

PRODUCT MONOGRAPH
INCLUDING PATIENT MEDICATION INFORMATION

^{Pr}**pms-NIFEDIPINE ER**

Nifedipine Extended-Release Tablets

Extended-Release Tablets, 20 mg, 30 mg and 60 mg, Oral

House Standard

Antianginal/Antihypertensive Agent

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RECENT MAJOR LABEL CHANGES

N/A

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Sections or subsections that are not applicable at the time of authorization are not listed.

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PART I: HEALTH PROFESSIONAL INFORMATION

1 INDICATIONS

pms-NIFEDIPINE ER (nifedipine extended-release tablets) is indicated for:

Chronic Stable Angina

pms-NIFEDIPINE ER (nifedipine extended-release tablets) is indicated in the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or nitrates, or who cannot tolerate these agents.

pms-NIFEDIPINE ER may be used in combination with beta blocking drugs in patients with chronic stable angina. However, available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities. When introducing such concomitant therapy, care must be taken to monitor blood pressure closely, since severe hypotension can occur from the combined effects of the drugs (see [7 WARNINGS AND PRECAUTIONS](#)).

Hypertension

pms-NIFEDIPINE ER is indicated in the management of mild to moderate essential hypertension.

Combination of nifedipine extended-release tablets with a diuretic has been found compatible and has shown added antihypertensive effect. Concurrent administration of low doses of nifedipine extended-release tablets and enalapril has been shown to produce an enhanced antihypertensive effect with no additional safety concerns when compared to that observed with either of the monotherapies.

Safety of concurrent use of nifedipine extended-release tablets with other antihypertensive agents has not been established.

1.1 Pediatrics

Pediatrics (< 18 years of age): No data are available to Health Canada; therefore, Health Canada has not authorized an indication for pediatric use.

1.2 Geriatrics

Geriatrics: pms-NIFEDIPINE ER should be administered cautiously to elderly patients, especially to those with a history of hypotension or cerebral vascular insufficiency (see [7.1.4 Geriatrics](#)).

2 CONTRAINDICATIONS

pms-NIFEDIPINE ER (nifedipine extended-release tablets) is contraindicated in:

- Pregnancy, and in women of childbearing potential. Fetal malformations and adverse effects on pregnancy have been reported in animals (see [16 NON-CLINICAL TOXICOLOGY, Reproductive and Developmental Toxicology](#)).
- Breastfeeding
- Patients who are hypersensitive to nifedipine, or to any ingredient in the formulation or component of the container. For a complete listing, see [6 DOSAGE FORMS, COMPOSITION AND PACKAGING](#).
- Patients with a known hypersensitivity to other dihydropyridines calcium antagonists, because of the theoretical risk of cross-reactivity
- Patients with severe hypotension or cardiovascular shock.
- Combination with rifampicin because effective plasma levels of nifedipine may not be achieved due to induction of the enzyme metabolizing nifedipine.
- Patients with a Kock pouch (ileostomy after proctocolectomy).
- Patients with moderate or severe hepatic impairment (see [7 WARNINGS AND PRECAUTIONS](#))
- Patients with severe gastrointestinal (GI)obstructive disorders (see [7 WARNINGS AND PRECAUTIONS](#))

4 DOSAGE AND ADMINISTRATION

4.1 Dosing Considerations

Dosage should be individualized depending on patient tolerance and response.

4.2 Recommended Dose and Dosage Adjustment

In general, titration steps should proceed over a 7-14-day period so that the physician can assess the response to each dose level before proceeding to higher doses. Since steady-state plasma levels are achieved on the second day of dosing, if symptoms so warrant, titration may proceed more rapidly provided that the patient is closely monitored.

Chronic Stable Angina

Therapy with pms-NIFEDIPINE ER should normally be initiated with 30 mg once daily. Experience with doses greater than 90 mg daily in patients with angina is limited, therefore, doses greater than 90 mg daily are not recommended.

Angina patients controlled on nifedipine capsules alone or in combination with beta-blockers may be safely switched to pms-NIFEDIPINE ER tablets at the nearest equivalent daily dose. Subsequent titration to higher or lower doses may be necessary and should be initiated as clinically warranted.

Hypertension

Therapy should normally be initiated with 20 mg or 30 mg once daily. The usual maintenance dose is 30 mg to 60 mg once daily. Doses greater than 90 mg daily are not recommended.

No “rebound effect” has been observed upon discontinuation of nifedipine extended-release tablets. However, if discontinuation of nifedipine is necessary, sound clinical practice suggests that the dosage should be decreased gradually under close physician supervision.

Pediatrics (< 18 years of age)

Health Canada has not authorized an indication for pediatric use.

Patients with Hepatic Impairment

In patients with mild impaired liver function, careful monitoring should be performed and a dose reduction may be necessary. As there is no pms-NIFEDIPINE ER formulation (<20 mg/dose) to up-titrate patients with moderate or severe hepatic impairment, and the pms-NIFEDIPINE ER formulation cannot be divided, pms-NIFEDIPINE ER is contraindicated in patients with moderate or severe hepatic impairment (see [2 CONTRAINDICATIONS](#); [7.1 Special Populations, Hepatic Insufficiency](#); and [10.3 Pharmacokinetics, Special Populations and Conditions, Hepatic Insufficiency](#)).

Patients with Diabetes

pms-NIFEDIPINE ER may produce hyperglycemia and lead to loss of glucose control. Use of pms-NIFEDIPINE ER in diabetic patients may require adjustment for their blood glucose control (see [7.1 Special Populations](#)).

Concomitant use with CYP34A Substrates/Inducers/Inhibitors

The use of pms-NIFEDIPINE ER with concomitant CYP34A inducers or inhibitors may need to be avoided or dosage adjustments made (see [9.4 Drug-Drug Interactions](#)).

4.4 Administration

For oral use. pms-NIFEDIPINE ER (nifedipine extended-release tablets) must be swallowed whole and should not be chewed or divided.

4.5 Missed Dose

If a dose of pms-NIFEDIPINE ER is missed, the dose should be taken as soon as the patient remembers prior to the next scheduled dose. However, if it is almost time for the next dose, the missed dose should not be taken and the patient should take his/her next dose as scheduled. The patient should not take two doses together to make up for the missed dose.

5 OVERDOSAGE

There are several well documented cases of nifedipine extended-release tablets overdose. The following symptoms are observed in cases of severe nifedipine intoxication: disturbance of consciousness to the point of coma, a drop in blood pressure, tachycardia/bradycardia, hyperglycemia, metabolic acidosis, hypoxia, and cardiogenic shock with pulmonary oedema.

As far as treatment is concerned, elimination of the active substance and the restoration of stable cardiovascular conditions have priority. After oral ingestion, thorough gastric lavage is indicated, if necessary, in combination with irrigation of the small intestine. Particularly in cases of intoxication with slow-release products like nifedipine extended-release tablets, elimination must be as complete as possible, including the small intestine, to prevent the otherwise inevitable subsequent absorption of the active substance. Hemodialysis serves no purpose, as nifedipine is not dialysable, but plasmapheresis is advisable (high plasma protein binding, relatively low volume of distribution).

Clinically significant hypotension calls for active cardiovascular support including monitoring of cardiac and respiratory function including elevation of extremities and attention to circulating fluid volume and urine output.

Hypotension as a result of arterial vasodilation can also be treated with calcium (10 mL of 10% calcium gluconate solution administered slowly via intravenous route and repeated if necessary). As a result, the serum calcium can reach the upper normal range to slightly elevated levels. If an insufficient increase in blood pressure is achieved with calcium, vasoconstricting sympathomimetics such as dopamine or noradrenaline are additionally administered as a last resort only in patients without cardiac arrhythmia or ischemic heart disease and when other safer measures have failed. The dosage of these drugs is determined solely by the effect obtained. Additional liquid or volume must be administered with caution because of the danger of overloading the heart.

Bradycardia and/or bradyarrhythmias have been observed in some cases of nifedipine overdose. