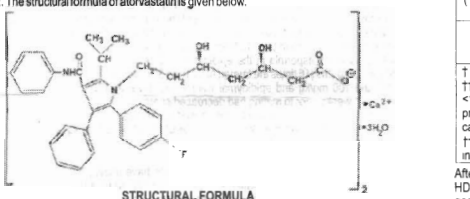
*For the use only of a Registered Medical Practitioner*

# Storvas Tablets
## (Atorvastatin Tablets)

**COMPOSITION**
**Storvas Tablets 10 mg**
Each film coated tablet contains:
Atorvastatin Calcium
equivalent to Atorvastatin ..... .... 10 mg

**Storvas Tablets 20 mg**
Each film coated tablet contains
Atorvastatin Calcium
equivalent to Atorvastatin .... ..... 20 mg

**DESCRIPTION**[1]
**Storvas Tablets** contain atorvastatin calcium. Atorvastatin is a synthetic lipid-lowering agent. Atorvastatin is an inhibitor of **3-hydroxy-3-methylglutaryl-coenzyme** A (HMG-CoA) reductase. This enzyme catalyzes the conversion of HMG-CoA to mevalonate, an early and rate-limiting step in cholesterol biosynthesis. It is chemically designated as [R-(R*, R*)]-2-(4-fluorophenyl)-β, dihydroxy-5-(1-methylethyl)-3-phenyl-4-[(phenylamino)carbonyl]-1H-pyrrole-1-heptanoic acid, calcium salt (2:1) trihydrate. The molecular formula of atorvastatin is $(C_{33}H_{34}FN_2O_5)_2Ca3H_2O$ and molecular weight is 1209.42. The structural formula of atorvastatin is given below.




STRUCTURAL FORMULA
ATORVASTATIN

**PHARMACOLOGY**[1,2]
- **Mechanism of Action**

Atorvastatin is a selective, competitive inhibitor of HMG-CoA reductase, the rate-limiting enzyme that converts 3-hydroxy-3-methylglutaryl-coenzyme A to mevalonate, a precursor of sterols, including cholesterol. Cholesterol and triglycerides circulate in the bloodstream as part of lipoprotein complexes. With ultracentrifugation, these complexes separate into HDL (high-density lipoprotein), IDL (intermediate-density lipoprotein), LDL (low-density lipoprotein), and VLDL (very-low-density lipoprotein) fractions. Triglycerides (TG) and cholesterol in the liver are incorporated into VLDL and released into the plasma for delivery to peripheral tissues. LDL is formed from VLDL and is catabolized primarily through the high-affinity LDL receptor. Clinical and pathologic studies show that elevated plasma levels of total cholesterol (total-C), LDL-cholesterol (LDL-C), and apolipoprotein B (apo B) promote human atherosclerosis and are risk factors for developing cardiovascular disease, while increased levels of HDL-C are associated with a decreased cardiovascular risk.

In animal models, atorvastatin lowers plasma cholesterol and lipoprotein levels by inhibiting HMG-CoA reductase and cholesterol synthesis in the liver and by increasing the number of hepatic LDL receptors on the cell-surface to enhance uptake and catabolism of LDL; atorvastatin also reduces LDL production and the number of LDL particles. Atorvastatin reduces LDL-C in some patients with homozygous familial hypercholesterolemia (FH), a population that rarely responds to other lipid-lowering medication(s).

A variety of clinical studies have demonstrated that elevated levels of total-C, LDL-C, and apo B (a membrane complex for LDL-C) promote human atherosclerosis. Similarly, decreased levels of HDL-C (and its transport complex, apo A) are associated with the development of atherosclerosis. Epidemiologic investigations have established that cardiovascular morbidity and mortality vary directly with the level of total-C and LDL-C and inversely with the level of HDL-C.

Atorvastatin reduces total-C, LDL-C, and apo B in patients with homozygous and heterozygous FH, nonfamilial forms of hypercholesterolemia, and mixed dyslipidemia. Atorvastatin also reduces VLDL-C and TG and produces variable increases in HDL-C and apolipoprotein A-1.

Atorvastatin reduces total-C, LDL-C, VLDL-C, apo B, TG, and non-HDL-C, and increases HDL-C in patients with isolated hypertriglyceridemia. Atorvastatin reduces intermediate-density lipoprotein cholesterol (IDL-C) in patients with dysbetalipoproteinemia.

Like LDL, cholesterol-enriched triglyceride-rich lipoproteins, including VLDL, intermediate-density lipoprotein (IDL), and remnants, can also promote atherosclerosis. Elevated plasma triglycerides are frequently found in a triad with low HDL-C levels and small LDL particles, as well as in association with non-lipid metabolic risk factors for coronary heart disease. As such, total plasma TG has not consistently been shown to be an independent risk factor for CHD. Furthermore, the independent effect of raising HDL or lowering TG on the risk of coronary and cardiovascular morbidity and mortality has not been determined.

Atorvastatin as well as some of its metabolites are pharmacologically active in humans. The liver is the primary site of action and the principal site of cholesterol synthesis and LDL clearance. Drug dosage rather than systemic drug concentration correlates better with LDL-C reduction. Individualization of drug dosage should be based on therapeutic response.

- **Pharmacokinetics**

Atorvastatin is rapidly absorbed after oral administration; maximum plasma concentrations occur within 1 to 2 hours. Extent of absorption increases in proportion to atorvastatin dose. The absolute bioavailability of atorvastatin (parent drug) is approximately 14% and the systemic availability of HMG-CoA reductase inhibitory activity is approximately 30%. The low systemic availability is attributed to presystemic clearance in gastrointestinal mucosa and/or hepatic first-pass metabolism. Although food decreases the rate and extent of drug absorption by approximately 25% and 9%, respectively, as assessed by $C_{max}$ and AUC, LDL-C reduction is similar whether atorvastatin is given with or without food. Plasma atorvastatin concentrations are lower (approximately 30% for $C_{max}$ and AUC) following evening drug administration compared with morning. However, LDL-C reduction is the same regardless of the time of day of drug administration.

Mean volume of distribution of atorvastatin is approximately 381 liters. Atorvastatin is ≥98% bound to plasma proteins. A blood/plasma ratio of approximately 0.25 indicates poor drug penetration into red blood cells. Based on observations in rats, atorvastatin is likely to be secreted in human milk.

Atorvastatin is extensively metabolized to ortho- and para-hydroxylated derivatives and various beta-oxidation products. *In vitro* inhibition of HMG-CoA reductase by ortho- and parahydroxylated metabolites is equivalent to that of atorvastatin. Approximately 70% of circulating inhibitory activity for HMG-CoA reductase is attributed to active metabolites. *In vitro* studies suggest the importance of atorvastatin metabolism by cytochrome P450 3A4, consistent with increased plasma concentrations of atorvastatin in humans following coadministration with erythromycin, a known inhibitor of this isozyme. In animals, the ortho-hydroxy metabolite undergoes further glucuronidation.

Atorvastatin and its metabolites are eliminated primarily in bile following hepatic and/or extrahepatic metabolism; however the drug does not appear to undergo enterohepatic recirculation. Mean plasma elimination half-life of atorvastatin in humans is approximately 14 hours, but the half-life of inhibitory activity for HMG-CoA reductase is 20 to 30 hours due to the contribution of active metabolites. Less than 2% of a dose of atorvastatin is recovered in urine following oral administration.

***Special Populations:***
*Geriatric:* Plasma concentrations of atorvastatin are higher (approximately 40% for $C_{max}$ and 30% for AUC) in healthy elderly subjects (age ≥65 years) than in young adults. Clinical data suggest a greater degree of LDL-lowering at any dose of drug in the elderly patient population compared to younger adults.

*Pediatric:* Pharmacokinetic data in the pediatric population are not available.

*Gender:* Plasma concentrations of atorvastatin in women differ from those in men (approximately 20% higher for $C_{max}$ and 10% lower for AUC); however, there is no clinically significant difference in LDL-C reduction with atorvastatin between men and women.

*Renal Insufficiency:* Renal disease has no influence on the plasma concentrations or LDL-C reduction of atorvastatin; thus, dose adjustment in patients with renal dysfunction is not necessary.

*Hemodialysis:* While studies have not been conducted in patients with end-stage renal disease, hemodialysis is not expected to significantly enhance clearance of atorvastatin since the drug is extensively bound to plasma proteins.

*Hepatic Insufficiency:* In patients with chronic alcoholic liver disease, plasma concentrations of atorvastatin are markedly increased. $C_{max}$ and AUC are each 4-fold greater in patients with Childs-Pugh A disease. $C_{max}$ and AUC are approximately 16-fold and 11-fold increased, respectively, in patients with Childs-Pugh B disease.

**INDICATIONS**[1,2]
***Prevention of Cardiovascular Disease***
In adult patients without clinically evident coronary heart disease, but with multiple risk factors for coronary heart disease such as age, smoking, hypertension, low HDL-C, or a family history of early coronary heart disease, **Storvas Tablets** (Atorvastatin Calcium Tablets) are indicated to:
- Reduce the risk of myocardial infarction
- Reduce the risk of stroke
- Reduce the risk for revascularization procedures and angina

In patients with type 2 diabetes, and without clinically evident coronary heart disease, but with multiple risk factors for coronary heart disease such as retinopathy, albuminuria, smoking, or hypertension, atorvastatin is indicated to
- Reduce the risk of myocardial infarction
- Reduce the risk of stroke

***Hypercholesterolemia***
**Storvas Tablets** (Atorvastatin Calcium Tablets) are indicated:
1. As an adjunct to diet to reduce elevated total-C, LDL-C, apo B, and TG levels and to increase HDL-C in patients with primary hypercholesterolemia (heterozygous familial and nonfamilial) and mixed dyslipidemia (Fredrickson Types IIa and IIb),
2. As an adjunct to diet for the treatment of patients with elevated serum TG levels (Fredrickson Type IV),
3. for the treatment of patients with primary dysbetalipoproteinemia (Fredrickson Type III) who do not respond adequately to diet;
4. To reduce total-C and LDL-C in patients with homozygous familial hypercholesterolemia as an adjunct to other lipid-lowering treatments (e.g. LDL apheresis) or if such treatments are unavailable;
5. As an adjunct to diet to reduce total-C, LDL-C, and apo B levels in boys and postmenarchal girls, 10 to 17 years of age, with heterozygous familial hypercholesterolemia if after an adequate trial of diet therapy the following findings are present:
   a. LDL-C remains ≥ 190 mg/dL or
   b. LDL-C remains ≥ 160 mg/dL and:
   - There is a positive family history of premature cardiovascular disease or
   - Two or more other CVD risk factors are present in the pediatric patient

Therapy with lipid-altering agents should be a component of multiple-risk-factor intervention in individuals at increased risk for atherosclerotic vascular disease due to hypercholesterolemia. Lipid-altering agents should be used in addition to a diet restricted in saturated fat and cholesterol only when the response to diet and other nonpharmacological measures has been inadequate (see National Cholesterol Education Program (NCEP) Guidelines, summarized in the table below).

**Table. NCEP Treatment Guidelines: LDL-C Goals and Cutpoints for Therapeutic Lifestyle Changes and Drug Therapy in Different Risk Categories**

| Risk Category | LDL Goal (mg/dL) | LDL Level at Which to Initiate Therapeutic Lifestyle Changes (mg/dL) | LDL Level at Which to Consider Drug Therapy (mg/dL) |
|---|---|---|---|
| CHD† or CHD risk equivalents (10-year risk >20%) | <100 | ≥100 | ≥130 (100-129: drug optional)†† |
| 2+ Risk factors (10 year risk ≥20%) | <130 | ≥130 | 10-year risk 10-20%: ≥130<br>10-year risk <10%: ≥ 160 |
| 0-1 Risk factor††† | <160 | ≥160 | >190 (160-189: LDL-lowering drug optional) |

† CHD, coronary heart disease
†† Some authorities recommend use of LDL-lowering drugs in this category if an LDL-C level of <100 mg/dL cannot be achieved by therapeutic lifestyle changes. Others prefer use of drugs that primarily modify triglycerides and HDL-C, e.g. nicotinic acid or fibrate. Clinical judgment also may call for deferring drug therapy in this subcategory
††† Almost all people with 0-1 risk factor have a 10-year risk <10%; thus, 10-year risk assessment in people with 0-1 risk factor is not necessary

After the LDL-C goal has been achieved, if the TG is still ≥200 mg/dL, non-HDL-C (total-C minus HDLC) becomes a secondary target of therapy. Non-HDL-C goals are set 30 mg/dL higher than LDL-C goals for each risk category.

Prior to initiating therapy with atorvastatin, secondary causes for hypercholesterolemia (e.g. poorly controlled diabetes mellitus, hypothyroidism, nephrotic syndrome, dysproteinemias, obstructive liver disease, other drug therapy, and alcoholism) should be excluded, and a lipid profile performed to measure total-C, LDL-C, HDL-C, and TG. For patients with TG <400 mg/dL (<4.5 mmol/L), LDL-C can be estimated using the following equation: **LDL-C** = total-C - (0.20 x [TG] + HDL-C). For TG levels >400 mg/dL (>4.5 mmol/L), this equation is less accurate and LDL-C concentrations should be determined by ultracentrifugation.

Atorvastatin has not been studied in conditions where the major lipoprotein abnormality is elevation of chylomicrons (*Fredrickson* Types I and V).

The NCEP classification of cholesterol levels in pediatric patients with a familial history of hypercholesterolemia or premature cardiovascular disease is summarized below:

| Category | Total-C (mg/dL) | LDL-C (mg/dL) |
|---|---|---|
| Acceptable | <170 | <110 |
| Borderline | 170-199 | 110-129 |
| High | ≥200 | ≥130 |

**DOSAGE AND ADMINISTRATION**[1,2]
The patient should be placed on a standard cholesterol-lowering diet before receiving **Storvas Tablets** (Atorvastatin Calcium Tablets) and should continue on this diet during treatment with **Storvas Tablets** (Atorvastatin Calcium Tablets).

***Hypercholesterolemia (Heterozygous Familial and Nonfamilial) and Mixed Dyslipidemia (Fredrickson Types IIa and IIb)***
The recommended starting dose of **Storvas Tablets** (Atorvastatin Calcium Tablets) is 10 or 20 mg once daily. Patients who require a large reduction in LDL-C (more than 45%) may be started at 40 mg once daily. The dosage range of **Storvas Tablets** (Atorvastatin Calcium Tablets) is 10 to 80 mg once daily. **Storvas Tablets** (Atorvastatin Calcium Tablets) can be administered as a single dose at any time of the day, with or without food. The starting dose and maintenance doses of **Storvas Tablets** (Atorvastatin Calcium Tablets) should be individualized according to patient characteristics such as goal of therapy and response (see NCEP Guidelines). After initiation and/or upon titration of **Storvas Tablets** (Atorvastatin Calcium Tablets), lipid levels should be analyzed within 2 to 4 weeks and dosage adjusted accordingly.

Since the goal of treatment is to lower LDL-C, the NCEP recommends that LDL-C levels be used to initiate and assess treatment response. Only if LDL-C levels are not available, should total-C be used to monitor therapy.

***Heterozygous Familial Hypercholesterolemia in Pediatric Patients (10-17 years of age)***
The recommended starting dose of **Storvas Tablets** (Atorvastatin Calcium Tablets) is 10 mg/day; the maximum recommended dose is 20 mg/day (doses greater than 20 mg have not been studied in this patient population). Doses should be individualized according to the recommended goal of therapy (see NCEP Pediatric Panel Guidelines, **PHARMACOLOGY** and **INDICATIONS**). Adjustments should be made at intervals of 4 weeks or more.

***Homozygous Familial Hypercholesterolemia***
The dosage of **Storvas Tablets** (Atorvastatin Calcium Tablets) in patients with homozygous FH is 10 to 80 mg daily. **Storvas Tablets** (Atorvastatin Calcium Tablets) should be used as an adjunct to other lipid-lowering treatments (e.g. LDL apheresis) in these patients or if such treatments are unavailable.

***Concomitant Therapy***
**Storvas Tablets** (Atorvastatin Calcium Tablets) may be used in combination with a bile acid binding resin for additive effect. The combination of HMG-CoA reductase inhibitors and fibrates should generally be avoided.

***Dosage in Patients With Renal Insufficiency***
Renal disease does not affect the plasma concentrations nor LDL-C reduction of atorvastatin; thus, dosage adjustment in patients with renal dysfunction is not necessary.

* National Cholesterol Education Program (NCEP): Highlights of the Report of the Expert Panel on Blood Cholesterol Levels in Children Adolescents, Pediatrics, 89(3) 495-501 1992.

**PRECAUTIONS**[1,2]
- **General**

Before instituting therapy with atorvastatin, an attempt should be made to control hypercholesterolemia with appropriate diet, exercise, and weight reduction in obese patients, and to treat other underlying medical problems (see **INDICATIONS**).

*Endocrine Function*
HMG-CoA reductase inhibitors interfere with cholesterol synthesis and theoretically might blunt adrenal and/or gonadal steroid production. Clinical studies have shown that atorvastatin does not reduce basal plasma cortisol concentration or impair adrenal reserve. The effects of HMG-CoA reductase inhibitors on male fertility have not been studied in adequate numbers of patients. The effects, if any, on the pituitary-gonadal axis in premenopausal women are unknown. Caution should be exercised if an HMG-CoA reductase inhibitor is administered concomitantly with drugs that may decrease the levels or activity of endogenous steroid hormones, such as ketoconazole, spironolactone, and cimetidine.

*CNS Toxicity*
Brain hemorrhage was seen in a female dog treated for 3 months at 120 mg/kg/day. Brain hemorrhage and optic nerve vacuolation were seen in another female dog that was sacrificed in moribund condition after 11 weeks of escalating doses up to 280 mg/kg/day. The 120 mg/kg dose resulted in a systemic exposure approximately 16 times the human plasma area-under-the-curve (AUC, 0-24 hours) based on the maximum human dose of 80 mg/day. A single tonic convulsion was seen in each of 2 male dogs (one treated at 90 mg/kg/day and one at 120 mg/kg/day) in a 2-year study. No CNS lesions have been observed in mice after chronic treatment for up to 2 years at doses up to 400 mg/kg/day or in rats at doses up to 100 mg/kg/day. These doses were 6 to 11 times (mouse) and 8 to 16 times (rat) the human $AUC_{0-24}$, based on the maximum recommended human dose of 80 mg/day.

CNS vascular lesions, characterized by perivascular hemorrhages, edema and mononuclear cell infiltration of perivascular spaces, have been observed in dogs treated with other members of this class. A chemically similar drug in this class produced optic nerve degeneration (Wallerian degeneration of retinogeniculate fibers) in clinically normal dogs in a dose-dependent fashion at a dose that produced plasma drug levels about 30 times higher than the mean drug level in humans taking the highest recommended dose.

*Children aged 10-17 years*
In patients aged <18 years efficacy and safety have not been studied for treatment periods >52 weeks' duration and effects on long-term cardiovascular outcomes are unknown.

The effects of atorvastatin in children aged <10 years and premenarchal girls have not been investigated.

Long term effects on cognitive development, growth and pubertal maturation are unknown.

- **Warnings**

***Liver Dysfunction***
HMG-CoA reductase inhibitors, like some other lipid-lowering therapies, have been associated with biochemical abnormalities of liver function. **Persistent elevations (>3 times the upper limit of normal [ULN] occurring on 2 or more occasions) in serum transaminases occurred in 0.7% of patients who received atorvastatin in clinical trials. The incidence of these abnormalities was** 0.2%, 0.2%, 0.8%, and 2.3% for 10, 20, 40, and 80 mg, respectively.

One patient in clinical trials developed jaundice. Increases in liver function tests (LFT) in other patients were not associated with jaundice or other clinical signs or symptoms. Upon dose reduction, drug interruption, or discontinuation, transaminase levels returned to or near pretreatment levels without sequelae. Eighteen of 30 patients with persistent LFT elevations continued treatment with a reduced dose of atorvastatin

**It is recommended that liver function tests be performed prior to and at 12 weeks following both the initiation of therapy and any elevation of dose, and periodically (e.g. semiannually) thereafter.** Liver enzyme changes generally occur in the first 3 months of treatment with atorvastatin. Patients who develop increased transaminase levels should be monitored until the abnormalities resolve. Should an increase in ALT or AST of >3 times ULN persist, reduction of dose or withdrawal of atorvastatin is recommended.

Atorvastatin should be used with caution in patients who consume substantial quantities of alcohol and/or have a history of liver disease. Active liver disease or unexplained persistent transaminase elevations are contraindications to the use of atorvastatin (see **CONTRAINDICATIONS**).

*Skeletal Muscle*

**Rare cases of rhabdomyolysis with acute renal failure secondary to myoglobinuria have been reported with atorvastatin and with other drugs in this class.**

Uncomplicated myalgia has been reported in atorvastatin-treated patients. Myopathy, defined as muscle aches or muscle weakness in conjunction with increases in creatine phosphokinase (CPK) values > 10 times ULN, should be considered in any patient with diffuse myalgias, muscle tenderness or weakness, and/or marked elevation of CPK. Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever. Atorvastatin therapy should be discontinued if markedly elevated CPK levels occur or myopathy is diagnosed or suspected.

The risk of myopathy during treatment with drugs in this class is increased with concurrent administration of cyclosporine, fibric acid derivatives, erythromycin, niacin, or azole antifungals. Physicians considering combined therapy with atorvastatin and fibric acid derivatives, erythromycin, immunosuppressive drugs, azole antifungals, or lipid-lowering doses of niacin should carefully weigh the potential benefits and risks and should carefully monitor patients for any signs or symptoms of muscle pain, tenderness, or weakness, particularly during the initial months of therapy and during any periods of upward dosage titration of either drug. Periodic creatine phosphokinase (CPK) determinations may be considered in such situations, but there is no assurance that such monitoring will prevent the occurrence of severe myopathy.

**Atorvastatin therapy should be temporarily withheld or discontinued in any patient with an acute, serious condition suggestive of a myopathy or having a risk factor predisposing to the development of renal failure secondary to rhabdomyolysis (e.g. severe acute infection, hypotension, major surgery, trauma, severe metabolic, endocrine and electrolyte disorders, and uncontrolled seizures).**

- **Contraindications**

**Storvas Tablets** (Atorvastatin Calcium Tablets) are contraindicated in following conditions:

Active liver disease or unexplained persistent elevations of serum transaminases.

*Hypersensitivity to any component of this medication.*

*Pregnancy and lactation:* Atherosclerosis is a chronic process and discontinuation of lipid-lowering drugs during pregnancy should have little impact on the outcome of long-term therapy of primary hypercholesterolemia. Cholesterol and other products of cholesterol biosynthesis are essential components for fetal development (including synthesis of steroids and cell membranes). Since HMG-CoA reductase inhibitors decrease cholesterol synthesis and possibly the synthesis of other biologically active substances derived from cholesterol, they may cause fetal harm when administered to pregnant women. Therefore, HMG-CoA reductase inhibitors are contraindicated during pregnancy and in nursing mothers. ATORVASTATIN SHOULD BE ADMINISTERED TO WOMEN OF CHILDBEARING AGE ONLY WHEN SUCH PATIENTS ARE HIGHLY UNLIKELY TO CONCEIVE AND HAVE BEEN INFORMED OF THE POTENTIAL HAZARDS. If the patient becomes pregnant while taking this drug, therapy should be discontinued and the patient apprised of the potential hazard to the fetus.

- **Pregnancy**

*Pregnancy Category X:* See **CONTRAINDICATIONS**

Safety in pregnant women has not been established. Atorvastatin crosses the rat placenta and reaches a level in fetal liver equivalent to that of maternal plasma. Atorvastatin was not teratogenic in rats at doses up to 300 mg/kg/day or in rabbits at doses up to 100 mg/kg/day. These doses resulted in multiples of about 30 times (rat) or 20 times (rabbit) the human exposure based on surface area ($mg/m^2$).

In a study in rats given 20, 100, or 225 mg/kg/day, from gestation day 7 through to lactation day 21 (weaning), there was decreased pup survival at birth, neonate, weaning, and maturity in pups of mothers dosed with 225 mg/kg/day. Body weight was decreased on days 4 and 21 in pups of mothers dosed at 100 mg/kg/day; pup body weight was decreased at birth and at days 4, 21, and 91 at 225 mg/kg/day. Pup development was delayed (rotorod performance at 100 mg/kg/day and acoustic startle at 225 mg/kg/day; pinnae detachment and eye opening at 225 mg/kg/day). These doses correspond to 6 times (100 mg/kg) and 22 times (225 mg/kg) the human AUC at 80 mg/day. Rare reports of congenital anomalies have been received following intrauterine exposure to HMG-CoA reductase inhibitors. There has been one report of severe congenital bony deformity, tracheo-esophageal fistula, and anal atresia (VATER association) in a baby born to a woman who took lovastatin with dextroamphetamine sulfate during the first trimester of pregnancy. Atorvastatin should be administered to women of child-bearing potential only when such patients are highly unlikely to conceive and have been informed of the potential hazards. If the woman becomes pregnant while taking atorvastatin, it should be discontinued and the patient advised again as to the potential hazards to the fetus.

- **Lactation**

Nursing rat pups had plasma and liver drug levels of 50% and 40%, respectively, of that in their mother's milk. Because of the potential for adverse reactions in nursing infants, women taking atorvastatin should not breast-feed (see **CONTRAINDICATIONS**).

