine clearance. Renal impairment had no evident effect on the relationship between apixaban plasma concentration and anti-FXa activity. In subjects with end-stage renal disease (ESRD), the AUC of apixaban was increased by 36% when a single dose of apixaban 5 mg was administered immediately after haemodialysis, compared to that seen in subjects with normal renal function. Haemodialysis, started two hours after administration of a single dose of apixaban 5 mg, decreased apixaban AUC by 14% in these ESRD subjects, corresponding to an apixaban dialysis clearance of 18 mL/min. Therefore, haemodialysis is unlikely to be an effective means of managing apixaban overdose.
Hepatic impairment: The single-dose pharmacokinetics and pharmacodynamics of apixaban 5 mg were not altered in subjects with hepatic impairment. Changes in anti-Factor Xa activity and INR were comparable between subjects with mild to moderate hepatic impairment and healthy subjects.
Gender: Exposure to apixaban was approximately 18% higher in females than in males.
Body weight: Compared to apixaban exposure in subjects with body weight of 65 to 85 kg, body weight > 120 kg was associated with approximately 30% lower exposure and body weight < 50 kg was associated with approximately 30% higher exposure.
INDICATIONS
Elapix® is indicated for the:
- Prevention of stroke and systemic embolism in adult patients with non-valvular atrial fibrillation (NVAF), with one or more risk factors, such as prior stroke or transient ischaemic attack (TIA); age ≥ 75 years; hypertension; diabetes mellitus; symptomatic heart failure (NYHA Class ≥ II).
- Treatment of deep vein thrombosis (DVT) and pulmonary embolism (PE), and prevention of recurrent DVT and PE in adults.
Elapix® 2.5 is also indicated for the:
- Prevention of venous thromboembolic events (VTE) in adult patients who have undergone elective hip or knee replacement surgery.
CONTRAINDICATIONS
– Hypersensitivity to the active substance or to any of the excipients listed.
– Active clinically significant bleeding.
– Hepatic disease associated with coagulopathy and clinically relevant bleeding risk.
– Lesion or condition if considered a significant risk factor for major bleeding. This may include current or recent gastrointestinal ulceration, presence of malignant neoplasms at high risk of bleeding, recent brain or spinal injury, recent brain, spinal or ophthalmic surgery, recent intracranial haemorrhage, known or suspected oesophageal varices, arteriovenous malformations, vascular aneurysms or major intraspinal or intracerebral vascular abnormalities.
– Concomitant treatment with any other anticoagulant agent e.g., unfractionated heparin (UFH), low molecular weight heparins (enoxaparin, dalteparin, etc.), heparin derivatives (fondaparinux, etc.), oral anticoagulants (warfarin, rivaroxaban, dabigatran, etc.) except under specific circumstances of switching anticoagulant therapy, when UFH is given at doses necessary to maintain an open central venous or arterial catheter or when UFH is given during catheter ablation for atrial fibrillation.
PRECAUTIONS
Haemorrhage risk: As with other anticoagulants, patients taking apixaban are to be carefully observed for signs of bleeding. It is recommended to be used with caution in conditions with increased risk of haemorrhage. Apixaban administration should be discontinued if severe haemorrhage occurs. Although treatment with apixaban does not require routine monitoring of exposure, a calibrated quantitative anti-Factor Xa assay may be useful in exceptional situations where knowledge of apixaban exposure may help to inform clinical decisions, e.g., overdose and emergency surgery. An agent to reverse the anti-factor Xa activity of apixaban is available.
Interaction with other medicinal products affecting haemostasis: Due to an increased bleeding risk, concomitant treatment with any other anticoagulants is contraindicated. The concomitant use of apixaban with antiplatelet agents increases the risk of bleeding. Care is to be taken if patients are treated concomitantly with selective serotonin reuptake inhibitors (SSRIs) or serotonin norepinephrine reuptake inhibitors (SNRIs), or non-steroidal anti-inflammatory medicinal products (NSAIDs), including acetylsalicylic acid. Following surgery, other platelet aggregation inhibitors are not recommended concomitantly with apixaban. In patients with atrial fibrillation and conditions that warrant mono or dual antiplatelet therapy, a careful assessment of the potential benefits against the potential risks should be made before combining this therapy with apixaban.
Use of thrombolytic agents for the treatment of acute ischemic stroke: There is very limited experience with the use of thrombolytic agents for this treatment.
Patients with prosthetic heart valves: Safety and efficacy of apixaban have not been studied in patients with prosthetic heart valves, with or without atrial fibrillation. Therefore, the use of apixaban is not recommended in this setting.
Patients with antiphospholipid syndrome: Direct acting Oral Anticoagulants (DOACs) including apixaban are not recommended for patients with a history of thrombosis who are diagnosed with antiphospholipid syndrome. In particular for patients that are triple positive (for lupus anticoagulant, anticardiolipin antibodies, and anti–beta 2-glycoprotein I antibodies), treatment with DOACs could be associated with increased rates of recurrent thrombotic events compared with vitamin K antagonist therapy.
Surgery and invasive procedures: Apixaban should be discontinued at least 48 hours prior to elective surgery or invasive procedures with a moderate or high risk of bleeding. This includes interventions for which the probability of clinically significant bleeding cannot be excluded or for which the risk of bleeding would be unacceptable. Apixaban should be discontinued at least 24 hours prior to elective surgery or invasive procedures with a low risk of bleeding. This includes interventions for which any bleeding that occurs is expected to be minimal, non-critical in its location or easily controlled. If surgery or invasive procedures cannot be delayed, appropriate caution should be exercised, taking into consideration an increased risk of bleeding that should be weighed against the urgency of intervention. Apixaban should be restarted after the invasive procedure or surgical intervention as soon as possible provided the clinical situation allows and adequate haemostasis has been established. For patients undergoing catheter ablation for atrial fibrillation, apixaban treatment does not need to be interrupted.
Temporary discontinuation: Discontinuing anticoagulants, including apixaban, for active bleeding, elective surgery, or invasive procedures places patients at an increased risk of thrombosis. Lapses in therapy should be avoided and if anticoagulation with apixaban must be temporarily discontinued for any reason, therapy should be restarted as soon as possible.
Spinal/epidural anaesthesia or puncture: When neuraxial anaesthesia (spinal/epidural anaesthesia) or spinal/epidural puncture is employed, patients treated with antithrombotic agents for prevention of thromboembolic complications are at risk of developing an epidural or spinal haematoma which can result in long-term or permanent paralysis. The risk of these events may be increased by the post-operative use of indwelling epidural catheters or the concomitant use of medicinal products affecting haemostasis. Indwelling epidural or intrathecal catheters must be removed at least 5 hours prior to the first dose of apixaban. The risk may also be increased by traumatic or repeated epidural or spinal puncture. Patients are to be frequently monitored for signs and symptoms of neurological impairment (e.g., numbness or weakness of the legs, bowel or bladder dysfunction). If neurological compromise is noted, urgent diagnosis and treatment is necessary. Prior to neuraxial intervention the physician should consider the potential benefit versus the risk in anticoagulated patients or in patients to be anticoagulated for thromboprophylaxis. In case there is such need and based on the general PK characteristics of apixaban, a time interval of 20-30 hours (i.e., 2 x half-life) between the last dose of apixaban and catheter withdrawal should elapse, and at least one dose should be omitted before catheter withdrawal. The next dose of apixaban may be given at least 5 hours after catheter removal. As with all new anticoagulant medicinal products, extreme caution is recommended when using apixaban in the presence of neuraxial blockade.
Haemodynamically unstable PE patients or patients who require thrombolysis or pulmonary embolectomyL: Apixaban is not recommended as an alternative to unfractionated heparin in these patients.
Patients with active cancer: They can be at high risk of both venous thromboembolism and bleeding events. When apixaban is considered for DVT or PE treatment in cancer patients, a careful assessment of the benefits against the risks should be made.
Patients with renal impairment: Limited clinical data indicate that apixaban plasma concentrations are increased in patients with severe renal impairment (creatinine clearance 15-29 mL/min) which may lead to an increased bleeding risk. For the prevention of VTE in elective hip or knee replacement surgery (VTEp), the treatment of DVT, treatment of PE and prevention of recurrent DVT and PE (VTEt), apixaban is to be used with caution in patients with severe renal impairment. For the prevention of stroke and systemic embolism in patients with NVAF, patients with severe renal impairment, and patients with serum creatinine ≥ 1.5 mg/dL (133 micromole/L) associated with age ≥ 80 years or body weight ≤ 60 kg should receive the lower dose of apixaban 2.5 mg twice daily.
Elderly patients: Increasing age may increase haemorrhagic risk. Also, the coadministration of apixaban with ASA in elderly patients should be used cautiously because of a potentially higher bleeding risk.
Body weight: Low body weight (< 60 kg) may increase haemorrhagic risk.
Patients with hepatic impairment: It is not recommended in patients with severe hepatic impairment. It should be used with caution in patients with mild or moderate hepatic impairment (Child Pugh A or B). Patients with elevated liver enzymes ALT/AST > 2 x ULN or total bilirubin ≥ 1.5 x ULN were excluded in clinical studies. Therefore, apixaban should be used cautiously in this population. Prior to initiating apixaban, liver function testing should be performed.
Interaction with inhibitors of both cytochrome P450 3A4 (CYP3A4) and P-glycoprotein (P-gp): The use of apixaban is not recommended in patients receiving concomitant systemic treatment with strong inhibitors of both CYP3A4 and P-gp, such as azole-antimycotics (e.g., ketoconazole, itraconazole, voriconazole and posaconazole) and HIV protease inhibitors (e.g., ritonavir). These medicinal products may increase apixaban exposure by 2-fold, or greater in the presence of additional factors that increase apixaban exposure (e.g., severe renal impairment).
Interaction with inducers of both CYP3A4 and P-gp: The concomitant use of apixaban with strong CYP3A4 and P-gp inducers (e.g., rifampicin, phenytoin, carbamazepine, phenobarbital or St. John's Wort) may lead to a ~50% reduction in apixaban exposure. The following recommendations apply:
- for the prevention of VTE in elective hip or knee replacement surgery, for the prevention of stroke and systemic embolism in patients with NVAF and for the prevention of recurrent DVT and PE, apixaban should be used with caution;
- for the treatment of DVT and treatment of PE, apixaban should not be used since efficacy may be compromised.
Hip fracture surgery: Apixaban has not been studied in patients undergoing hip fracture surgery to evaluate efficacy and safety in these patients. Therefore, it is not recommended in these patients.
Laboratory parameters: Clotting tests [e.g., prothrombin time (PT), INR, and activated partial thromboplastin time (aPTT)] are affected as expected by the mechanism of action of apixaban. Changes observed are small and subject to a high degree of variability.
Information about excipients: Elapix® contains lactose. Patients with rare hereditary problems of galactose intolerance, total lactase deficiency or glucose-galactose malabsorption should not take this medicinal product.
This medicinal product contains less than 1 mmol sodium (23 mg) per film-coated tablet, that is to say essentially “sodium-free”.

Effects on ability to drive and use machines
Apixaban has no or negligible influence on the ability to drive and use machines.

PREGNANCY AND LACTATION

Pregnancy: As a precautionary measure, it is preferable to avoid the use of apixaban during pregnancy.

Breast-feeding: It is unknown whether apixaban or its metabolites are excreted in human milk. Available data in animals have shown excretion of apixaban in milk. A risk to the suckling child cannot be excluded. A decision must be made whether to discontinue breast-feeding or to discontinue/abstain from apixaban therapy taking into account the benefit of breast-feeding for the child and the benefit of therapy for the woman.

DRUG INTERACTIONS

Inhibitors of CYP3A4 and P-gp: Coadministration of apixaban with ketoconazole (400 mg once a day), a strong inhibitor of both CYP3A4 and P-gp, led to a 2-fold increase in mean apixaban AUC and a 1.6-fold increase in mean apixaban C_{max}. The use of apixaban is not recommended in patients receiving concomitant systemic treatment with strong inhibitors of both CYP3A4 and P-gp, such as azole-antimycotics (e.g., ketoconazole, itraconazole, voriconazole and posaconazole) and HIV protease inhibitors (e.g., ritonavir). Active substances which are not considered strong inhibitors of both CYP3A4 and P-gp, (e.g., amiodarone, clarithromycin, diltiazem, fluconazole, naproxen, quinidine, verapamil) are expected to increase apixaban plasma concentration to a lesser extent. No dose adjustment for apixaban is required when coadministered with agents that are not strong inhibitors of both CYP3A4 and P-gp.

Inducers of CYP3A4 and P-gp: Coadministration of apixaban with rifampicin, a strong inducer of both CYP3A4 and P-gp, led to an approximate 54% and 42% decrease in mean apixaban AUC and C_{max}, respectively. The concomitant use of apixaban with other strong CYP3A4 and P-gp inducers (e.g., phenytoin, carbamazepine, phenobarbital or St. John's Wort) may also lead to reduced apixaban plasma concentrations. No dose adjustment for apixaban is required during concomitant therapy with such medicinal products, however in patients receiving concomitant systemic treatment with strong inducers of both CYP3A4 and P-gp apixaban should be used with caution for the prevention of VTE in elective hip or knee replacement surgery, for the prevention of stroke and systemic embolism in patients with NVAF and for the prevention of recurrent DVT and PE. Apixaban is not recommended for the treatment of DVT and PE in patients receiving concomitant systemic treatment with strong inducers of both CYP3A4 and P-gp since efficacy may be compromised.

Anticoagulants, platelet aggregation inhibitors, SSRIs/SNRIs and NSAIDs: Due to an increased bleeding risk, concomitant treatment with any other anticoagulants is contraindicated except under specific circumstances of switching anticoagulant therapy, when UFH is given at doses necessary to maintain an open central venous or arterial catheter or when UFH is given during catheter ablation for atrial fibrillation. After combined administration of enoxaparin (40 mg single dose) with apixaban (5 mg single dose), an additive effect on anti-Factor Xa activity was observed. Increases in clotting tests (PT, INR, and aPTT) were consistent with the effects of apixaban alone. Naproxen (500 mg), an inhibitor of P-gp, led to a 1.5-fold and 1.6-fold increase in mean apixaban AUC and C_{max}, respectively. No changes were observed in the effect of naproxen on arachidonic acid-induced platelet aggregation and no clinically relevant prolongation of bleeding time was observed after concomitant administration of apixaban and naproxen. Despite these findings, there may be individuals with a more pronounced pharmacodynamic response when antiplatelet agents are coadministered with apixaban. Apixaban should be used with caution when coadministered with SSRIs/SNRIs, NSAIDs, ASA and/or P2Y12 inhibitors because these medicinal products typically increase the bleeding risk.

Effect of apixaban on other medicinal products: *In vitro* apixaban studies showed no inhibitory effect on the activity of CYP1A2, CYP2A6, CYP2B6, CYP2C8, CYP2C9, CYP2D6 or CYP3A4 (IC50 > 45 µM) and weak inhibitory effect on the activity of CYP2C19 (IC50 > 20 µM) at concentrations that are significantly greater than peak plasma concentrations observed in patients. Apixaban did not induce CYP1A2, CYP2B6, CYP3A4/5 at a concentration up to 20 µM. Therefore, apixaban is not expected to alter the metabolic clearance of coadministered medicinal products that are metabolised by these enzymes. Apixaban is not a significant inhibitor of P-gp.

Activated charcoal: Administration of activated charcoal reduces apixaban exposure.

ADVERSE EFFECTS

Adverse effects are listed below by system organ class and frequency. Frequencies are defined as: 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 following side effects may occur during the prevention of VTE in adult patients who have undergone elective hip or knee replacement surgery:

Common: anaemia, haematoma, nausea, contusion.

Uncommon: thrombocytopenia, pruritus, hypotension (including procedural hypotension), epistaxis, gastrointestinal haemorrhage, haematochezia, liver function test abnormal, aspartate aminotransferase increased, blood alkaline phosphatase increased, blood bilirubin increased, gamma-glutamyltransferase increased, alanine aminotransferase increased, haematuria, abnormal vaginal haemorrhage, urogenital haemorrhage, post procedural haemorrhage (including post procedural haematoma, wound haemorrhage, vessel puncture site haematoma and catheter site haemorrhage), wound secretion, incision site haemorrhage (including incision site haematoma), operative haemorrhage.

Rare: hypersensitivity, allergic oedema and anaphylaxis, eye haemorrhage (including conjunctival haemorrhage), haemoptysis, rectal haemorrhage, gingival bleeding, alopecia, muscle haemorrhage.

Not known: angioedema, brain haemorrhage, intra-abdominal haemorrhage, respiratory tract haemorrhage, haemorrhoidal haemorrhage, mouth haemorrhage, retroperitoneal haemorrhage, skin rash, erythema multiforme, cutaneous vasculitis, application site bleeding, occult blood positive, traumatic haemorrhage.

- The following side effects may occur during the prevention of stroke and systemic embolism in adult patients with NVAF, with one or more risk factors:

Common: anaemia, eye haemorrhage (including conjunctival haemorrhage), haematoma, hypotension (including procedural hypotension), epistaxis, nausea, gastrointestinal haemorrhage, rectal haemorrhage, gingival bleeding, gamma-glutamyltransferase increased, haematuria, contusion.

Uncommon: thrombocytopenia, hypersensitivity, allergic oedema and anaphylaxis, pruritus, brain haemorrhage, intra-abdominal haemorrhage, haemoptysis, haemorrhoidal haemorrhage, mouth haemorrhage, haematochezia, liver function test abnormal, aspartate aminotransferase increased, blood alkaline phosphatase increased, blood bilirubin increased, alanine aminotransferase increased, skin rash, alopecia, abnormal vaginal haemorrhage, urogenital haemorrhage, application site bleeding, occult blood positive, post procedural haemorrhage (including post procedural haematoma, wound haemorrhage, vessel puncture site haematoma and catheter site haemorrhage), wound secretion, incision site haemorrhage (including incision site haematoma), operative haemorrhage, traumatic haemorrhage.

Rare: respiratory tract haemorrhage, retroperitoneal haemorrhage, muscle haemorrhage.

Very rare: erythema multiforme.

Not known: angioedema, cutaneous vasculitis.

- The following side effects may occur during the treatment of DVT and PE, and prevention of recurrent DVT and PE (VTEt):

Common: anaemia, thrombocytopenia, haematoma, epistaxis, nausea, gastrointestinal haemorrhage, mouth haemorrhage, rectal haemorrhage, gingival bleeding, gamma-glutamyltransferase increased, alanine aminotransferase increased, skin rash, haematuria, abnormal vaginal haemorrhage, urogenital haemorrhage, contusion.

Uncommon: hypersensitivity, allergic oedema and anaphylaxis, pruritis, eye haemorrhage (including conjunctival haemorrhage), hypotension (including procedural hypotension), haemoptysis, haemorrhoidal haemorrhage, haematochezia, liver function test abnormal, aspartate aminotransferase increased, blood bilirubin increased, alopecia, muscle haemorrhage, application site bleeding, occult blood positive, post procedural haemorrhage (including post procedural haematoma, wound haemorrhage, vessel puncture site haematoma and catheter site haemorrhage), wound secretion, incision site haemorrhage (including incision site haematoma), operative haemorrhage, traumatic haemorrhage.

Rare: brain haemorrhage, respiratory tract haemorrhage.

Not known: angioedema, intra-abdominal haemorrhage, retroperitoneal haemorrhage, erythema multiforme, cutaneous vasculitis.

DOSAGE AND ADMINISTRATION

Posology

Prevention of VTE (VTEp): elective hip or knee replacement surgery

The recommended dose is Elapix® 2.5 taken orally twice daily. The initial dose should be taken 12 to 24 hours after surgery. Physicians may consider the potential benefits of earlier anticoagulation for VTE prophylaxis as well as the risks of post-surgical bleeding in deciding on the time of administration within this time window.

In patients undergoing hip replacement surgery: The recommended duration of treatment is 32 to 38 days.

In patients undergoing knee replacement surgery: The recommended duration of treatment is 10 to 14 days.

Prevention of stroke and systemic embolism in patients with non-valvular atrial fibrillation (NVAF)

The recommended dose is Elapix® 5 taken orally twice daily.

Dose reduction: The recommended dose is Elapix® 2.5 taken orally twice daily in patients with NVAF and at least two of the following characteristics: age ≥ 80 years, body weight ≤ 60 kg, or serum creatinine ≥ 1.5 mg/dL (133 micromole/L). Therapy should be continued long-term.

Treatment of DVT, treatment of PE and prevention of recurrent DVT and PE (VTEt)

The recommended dose of apixaban for the treatment of acute DVT and treatment of PE is 10 mg taken orally twice daily for the first 7 days followed by 5 mg taken orally twice daily. As per available medical guidelines, short duration of treatment (at least 3 months) should be based on transient risk factors (e.g., recent surgery, trauma, immobilisation). The recommended dose for the prevention of recurrent DVT and PE is Elapix® 2.5 taken orally twice daily and should be initiated following completion of 6 months of treatment with Elapix® 5 twice daily or with another anticoagulant. The duration of overall therapy should be individualised after careful assessment of the treatment benefit against the risk for bleeding.

Missed dose: If a dose is missed, the patient should take Elapix® immediately and then continue with twice daily intake as before.

Switching

Switching treatment from parenteral anticoagulants to Elapix® (and vice versa) can be done at the next scheduled dose. These medicinal products should not be administered simultaneously.

Switching from vitamin K antagonist (VKA) therapy to Elapix®: warfarin or other VKA therapy should be discontinued and Elapix® started when the international normalised ratio (INR) is < 2.

Switching from Elapix® to VKA therapy: administration of Elapix® should be continued for at least 2 days after beginning VKA therapy. After 2 days of coadministration of Elapix® with VKA therapy, an INR should be obtained prior to the next scheduled dose of Elapix®. Coadministration of Elapix® and VKA therapy should be continued until the INR is ≥ 2.

Elderly

VTEp and VTEt – No dose adjustment required.

NVAF – No dose adjustment required, unless criteria for dose reduction are met.

Renal impairment

In patients with mild or moderate renal impairment, the following recommendations apply:

- for the prevention of VTE in elective hip or knee replacement surgery (VTEp), for the treatment of DVT, treatment of PE and prevention of recurrent DVT and PE (VTEt), no dose adjustment is necessary.
- for the prevention of stroke and systemic embolism in patients with NVAF and serum creatinine ≥ 1.5 mg/dL (133 micromole/L) associated with age ≥ 80 years or body weight ≤ 60 kg, a dose reduction is necessary and described above. In the absence of other criteria for dose reduction (age, body weight), no dose adjustment is necessary.

In patients with severe renal impairment (creatinine clearance 15-29 mL/min) the following recommendations apply:

- for the prevention of VTE in elective hip or knee replacement surgery (VTEp), for the treatment of DVT, treatment of PE and prevention of recurrent DVT and PE (VTEt) Elapix® is to be used with caution;
- for the prevention of stroke and systemic embolism in patients with NVAF, patients should receive the lower dose of Elapix® 2.5 twice daily.

In patients with creatinine clearance < 15 mL/min, or in patients undergoing dialysis, there is no clinical experience therefore apixaban is not recommended.

Hepatic impairment: No dose adjustment is required in patients with mild or moderate hepatic impairment.

