

Atacand Plus 8 mg/12.5 mg tablets
Atacand Plus 16 mg/12.5 mg tablets
Atacand Plus 32 mg/12.5 mg tablets
Atacand Plus 32 mg/25 mg tablets

Candesartan cilexetil/hydrochlorothiazide

Tablets

Composition

One Atacand Plus 8 mg/12.5 mg tablet contains 8 mg candesartan cilexetil and 12.5 mg hydrochlorothiazide.

Excipient with known effect: Each tablet contains 77 mg lactose monohydrate.

One Atacand Plus 16 mg/12.5 mg tablet contains 16 mg candesartan cilexetil and 12.5 mg hydrochlorothiazide.

Excipient with known effect: Each tablet contains 68 mg lactose monohydrate.

One Atacand Plus 32 mg/12.5 mg tablet contains 32 mg candesartan cilexetil and 12.5 mg hydrochlorothiazide.

Excipient with known effect: Each tablet contains 148.5 mg lactose monohydrate.

One Atacand Plus 32 mg/25 mg tablet contains 32 mg candesartan cilexetil and 25 mg hydrochlorothiazide.

Excipient with known effect: Each tablet contains 136 mg lactose monohydrate.

Pharmaceutical Form

Tablet.

Atacand Plus 8 mg/12.5 mg tablets are white, oval, biconvex tablets with a score on both sides and engraved $\frac{A}{CK}$ on one side.

Atacand Plus 16 mg/12.5 mg tablets are peach, oval, biconvex tablets with a score on both sides and engraved $\frac{A}{CS}$ on one side.

Atacand Plus 32 mg/12.5 mg tablets are yellow, oval, biconvex tablets with a score and engraving $\frac{A}{CJ}$ on one side and a pressure sensitive bisect on the other side.

Atacand Plus 32 mg /25 mg tablets are pink, oval, biconvex tablets with a score and engraving $\frac{A}{CD}$ on one side and a pressure sensitive bisect on the other side.

Atacand Plus 32 mg/12.5 mg and 32 mg/25 mg tablets can be divided into two equal halves.

Therapeutic indication

Atacand Plus is indicated for the:

Treatment of primary hypertension, in patients whose blood pressure is not adequately controlled with candesartan cilexetil or hydrochlorothiazide monotherapy.

Posology and method of administration

Oral use

Atacand Plus should be taken once daily and may be taken with or without food.

The bioavailability of candesartan is not affected by food.

There is no clinically significant interaction between hydrochlorothiazide and food.

When clinically appropriate a direct change from monotherapy to Atacand Plus may be considered. Dose titration of candesartan cilexetil is recommended when switching from hydrochlorothiazide monotherapy. Atacand Plus 32 mg/12.5 mg or 32 mg/25 mg may be administered in patients whose blood pressure is not optimally controlled with candesartan cilexetil 32 mg or Atacand Plus at lower doses.

Most of the antihypertensive effect is usually attained within 4 weeks of initiation of treatment.

Use in the elderly

No dosage adjustment is necessary in elderly patients.

Use in impaired renal function

Dose titration is recommended in patients with renal impairment whose creatinine clearance is ≥ 30 -80 ml/min/1.73 m² BSA.

Atacand Plus should not be used in patients with severe renal impairment (creatinine clearance <30 ml/min/1.73 m² BSA). See section Contraindications.

Use in impaired hepatic function

Dose titration of candesartan cilexetil is recommended in patients with mild to moderate hepatic impairment.

Atacand Plus should not be used in patients with severe hepatic impairment and/or cholestasis. See section Contraindications.

Use in children and adolescents

The safety and efficacy of Atacand Plus in children and adolescents (less than 18 years of age) have not been established. No data is available.

Contraindications

Hypersensitivity to the active substances or to any of the excipients or to other sulfonamides. Hydrochlorothiazide is a sulphonamide.

Pregnancy and lactation.

Severe renal impairment (creatinine clearance <30 ml/min/1.73 m² BSA).

Severe hepatic impairment and/or cholestasis.

Refractory hypokalaemia and hypercalcaemia.

Gout.

The concomitant use of Atacand Plus with aliskiren-containing products is contraindicated in patients with diabetes mellitus or renal impairment (GFR < 60 ml/min/1.73 m²) (see sections Interaction and Pharmacodynamic properties).

Special warnings and precautions for use

Dual blockade of the renin-angiotensin-aldosterone system (RAAS)

There is evidence that the concomitant use of ACE-inhibitors, angiotensin II receptor blockers or aliskiren increases the risk of hypotension, hyperkalaemia and decreased renal function (including acute renal failure). Dual blockade of RAAS through the combined use of ACE-inhibitors, angiotensin II receptor blockers or aliskiren is therefore not recommended (see sections Interaction and Pharmacodynamic properties).

If dual blockade therapy is considered absolutely necessary, this should only occur under specialist supervision and the patient should be subject to regular close monitoring of renal function, electrolytes and blood pressure. ACE inhibitors and angiotensin II receptor blockers should not be used concomitantly in patients with diabetic nephropathy.

Renal impairment

As with other agents inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible patients treated with Atacand Plus (see section Contraindications).

Kidney transplantation

There is limited experience regarding the administration of Atacand Plus in patients who have undergone kidney transplantation.

Renal artery stenosis

Other medicinal products that affect the renin-angiotensin-aldosterone system, i.e. angiotensin converting enzyme (ACE) inhibitors, may increase blood urea and serum creatinine in patients with bilateral renal artery stenosis or renal artery stenosis in patients with a solitary kidney. A similar effect may be anticipated with angiotensin II receptor antagonists.

Intravascular volume depletion

In patients with intravascular volume and/or sodium depletion symptomatic hypotension may occur, as described for other agents acting on the renin-angiotensin-aldosterone system. Therefore, the use of Atacand Plus is not recommended until this condition has been corrected.

Anaesthesia and surgery

Hypotension may occur during anaesthesia and surgery in patients treated with angiotensin II antagonists due to blockade of the renin-angiotensin system. Very rarely, hypotension may be severe such that it may warrant the use of intravenous fluids and/or vasopressors.

Hepatic impairment

Thiazides should be used with caution in patients with impaired hepatic function or progressive liver disease, since even minor alterations of fluid and electrolyte balance

may precipitate hepatic coma. There is no clinical experience with Atacand Plus in patients with hepatic impairment.

Aortic and mitral valve stenosis (obstructive hypertrophic cardiomyopathy)

As with other vasodilators, special caution is indicated in the treatment of patients suffering from haemodynamically relevant aortic or mitral valve stenosis, or obstructive hypertrophic cardiomyopathy.

Primary hyperaldosteronism

Patients with primary hyperaldosteronism generally will not respond to antihypertensive drugs acting through inhibition of the renin-angiotensin-aldosterone system. Therefore the use of Atacand Plus is not recommended.

Electrolyte imbalance

As for any patient receiving diuretic therapy, periodic determination of serum electrolytes should be performed at appropriate intervals.

Thiazides, including hydrochlorothiazide, can cause fluid or electrolyte imbalance (hypercalcaemia, hypokalaemia, hyponatraemia, hypomagnesaemia and hypochloraemic alkalosis).

Thiazide diuretics may decrease the urinary calcium excretion and may cause recurrent and slightly increased serum calcium concentrations.

Marked hypercalcaemia may be a sign of hidden hyperparathyroidism. Thiazides should be discontinued before carrying out tests for parathyroid function.

Hydrochlorothiazide dose-dependently increases urinary potassium excretion which may result in hypokalaemia. This effect of hydrochlorothiazide seems to be less evident when combined with candesartan cilexetil. The risk for hypokalaemia may be increased in patients with cirrhosis of the liver, in patients experiencing brisk diuresis,

in patients with an inadequate oral intake of electrolytes and in patients receiving concomitant therapy with corticosteroids or adrenocorticotrophic hormone (ACTH).

Based on experience with the use of other medicinal products that affect the renin-angiotensin-aldosterone system, concomitant use of Atacand Plus and ACE inhibitors, aliskiren, potassium-sparing diuretics, potassium supplements salt substitutes or other medicinal products that increase serum potassium levels (e.g. heparin sodium and combination of trimetoprim/sulfametoxazol) may lead to increases in serum potassium.

Although not documented with Atacand Plus treatment with angiotensin converting enzyme inhibitors or angiotensin II receptor antagonists may cause hyperkalaemia, especially in the presence of heart failure and/or renal impairment.

Thiazides have been shown to increase the urinary excretion of magnesium, which may result in hypomagnesaemia.

Metabolic and endocrine effects

Treatment with a thiazide diuretic may impair glucose tolerance. Dosage adjustment of antidiabetic medicinal products, including insulin, may be required. Latent diabetes mellitus may become manifest during thiazide therapy. Increases in cholesterol and triglyceride levels have been associated with thiazide diuretic therapy. At the doses contained in Atacand Plus only minimal effects were observed. Thiazide diuretics increase serum uric acid concentration and may precipitate gout in susceptible patients.

Non-melanoma skin cancer

An increased risk of non-melanoma skin cancer (NMSC) [basal cell carcinoma (BCC) and squamous cell carcinoma (SCC)] with increasing cumulative dose of

hydrochlorothiazide (HCTZ) exposure has been observed in two epidemiological studies based on the Danish National Cancer Registry.

Photosensitizing actions of HCTZ could act as a possible mechanism for NMSC. Patients taking HCTZ should be informed of the risk of NMSC and advised to regularly check their skin for any new lesions and promptly report any suspicious skin lesions. Possible preventive measures such as limited exposure to sunlight and UV rays and, in case of exposure, adequate protection should be advised to the patients in order to minimize the risk of skin cancer. Suspicious skin lesions should be promptly examined potentially including histological examinations of biopsies. The use of HCTZ may also need to be reconsidered in patients who have experienced previous NMSC (see section Undesirable effects).

Choroidal effusion, acute myopia and secondary angle-closure glaucoma

Medicinal products containing hydrochlorothiazide can trigger an idiosyncratic reaction that can lead to choroidal effusion with visual field defects, transient myopia and acute angle-closure glaucoma. Symptoms include rapid onset of decreased visual acuity or eye pain and typically appear within hours to weeks after the start of therapy. Untreated angle closure glaucoma can lead to permanent loss of vision. Primary therapy consists of immediate discontinuation of the medicinal product. If intraocular pressure remains elevated, immediate medical treatment or surgery must be considered. Risk factors for developing angle-closure glaucoma may be a history of sulphonamide or penicillin allergy.

Acute respiratory toxicity

Very rare severe cases of acute respiratory toxicity, including acute respiratory distress syndrome (ARDS), have been reported after taking hydrochlorothiazide. Pulmonary oedema typically develops within minutes to hours after

hydrochlorothiazide intake. At the onset, symptoms include dyspnoea, fever, pulmonary deterioration, and hypotension. If ARDS is suspected, Atacand Plus should be discontinued and appropriate treatment instituted. Hydrochlorothiazide must not be used in patients who have previously experienced ARDS after taking hydrochlorothiazide.

General

In patients whose vascular tone and renal function depend predominantly on the activity of the renin-angiotensin-aldosterone system (e.g. patients with severe heart failure or underlying renal disease, including renal artery stenosis), treatment with other medicinal products that affect this system has been associated with acute hypotension, azotaemia, oliguria or, rarely, acute renal failure. The possibility of similar effects cannot be excluded with angiotensin II receptor antagonists. As with any antihypertensive agent, excessive blood pressure decrease in patients with ischaemic heart disease or atherosclerotic cerebrovascular disease could result in a myocardial infarction or stroke.

Hypersensitivity reactions to hydrochlorothiazide may occur in patients with or without a history of allergy or bronchial asthma, but are more likely in patients with such a history.

Exacerbation or activation of systemic lupus erythematosus has been reported with the use of thiazide diuretics.

This medicinal product contains lactose, as an excipient, and patients with rare hereditary problems of galactose intolerance, total lactase deficiency or glucose-galactose malabsorption should not take this medicine.

Interaction with other medicinal products and other forms of interaction

Substances which have been investigated with candesartan cilexetil in clinical pharmacokinetic studies include hydrochlorothiazide, warfarin, digoxin, oral

contraceptives (i.e. ethinylestradiol/levonorgestrel), glibenclamide and nifedipine. No pharmacokinetic interactions of clinical significance were identified in these studies.

The bioavailability of candesartan is not affected by food.

The antihypertensive effect of Atacand Plus may be enhanced by other antihypertensives.

The potassium depleting effect of hydrochlorothiazide could be expected to be potentiated by other medicinal products associated with potassium loss and hypokalaemia (e.g. other kaliuretic diuretics, laxatives, amphotericin, carbenoxolone, penicillin G sodium, salicylic acid derivatives).

Based on experience with the use of other medicinal products that affect the renin-angiotensin-aldosterone system, concomitant use of Atacand Plus and ACE inhibitors, aliskiren, potassium-sparing diuretics, potassium supplements or salt substitutes or other medicinal products that increase serum potassium levels (e.g. heparin sodium and combination of trimetoprim/sulfametoxazol) may lead to increases in serum potassium. Monitoring of potassium levels should be undertaken as appropriate.

Diuretic-induced hypokalaemia and hypomagnesaemia predisposes to the potential cardiotoxic effects of digitalis glycosides and antiarrhythmics. Periodic monitoring of serum potassium is recommended when Atacand Plus is administered with such medicinal products.

Reversible increases in serum lithium concentrations and toxicity have been reported during concomitant administration of lithium with ACE inhibitors or hydrochlorothiazide. A similar effect may occur with angiotensin II receptor antagonists (AIIARs) and careful monitoring of serum lithium levels is recommended during concomitant use.

When angiotensin II receptor antagonists are administered simultaneously with non-steroidal anti-inflammatory drugs (i.e. selective COX-2 inhibitors, acetylsalicylic acid (>3g/day) and non-selective NSAIDs), attenuation of the antihypertensive effect may occur.

As with ACE inhibitors, concomitant use of angiotensin II receptor antagonists and NSAIDs may lead to an increased risk of worsening of renal function, including possible acute renal failure, and an increase in serum potassium, especially in patients with poor pre-existing renal function. The combination should be administered with caution, especially in the elderly. Patients should be adequately hydrated and consideration should be given to monitoring renal function after initiation of concomitant therapy, and periodically thereafter.

The diuretic, natriuretic and antihypertensive effect of hydrochlorothiazide is blunted by NSAIDs.

The absorption of hydrochlorothiazide is reduced by colestipol or cholestyramine. The effect on nondepolarizing skeletal muscle relaxants (e.g. tubocurarine) may be potentiated by hydrochlorothiazide.

Thiazide diuretics may increase serum calcium levels due to decreased excretion. If calcium supplements or Vitamin D must be prescribed, serum calcium levels should be monitored and dosage adjusted accordingly.

The hyperglycaemic effect of beta-blockers and diazoxide may be enhanced by thiazides.

Anticholinergic agents (e.g. atropine, biperiden) may increase the bioavailability of thiazide-type diuretics by decreasing gastrointestinal motility and stomach emptying rate.

Thiazide may increase the risk of adverse effects caused by amantadine.

Thiazides may reduce the renal excretion of cytotoxic medicinal products (e.g. cyclophosphamide, methotrexate) and potentiate their myelosuppressive effects.

The risk for hypokalaemia may be increased during concomitant use of steroids or adrenocorticotrophic hormone (ACTH).

Postural hypotension may become aggravated by simultaneous intake of alcohol, barbiturates or anaesthetics.

Treatment with a thiazide diuretic may impair glucose tolerance. Dosage adjustment of antidiabetic medicinal products, including insulin, may be required.

Hydrochlorothiazide may cause the arterial response to pressor amines (e.g. adrenaline) to decrease but not enough to exclude a pressor effect.

Hydrochlorothiazide may increase the risk of acute renal insufficiency especially with high doses of iodinated contrast media.

There is no clinically significant interaction between hydrochlorothiazide and food.

Clinical trial data have shown that the incidence of adverse events such as hypotension, hyperkalaemia and decreased renal function (including acute renal failure) is higher with dual blockade of the renin-angiotensin-aldosterone system (RAAS) through the combined use of ACE inhibitors, angiotensin II receptor blockers or aliskiren compared to the use of a single RAAS-acting agent (see sections Contraindications, Special warnings and precautions for use and Pharmacodynamic properties).

Fertility, pregnancy and lactation

Use in pregnancy

The use of Atacand Plus is contraindicated during pregnancy (see Contraindications). Patients receiving Atacand Plus should be made aware of that before contemplating a possibility of becoming pregnant so that they can discuss appropriate options with their treating physician. When pregnancy is diagnosed, treatment with Atacand Plus

must be stopped immediately and if appropriate, alternative therapy should be started.

When used in pregnancy medicinal products that act directly on the renin-angiotensin system can cause foetal and neonatal injury (hypotension, renal dysfunction, oliguria and/or anuria, oligohydramnios, skull hypoplasia, intrauterine growth retardation) and death. Cases of lung hypoplasia, facial abnormalities and limb contractures have also been described.

There is limited experience with hydrochlorothiazide during pregnancy, especially during the first trimester. Animal studies are insufficient. Hydrochlorothiazide crosses the placenta. Based on the pharmacological mechanism of action of hydrochlorothiazide, its use during pregnancy may compromise foeto-placental perfusion and may cause foetal and neonatal effects like icterus, disturbance of electrolyte balance and thrombocytopenia.

Use in lactation

It is not known whether candesartan is excreted in human milk. However, candesartan is excreted in the milk of lactating rats. Hydrochlorothiazide passes into mother's milk. Because of the potential for adverse effects on the nursing infant, Atacand Plus is contra-indicated during breast-feeding (see Contraindications).

Effects on ability to drive and use machines

No studies on the effects on the ability to drive and use machines have been performed. Based on its pharmacodynamic properties Atacand Plus is unlikely to affect this ability. When driving vehicles or operating machines, it should be taken into account that occasionally dizziness or tiredness may occur during treatment of hypertension.

Undesirable effects

In controlled clinical studies with candesartan cilexetil/hydrochlorothiazide adverse events were mild and transient. Withdrawals from treatment due to adverse events were similar with candesartan cilexetil/hydrochlorothiazide (2.3 - 3.3%) and placebo (2.7 - 4.3%).

In analysis of data from clinical trials with candesartan cilexetil/hydrochlorothiazide adverse reactions were limited to those that were reported previously with candesartan cilexetil and/or hydrochlorothiazide.

The following terminologies have been used in order to classify the occurrence of undesirable effects:

very common ($\geq 1/10$)

common ($\geq 1/100 < 1/10$)

uncommon ($\geq 1/1000 < 1/100$)

rare ($\geq 1/10\,000 < 1/1000$)

very rare ($< 1/10\,000$)

not known (cannot be estimated from the available data)

The following adverse reactions have been reported with candesartan cilexetil in post marketing experience:

System Organ Class	Frequency	Undesirable Effect
Blood and lymphatic system disorders	Very rare	Leukopenia, neutropenia and agranulocytosis
Nervous system disorders	Very rare	Dizziness, headache
Respiratory, thoracic and	Very rare	Cough

System Organ Class	Frequency	Undesirable Effect
mediastinal disorders		
Gastrointestinal disorders	Very rare	Nausea
Renal and urinary disorders	Very rare	Renal impairment, including renal failure in susceptible patients (see Special warnings and precautions for use)
Skin and subcutaneous tissue disorders	Very rare	Angioedema, rash, urticaria, pruritus
Musculoskeletal, connective tissue and bone disorders	Very rare	Back pain, arthralgia, myalgia
Hepatobiliary disorders	Very rare	Increased liver enzymes, abnormal hepatic function or hepatitis
Metabolism and nutrition disorders	Very rare	Hyperkalaemia, hyponatraemia

The following adverse reactions have been reported with hydrochlorothiazide monotherapy, usually with doses of 25 mg or greater:

System Organ Class	Frequency	Undesirable Effect
Neoplasms benign, malignant and unspecified (incl cysts and polyps)	Not known	Non-melanoma skin cancer (Basal cell carcinoma and Squamous cell carcinoma)
Investigations	Common	Increases in cholesterol and triglycerides
	Rare	Increases in BUN and serum

System Organ Class	Frequency	Undesirable Effect
		creatinine
Cardiac disorders	Rare	Cardiac arrhythmias
Blood and lymphatic system disorders	Rare	Leucopenia, neutropenia/agranulocytosis, thrombocytopenia, aplastic anaemia, bone marrow depression, haemolytic anaemia
Nervous system disorders	Common	Light-headedness, vertigo
	Rare	Paraesthesia
Eye disorders	Rare	Transient blurred vision
	Not Known	Acute myopia, acute angle-closure glaucoma, choroidal effusion
Respiratory, thoracic and mediastinal disorders	Rare	Respiratory distress (including pneumonitis and pulmonary oedema)
	Very rare	Acute respiratory distress syndrome (ARDS)
Gastrointestinal disorders	Uncommon	Anorexia, loss of appetite, gastric irritation, diarrhoea, constipation
	Rare	Pancreatitis
Renal and urinary disorders	Common	Glycosuria

System Organ Class	Frequency	Undesirable Effect
	Rare	Renal dysfunction and interstitial nephritis
Skin and subcutaneous tissue disorders	Uncommon	Rash, urticaria, photosensitivity reactions
	Rare	Toxic epidermal necrolysis
	Not Known	Systemic lupus erythematosus, cutaneous lupus erythematosus
Musculoskeletal, connective tissue and bone disorders	Rare	Muscle spasm
Metabolism and nutrition disorders	Common	Hyperglycaemia, hyperuricaemia, electrolyte imbalance (including hyponatraemia and hypokalaemia)
Vascular disorders	Uncommon	Postural hypotension
	Rare	Necrotising angitis (vasculitis, cutaneous vasculitis)
General disorders and administration site conditions	Common	Weakness
	Rare	Fever
Immune system disorders	Rare	Anaphylactic reactions
Hepatobiliary disorders	Rare	Jaundice (intrahepatic

System Organ Class	Frequency	Undesirable Effect
		cholestatic jaundice)
Psychiatric disorders	Rare	Sleep disturbances, depression, restlessness

Description of selected adverse reactions

Non-melanoma skin cancer: Based on available data from epidemiological studies, cumulative dose dependent association between HCTZ and NMSC has been observed (see section Special warnings and precautions for use and also section Undesirable effects).

Laboratory findings

Increases in creatinine, urea, potassium, uric acid, glucose and ALAT (SGPT) and decrease in sodium have been observed. Minor decreases in haemoglobin and increases in ASAT (SGOT) have been observed in single patients.

Overdose

Symptoms

With regards to the overdose of candesartan cilexetil is likely to mainly cause symptomatic hypotension and dizziness. In individual case reports of overdose (of up to 672 mg candesartan cilexetil) patient recovery was uneventful.

The main effect of an overdose of hydrochlorothiazide is acute loss of fluid and electrolytes. Symptoms such as dizziness, hypotension, thirst, tachycardia, ventricular arrhythmias, sedation/impairment of consciousness and muscle cramps can also occur.

Management

No specific information is available on the treatment of overdose with Atacand Plus. The following measures are, however, suggested in case of overdose.

When indicated, induction of vomiting or gastric lavage should be considered. If symptomatic hypotension should occur, symptomatic treatment should be instituted and vital signs monitored. The patient should be placed supine with the legs elevated. If this is not sufficient, plasma volume should be increased by infusion of isotonic saline solution. Serum electrolytes and acid-base balance should be checked and corrected, if needed. Sympathomimetic medicinal products may be administered if the above-mentioned measures are not sufficient.

Candesartan can not be removed by haemodialysis. It is not known to what extent hydrochlorothiazide is removed by haemodialysis.

Pharmacodynamic properties

Pharmaco-therapeutic group: Angiotensin II antagonists + diuretics, ATC code C09D A06.

Mechanism of action

Angiotensin II is the primary vasoactive hormone of the renin-angiotensin-aldosterone system and plays a role in the pathophysiology of hypertension and other cardiovascular disorders. It also has a role in the pathogenesis of organ hypertrophy and end organ damage. The major physiological effects of angiotensin II, such as vasoconstriction, aldosterone stimulation, regulation of salt and water homeostasis and stimulation of cell growth, are mediated via the type 1 (AT₁) receptor.

Pharmacodynamic effects

Candesartan cilexetil is a prodrug which is rapidly converted to the active drug, candesartan, by ester hydrolysis during absorption from the gastrointestinal tract. Candesartan is an angiotensin II receptor antagonist, and binds selective to AT₁

receptors, with tight binding to and slow dissociation from the receptor. It has no agonist activity.

Candesartan does not influence ACE or other enzyme systems usually associated with the use of ACE inhibitors. Since there is no effect on the degradation of quinines, or on the metabolism of other substances, such as substance P, angiotensin II receptor antagonists are unlikely to be associated with cough. In controlled clinical trials comparing candesartan cilexetil with ACE inhibitors, the incidence of cough was lower in patients receiving candesartan cilexetil. Candesartan does not bind to or block other hormone receptors or ion channels known to be important in cardiovascular regulation. The antagonism of the AT₁ receptors results in dose related increases in plasma renin levels, angiotensin I and angiotensin II levels, and a decrease in plasma aldosterone concentration.

Non-melanoma skin cancer

Based on available data from epidemiological studies, cumulative dose-dependent association between HCTZ and NMSC has been observed. One study included a population comprised of 71,533 cases of BCC and of 8,629 cases of SCC matched to 1,430,833 and 172,462 population controls, respectively.

High HCTZ use (≥50,000 mg cumulative) was associated with an adjusted OR of 1.29 (95% CI: 1.23- 1.35) for BCC and 3.98 (95% CI: 3.68-4.31) for SCC. A clear cumulative dose response relationship was observed for both BCC and SCC. Another study showed a possible association between lip cancer (SCC) and exposure to HCTZ: 633 cases of lip-cancer were matched with 63,067 population controls, 12 using a risk-set sampling strategy. A cumulative dose-response relationship was demonstrated with an adjusted OR 2.1 (95% CI: 1.7-2.6) increasing to OR 3.9 (3.0-4.9) for high use (~25,000 mg) and OR 7.7 (5.7-10.5) for the highest cumulative dose (~100,000 mg) (see section Special warnings and precautions for use).

Clinical efficacy and safety

The effects of candesartan cilexetil 8-16 mg (mean dose 12 mg) once daily on cardiovascular morbidity and mortality were evaluated in a randomised clinical trial with 4,937 elderly patients (aged 70-89 years, 21% aged 80 or above) with mild to moderate hypertension followed for a mean of 3.7 years (Study on Cognition and Prognosis in the Elderly). Patients received candesartan or placebo with other antihypertensive treatment added as needed. The blood pressure was reduced from 166/90 to 145/80 mmHg in the candesartan group, and from 167/90 to 149/82 mmHg in the control group. There was no statistically significant difference in the primary endpoint, major cardiovascular events (cardiovascular mortality, non-fatal stroke and non-fatal myocardial infarction). There were 26.7 events per 1000 patient-years in the candesartan group versus 30.0 events per 1000 patient-years in the control group (relative risk 0.89, 95% CI 0.75 to 1.06, $p=0.19$).