- **Pediatric**

Safety and effectiveness in patients 10-17 years of age with heterozygous familial hypercholesterolemia have been evaluated in a controlled clinical trial of 6 months duration in adolescent boys and postmenarchal girls. Patients treated with atorvastatin had an adverse experience profile generally similar to that of patients treated with placebo, the most common adverse experiences observed in both groups, regardless of causality assessment, were infections. Doses greater than 20 mg have not been studied in this patient population. In this limited controlled study, there was no detectable effect on growth or sexual maturation in boys or on menstrual cycle length in girls. Adolescent females should be counseled on appropriate contraceptive methods while on atorvastatin therapy. Atorvastatin has not been studied in controlled clinical trials involving pre-pubertal patients or patients younger than 10 years of age.

Clinical efficacy with doses up to 80 mg/day for 1 year have been evaluated in an uncontrolled study of patients with homozygous FH including 8 pediatric patients.

- **Geriatric**

The safety and efficacy of atorvastatin (10-80 mg) in the geriatric population (65 years of age) was evaluated in a study. In this 54-week open-label trial 1,958 patients initiated therapy with atorvastatin 10 mg. Of these, 835 were elderly (65 years) and 1,123 were non-elderly. The mean change in LDL-C from baseline after 6 weeks of treatment with atorvastatin 10 mg was 38.2% in the elderly patients versus 34.6% in the non-elderly group.

The rates of discontinuation due to adverse events were similar between the two age groups. There were no differences in clinically relevant laboratory abnormalities between the age groups.

- **Drug Interactions**

The risk of myopathy during treatment with other drugs in this class is increased with concurrent administration of cyclosporine, fibric acid derivatives, erythromycin, azole antifungals, or niacin. This increase in risk may also occur when combining these drugs with atorvastatin.

Phenazone (antipyrine) is a non-specific model for evaluation of drug metabolism by the hepatic microsomal enzyme system. Administration of multiple doses of atorvastatin with phenazone showed little or no detectable effect on the pharmacokinetics of phenazone in healthy subjects (no change in the clearance of phenazone but the formation clearance of 4-hydroxyphenazone increased by 20% and that of norphenazone by 8%).

More specific *in vitro* studies using human hepatic microsomes and cells expressing human cytochrome P450 isozymes show that atorvastatin, like other HMG-CoA reductase inhibitors, is metabolized by cytochrome P450 3A4 indicating the possibility of an interaction with drugs also metabolized by this isozyme. When combining atorvastatin with other drugs which are the substrate of this isozyme (e.g. immunomodulators, many antiarrhythmic agents, some calcium channel antagonists and some benzodiazepines) the possibility of a change in the plasma drug levels of either drug should be considered. In clinical studies in which atorvastatin was administered with antihypertensives (including ACE inhibitors, beta-blockers, calcium channel antagonists, and diuretics) or hypoglycemic agents no clinically significant interactions were seen.

Based on experience with other HMG-CoA reductase inhibitors caution should also be exercised when atorvastatin is administered with inhibitors of cytochrome P450 3A4 (e. g. certain macrolide antibiotics and azole antifungals). Increases and decreases in plasma phenytoin levels have been reported, but the relationship with atorvastatin is unknown.

*Inhibitors of P-glycoprotein.* Atorvastatin and atorvastatin metabolites are substrates of P-glycoprotein. Inhibitors of the P-glycoprotein (e.g. cyclosporine) can increase the bioavailability of atorvastatin and thereby increase the risk of dose-related side effects such as myopathy.

*Gemfibrozil/fibric acid derivatives:* The use of fibrates alone is occasionally associated with myopathy. An increased risk of muscle related adverse event has been described when fibrates are co-administered with HMG-CoA reductase inhibitors. The risk of atorvastatin induced myopathy may therefore be increased with concomitant use of fibric acid derivatives. Pre-clinical data suggest that gemfibrozil may also interact with atorvastatin by inhibiting its glucuronidation. Co-administration of atorvastatin with fibrates (especially gemfibrozil) should only be undertaken with caution.

*Digoxin:* When multiple doses of digoxin and 10 mg atorvastatin were coadministered, steady state plasma digoxin concentrations were unaffected. However, digoxin concentrations increased approximately 20% following administration of digoxin with 80 mg atorvastatin daily. Patients taking digoxin should be monitored appropriately.

*Macrolide antibiotics.*

*Erythromycin, clarithromycin:* Coadministration of atorvastatin and erythromycin (500 mg QID), or clarithromycin (500 mg BID), known inhibitors of cytochrome P450 3A4, were associated with higher plasma concentrations of atorvastatin.

*Azithromycin:* Coadministration of atorvastatin (10 mg OD) and azithromycin (500 mg OD) did not alter the plasma concentrations of atorvastatin.

*Oral contraceptives:* Administration of atorvastatin with an oral contraceptive containing norethisterone and ethinyl estradiol produced increases in plasma concentrations of norethisterone and ethinyl estradiol. These increased concentrations should be considered when selecting oral contraceptive doses.

*Amlodipine:* Atorvastatin pharmacokinetics were not altered by the coadministration of atorvastatin 80 mg and amlodipine 10 mg at steady state.

*Colestipol:* Plasma concentrations of atorvastatin were lower (approximately 25%) when colestipol was administered with atorvastatin. However, lipid effects were greater when atorvastatin and colestipol were administered together than when either drug was given alone.

*Antacid:* Administration of atorvastatin with an oral antacid suspension containing magnesium and aluminum hydroxides decreased atorvastatin plasma concentrations approximately 35%; however, LDL-C reduction was not altered.

*Warfarin:* Administration of atorvastatin with warfarin caused a minimal decrease in prothrombin time (mean ± SE of 1.7 ± 0.4 seconds) during the first 4 days of dosing with 80 mg atorvastatin. Dosing continued for 15 days and prothromoin time returned to normal by the end of atorvastatin treatment. Nevertheless, patients receiving warfarin should be closely monitored when atorvastatin is added to their therapy.

*Cimetidine:* An interaction study with cimetidine and atorvastatin was conducted, and no interaction was seen.

*Grapefruit juice:* Contains one or more components that inhibit CYP3A4 and can increase plasma concentrations of drugs metabolized by CYP3A4, Intake of one 240 ml glass of grapefruit juice resulted in an increase in atorvastatin AUC of 37 % and a decreased AUC of 20.4 % for the active ortho-hydroxy metabolite. However, large quantities of grapefruit juice (over 1.2L daily for 5 days) increased AUC of atorvastatin 2.5 fold and AUC of active (atorvastatin and metabolites) HMG-CoA reductase inhibitors 1.3 fold. Concomitant intake of large quantities of grapefruit juice and atorvastatin is therefore not recommended.

*Protease inhibitors.* Co-administration of atorvastatin and protease inhibitors, known inhibitors of cytochrome P450 3A4, was associated with an approximately two-fold increase in plasma concentrations of atorvastatin. Consideration should be given to starting atorvastatin at a lower dose when co-administered with a protease inhibitor.

- **Carcinogenicity/ Mutagenicity/ Impairment of Fertility**

In a 2-year carcinogenicity study in rats at dose levels of 10, 30 and 100 mg/kg/day, 2 rare tumors were found in muscle in high-dose females: in one, there was a rhabdomyosarcoma and, in another, there was a fibrosarcoma. This dose represents a plasma $AUC_{(0-24)}$ value of approximately 16 times the mean human plasma drug exposure after an 80 mg oral dose.

A 2-year carcinogenicity study in mice given 100, 200, or 400 mg/kg/day resulted in a significant increase in liver adenomas in high-dose males and liver carcinomas in high-dose females. These findings occurred at plasma $AUC_{(0-24)}$ values of approximately 6 times the mean human plasma drug exposure after an 80 mg oral dose.

*In vitro*, atorvastatin was not mutagenic or clastogenic in the following tests with and without metabolic activation: the Ames test with *Salmonella typhimurium* and *Escherichia coli*, the HGPRT forward mutation assay in Chinese hamster lung cells, and the chromosomal aberration assay in Chinese hamster lung cells. Atorvastatin was negative in the *in vivo* mouse micronucleus test. Studies in rats performed at doses up to 175 mg/kg (15 times the human exposure) produced no changes in fertility. There was aplasia and aspermia in the epididymis of 2 of 10 rats treated with 100 mg/kg/day of atorvastatin for 3 months (16 times the human AUC at the 80 mg dose); testis weights were significantly lower at 30 and 100 mg/kg and epididymal weight was lower at 100 mg/kg. Male rats given 100 mg/kg/day for 11 weeks prior to mating had decreased sperm motility, spermatid head concentration, and increased abnormal sperm. Atorvastatin caused no adverse effects on semen parameters, or reproductive organ histopathology in dogs given doses of 10, 40, or 120 mg/kg for two years.

- **Adverse reactions**

Atorvastatin is generally well tolerated. Adverse reactions have usually been mild and transient. In controlled clinical studies of 2502 patients, <2% of patients were discontinued due to adverse experiences attributable to atorvastatin. The most frequent adverse events thought to be related to atorvastatin were constipation, flatulence, dyspepsia and abdominal pain.

*Clinical Adverse Experiences*

Adverse experiences reported in ≥2% of patients in placebo-controlled clinical studies of atorvastatin, regardless of causality assessment, are shown in the table below

**Table. Adverse Events in Placebo-Controlled Studies (% of Patients)**

| Body System/Adverse Event | Placebo (N = 270) | Atorvastatin 10 mg (N = 863) | Atorvastatin 20 mg (N = 36) | Atorvastatin 40 mg (N = 79) | Atorvastatin 80 mg (N = 94) |
|---|---|---|---|---|---|
| *Body As a Whole* | | | | | |
| Infection | 10.0 | 10.3 | 2.8 | 10.1 | 7.4 |
| Headache | 7.0 | 5.4 | 16.7 | 2.5 | 6.4 |
| Accidental Injury | 3.7 | 4.2 | 0.0 | 1.3 | 3.2 |
| Flu Syndrome | 1.9 | 2.2 | 0.0 | 2.5 | 3.2 |
| Abdominal Pain | 0.7 | 2.8 | 0.0 | 3.8 | 2.1 |
| Back Pain | 3.0 | 2.8 | 0.0 | 3.8 | 1.1 |
| Allergic Reaction | 2.6 | 0.9 | 2.8 | 1.3 | 0.0 |
| Asthenia | 1.9 | 2.2 | 0.0 | 3.8 | 0.0 |
| *Digestive System* | | | | | |
| Constipation | 1.8 | 2.1 | 0.0 | 2.5 | 1.1 |
| Diarrhea | 1.5 | 2.7 | 0.0 | 3.8 | 5.3 |
| Dyspepsia | 4.1 | 2.3 | 2.8 | 1.3 | 2.1 |
| Flatulence | 3.3 | 2.1 | 2.8 | 1.3 | 1.1 |
| *Respiratory System* | | | | | |
| Sinusitis | 2.6 | 2.8 | 0.0 | 2.5 | 6.4 |
| Pharyngitis | 1.5 | 2.5 | 0.0 | 1.3 | 2.1 |
| *Skin and Appendages* | | | | | |
| Rash | 0.7 | 3.9 | 2.8 | 3.8 | 1.1 |
| *Musculoskeletal System* | | | | | |
| Arthralgia | 1.5 | 2.0 | 0.0 | 5.1 | 0.0 |
| Myalgia | 1.1 | 3.2 | 5.6 | 1.3 | 0.0 |