Body weight

VTEp and VTEt - No dose adjustment required.

NVAF - No dose adjustment required, unless criteria for dose reduction are met.

Gender: No dose adjustment required.

Patients undergoing catheter ablation (NVAF): Patients can continue Elapix® use while undergoing catheter ablation.

Patients undergoing cardioversion: Elapix® can be initiated or continued in NVAF patients who may require cardioversion. For patients not previously treated with anticoagulants, exclusion of left atrial thrombus using an image guided approach (e.g. transesophageal echocardiography (TEE) or computed tomographic scan (CT)) prior to cardioversion should be considered, in accordance with established medical guidelines. For patients initiating treatment with apixaban, 5 mg should be given twice daily for at least 2.5 days (5 single doses) before cardioversion to ensure adequate anticoagulation. The dosing regimen should be reduced to 2.5 mg given twice daily for at least 2.5 days (5 single doses) if the patient meets the criteria for dose reduction. If cardioversion is required before 5 doses of apixaban can be administered, a 10 mg loading dose should be given, followed by 5 mg twice daily. The dosing regimen should be reduced to a 5 mg loading dose followed by 2.5 mg twice daily if the patient meets the criteria for dose reduction. The administration of the loading dose should be given at least 2 hours before cardioversion. For all patients undergoing cardioversion, confirmation should be sought prior to cardioversion that the patient has taken apixaban as prescribed. Decisions on initiation and duration of treatment should take established guideline recommendations for anticoagulant treatment in patients undergoing cardioversion into account.

Patients with NVAF and acute coronary syndrome (ACS) and/or percutaneous coronary intervention (PCI): There is limited experience of treatment with Elapix® at the recommended dose for NVAF patients when used in combination with antiplatelet agents in patients with ACS and/or undergoing PCI after haemostasis is achieved.

Method of administration

Oral use.

Elapix® should be swallowed with water, with or without food.

For patients who are unable to swallow whole tablets, Elapix® may be crushed and suspended in water, or 5% glucose in water (G5W), or apple juice or mixed with apple puree and immediately administered orally. Alternatively, Elapix® may be crushed and suspended in 60 mL of water or G5W and immediately delivered through a nasogastric tube.

Crushed Elapix® are stable in water, G5W, apple juice, and apple puree for up to 4 hours.

OVERDOSAGE

Overdose of Elapix® may result in a higher risk of bleeding. In the event of haemorrhagic complications, treatment must be discontinued and the source of bleeding investigated. The initiation of appropriate treatment, e.g., surgical haemostasis, the transfusion of fresh frozen plasma or the administration of a reversal agent for factor Xa inhibitors should be considered.

Mean half-life of apixaban decreased from 13.4 hours when apixaban was administered alone to 5.3 hours and 4.9 hours, respectively, when activated charcoal was administered 2 and 6 hours after apixaban. Thus, administration of activated charcoal may be useful in the management of apixaban overdose or accidental ingestion. For situations when reversal of anticoagulation is needed due to life-threatening or uncontrolled bleeding, a reversal agent for factor Xa inhibitors is available. Administration of prothrombin complex concentrates (PCCs) or recombinant factor VIIa may also be considered. Reversal of apixaban pharmacodynamic effects, as demonstrated by changes in the thrombin generation assay, was evident at the end of infusion and reached baseline values within 4 hours after the start of a 4-factor PCC 30 minutes infusion in healthy subjects. Re-dosing of recombinant factor VIIa could be considered and titrated depending on improvement of bleeding. Depending on local availability, a consultation of a coagulation expert should be considered in case of major bleedings. Haemodialysis decreased apixaban AUC by 14% in subjects with end-stage renal disease (ESRD), when a single dose of apixaban 5mg was administered orally. Therefore, haemodialysis is unlikely to be an effective means of managing apixaban overdose.

STORAGE CONDITIONS

Store below 30°C.

Keep in original pack in intact conditions.

Date of revision: January 2025.

Marketing Authorization Holder and Manufacturer
Benta S.A.L. - Lebanon

BPI

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