Hydrochlorothiazide inhibits the active reabsorption of sodium, mainly in the distal kidney tubules, and promotes the excretion of sodium, chloride and water. The renal excretion of potassium and magnesium increases dose-dependently, while calcium is reabsorbed to a greater extent. Hydrochlorothiazide decreases plasma volume and extracellular fluid and reduces cardiac output and blood pressure. During long-term therapy, reduced peripheral resistance contributes to the blood pressure reduction.

Large clinical studies have shown that long-term treatment with hydrochloro-thiazide reduces the risk for cardiovascular morbidity and mortality.

Candesartan and hydrochlorothiazide have additive antihypertensive effects.

In hypertensive patients, Atacand Plus results in a dose-dependent and long-lasting reduction in arterial blood pressure without reflex increase in heart rate. There is no indication of serious or exaggerated first dose hypotension or rebound effect after cessation of treatment. After administration of a single dose of candesartan cilexetil, onset of the antihypertensive effect generally occurs within 2 hours. With continuous

treatment, most of the reduction in blood pressure is attained within four weeks and is sustained during long-term treatment. Atacand Plus once daily provides effective and smooth blood pressure reduction over 24 hours, with little difference between peak and trough effects during the dosing interval. In a double-blind randomised study, Atacand Plus 16 mg/12.5 mg once daily reduced blood pressure significantly more, and controlled the blood pressure of significantly more patients, than an approved similar fixed combination product containing an angiotensin II receptor antagonist and hydrochlorothiazide. In double-blind, randomised studies, the incidence of adverse events, especially cough, were lower during treatment with candesartan cilexetil/hydrochlorothiazide than during treatment with combinations of ACE inhibitors and hydrochlorothiazide.

In two clinical studies (randomised, double-blind, placebo controlled, parallel group) including 275 and 1524 randomised patients respectively, the candesartan cilexetil/hydrochlorothiazide combinations 32 mg/12.5 mg and 32 mg/25 mg resulted in blood pressure reductions of 21/14 mmHg for the highest dose, and were significantly more effective than the respective monocomponents.

In a randomised, double-blind, parallel group clinical study including 1975 randomised patients not optimally controlled on 32 mg candesartan cilexetil once daily, the addition of 12.5 mg or 25 mg hydrochlorothiazide resulted in additional blood pressure reductions. The candesartan cilexetil/hydrochlorothiazide combination 32 mg/25 mg was significantly more effective than the 32 mg/12.5 mg combination, and the overall mean blood pressure reductions were 16/10 mmHg and 13/9 mmHg, respectively.

Candesartan cilexetil/hydrochlorothiazide is similarly effective in patients irrespective of age and gender.

Currently there are no data on the use of candesartan cilexetil/hydrochlorothiazide in patients with renal disease/nephropathy, reduced left ventricular function heart failure and post myocardial infarction.

Two large randomised, controlled trials (ONTARGET (ONgoing Telmisartan Alone and in combination with Ramipril Global Endpoint Trial)) and VA NEPHRON-D (The Veterans Affairs Nephrology in Diabetes) have examined the combined use of an ACE inhibitor and an angiotensin II receptor blocker.

ONTARGET was a study conducted in patients with a history of cardiovascular or cerebrovascular disease, or type 2 diabetes mellitus accompanied by evidence of end-organ damage. VA NEPHRON-D was a study in patients with type 2 diabetes mellitus and diabetic nephropathy.

These studies have shown no significant beneficial effect on renal and/or cardiovascular outcomes and mortality, while an increased risk of hyperkalaemia, acute kidney injury and/or hypotension was observed to monotherapy. Given their similar pharmacodynamic properties, these results are also relevant for other ACE inhibitors and angiotensin II receptor blockers. ACE inhibitors and angiotensin II receptor blockers should therefore not be used concomitantly in patients with diabetic nephropathy.

ALTITUDE (Aliskiren Trial in Type 2 Diabetes Using Cardiovascular and Renal Disease Endpoints) was a study designed to test the benefit of adding aliskiren to a standard therapy of an ACE inhibitor or an angiotensin II receptor blocker in patients with type 2 diabetes mellitus and chronic kidney disease, cardiovascular disease, or both. The study was terminated early because of an increased risk of adverse outcomes. Cardiovascular death and stroke were both numerically more frequent in the aliskiren group than in the placebo group and adverse events and serious

adverse events of interest (hyperkalaemia, hypotension and renal dysfunction) were more frequently reported in the aliskiren group than in the placebo group.

Pharmacokinetic properties

Concomitant administration of candesartan cilexetil and hydrochlorothiazide has no clinically significant effect on the pharmacokinetics of either substance.

Absorption and distribution

Candesartan cilexetil

Following oral administration, candesartan cilexetil is converted to the active drug candesartan. The absolute bioavailability of candesartan is approximately 40% after an oral solution of candesartan cilexetil. The relative bioavailability of a tablet formulation of candesartan cilexetil compared with the same oral solution is approximately 34% with very little variability. The mean peak serum concentration (C_{max}) is reached 3-4 hours following tablet intake. The candesartan serum concentrations increase linearly with increasing doses in the therapeutic dose range. No gender related differences in the pharmacokinetics of candesartan have been observed. The area under the serum concentration *versus* time curve (AUC) of candesartan is not significantly affected by food.

Candesartan is highly bound to plasma protein (more than 99%). The apparent volume of distribution of candesartan is 0.1 l/kg.

Hydrochlorothiazide

Hydrochlorothiazide is rapidly absorbed from the gastrointestinal tract with an absolute bioavailability of approximately 70%. Concomitant intake of food increases

the absorption by approximately 15%. The bioavailability may decrease in patients with cardiac failure and pronounced oedema.

The plasma protein binding of hydrochlorothiazide is approximately 60%. The apparent volume of distribution is approximately 0.8 l/kg.

Metabolism and elimination

Candesartan cilexetil

Candesartan is mainly eliminated unchanged via urine and bile and only to a minor extent eliminated by hepatic metabolism (CYP2C9). Available interaction studies indicate no effect on CYP2C9 and CYP3A4. Based on *in vitro* data, no interaction would be expected to occur *in vivo* with medicinal products whose metabolism is dependent upon cytochrome P450 isoenzymes CYP1A2, CYP2A6, CYP2C9, CYP2C19, CYP2D6, CYP2E1 or CYP3A4. The terminal half-life ($t_{1/2}$) of candesartan is approximately 9 hours. There is no accumulation following multiple doses. The half-life of candesartan remains unchanged (approximately 9 h) after administration of candesartan cilexetil in combination with hydrochlorothiazide. No additional accumulation of candesartan occurs after repeated doses of the combination compared to monotherapy.

Total plasma clearance of candesartan is about 0.37 ml/min/kg, with a renal clearance of about 0.19 ml/min/kg. The renal elimination of candesartan is both by glomerular filtration and active tubular secretion. Following an oral dose of ^{14}C -labelled candesartan cilexetil, approximately 26% of the dose is excreted in the urine

as candesartan and 7% as an inactive metabolite while approximately 56% of the dose is recovered in the faeces as candesartan and 10% as the inactive metabolite.

Hydrochlorothiazide

Hydrochlorothiazide is not metabolized and is excreted almost entirely as unchanged drug by glomerular filtration and active tubular secretion. The terminal half-life of hydrochlorothiazide is approximately 8 hours. Approximately 70% of an oral dose is eliminated in the urine within 48 hours. The half-life of hydrochlorothiazide remains unchanged (approximately 8 h) after administration of hydrochlorothiazide in combination with candesartan cilexetil. No additional accumulation of hydrochlorothiazide occurs after repeated doses of the combination compared to monotherapy.

Pharmacokinetics in special populations

Candesartan cilexetil

In elderly subjects (over 65 years), C_{max} and AUC of candesartan are increased by approximately 50% and 80%, respectively in comparison to young subjects. However, the blood pressure response and the incidence of adverse events are similar after a given dose of Atacand Plus in young and elderly patients (see Posology and method of administration).

In patients with mild to moderate renal impairment, C_{max} and AUC of candesartan increased during repeated dosing by approximately 50% and 70%, respectively, but the terminal half-life was not altered, compared to patients with normal renal function. The corresponding changes in patients with severe renal impairment were approximately 50% and 110%, respectively. The terminal half-life of candesartan was approximately doubled in patients with severe renal impairment. The

pharmacokinetics in patients undergoing haemodialysis were similar to those in patients with severe renal impairment.

In patients with mild to moderate hepatic impairment, there was a 23% increase in the AUC of candesartan.

Hydrochlorothiazide

The terminal half life of hydrochlorothiazide is prolonged in patients with renal impairment.

List of excipients

Carmellose calcium

Hydroxypropylcellulose

Iron oxide red E 172 (only 16 mg/12.5 mg and 32 mg/25 mg tablets)

Iron oxide yellow E 172 (only 16 mg/12.5 mg, 32 mg/12.5 mg and 32 mg/25 mg)

Lactose monohydrate

Magnesium stearate

Maize starch

Macrogol

Shelf life

Please refer to expiry date on outer carton.

Special precautions for storage

Do not store above 30 °C

Pack size

Please refer to outer carton for pack size

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**Manufactured by AstraZeneca AB, Södertälje, Sweden for AstraZeneca AG,
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