In a study involving 10,305 participants treated with atorvastatin 10 mg daily (n=5,168) or placebo (n=5,137), the safety and tolerability profile of the group treated with atorvastatin was comparable to that of the group treated with placebo during a median of 3.3 years of follow-up.

In another study involving 2838 subjects with type 2 diabetes treated with atorvastatin 10 mg daily (n=1428) or placebo (n=1410), there was no difference in the overall frequency of adverse events or serious adverse events between the treatment groups during a median follow-up of 3.9 years. No cases of rhabdomyolysis were reported.

The following adverse events were reported, regardless of causality assessment in patients treated with atorvastatin in clinical trials. The events in italics occurred in ≥2% of patients and the events in plain type occurred in <2% of patients.

*Body as a Whole:* Chest pain, face edema, fever, neck rigidity, malaise, photosensitivity reaction, generalized edema.

*Digestive System:* Nausea, gastroenteritis, liver function tests abnormal, colitis, vomiting, gastritis, dry mouth, rectal hemorrhage, esophagitis, eructation, glossitis, mouth ulceration, anorexia, increased appetite, stomatitis, biliary pain, cheilitis, duodenal ulcer, dysphagia, enteritis, melena, gum hemorrhage, stomach ulcer, tenesmus, ulcerative stomatitis, hepatitis, pancreatitis, cholestatic jaundice.

*Respiratory System:* Bronchitis, rhinitis, pneumonia, dyspnea, asthma, epistaxis.

*Nervous System:* Insomnia, dizziness, paresthesia, somnolence, amnesia, abnormal dreams, libido decreased, emotional lability, incoordination, peripheral neuropathy, torticollis, facial paralysis, hyperkinesia, depression, hypesthesia, hypertonia.

*Musculoskeletal System:* Arthritis, leg cramps, bursitis, tenosynovitis, myasthenia, tendinous contracture, myositis.

*Skin and Appendages:* Pruritus, contact dermatitis, alopecia, dry skin, sweating, acne, urticaria, eczema, seborrhea, skin ulcer.

*Urogenital System:* Unnary tract infection, hematuria, albuminuria, urinary frequency, cystitis, impotence, dysuna, kidney calculus, nocturia, epididymitis, fibrocystic breast, vaginal hemorrhage, breast enlargement, metrorrhagia, nephritis, urinary incontinence, urinary retention, urinary urgency, abnormal ejaculation, uterine hemorrhage.

*Special Senses:* Amblyopia, tinnitus, dry eyes, refraction disorder, eye hemorrhage, deafness, glaucoma, parosmia, taste loss, taste perversion.

*Cardiovascular System:* Palpitation, vasodilatation, syncope, migraine, postural hypotension, phlebitis, arrhythmia, angina pectoris, hypertension.

*Metabolic and Nutritional Disorders:* Peripheral edema, hyperglycemia, creatine phosphokinase increased, gout, weight gain, hypoglycemia.

*Hemic and Lymphatic System:* Ecchymosis, anemia, lymphadenopathy, thrombocytopenia, petechia.

*Postintroduction Reports*

Adverse events associated with atorvastatin therapy reported since market introduction, that are not listed above, regardless of causality assessment, include the following:

anaphylaxis, angioneurotic edema, bullous rashes (including erythema multiforme, Stevens-Johnson syndrome, and toxic epidermal necrolysis), rhabdomyolysis and fatigue.

*Pediatric Patients (ages 10-17 years)*

In a 26-week controlled study in boys and postmenarchal girls (n=140), the safety and tolerability profile of atorvastatin 10 to 20 mg daily was generally similar to that of placebo.

**OVERDOSAGE**[1,2]

There is no specific treatment for atorvastatin overdosage. In the event of an overdose, the patient should be treated symptomatically, and supportive measures instituted as required. Due to extensive drug binding to plasma proteins, hemodialysis is not expected to significantly enhance atorvastatin clearance.

**STORAGE**

Store below 25°C, protected from moisture.

**KEEP ALL MEDICINES OUT OF REACH OF CHILDREN**

**SUPPLY**

**Storvas Tablets 10mg :** Strip pack of 10's.
**Storvas Tablets 20mg :** Strip pack of 10's.

**REFERENCE**


1. US Prescribing information of *LIPITOR*®, Pfizer Ireland Pharmaceuticals, September 2005.
2. ABPI Compendium of Data Sheets and Summary of Product Characteristics; *LIPITOR*™ 10 mg, 20 mg, 40 mg, 80 mg Tablets Pfizer Ireland Pharmaceuticals, March 2005.


*Information compiled in January 2006.*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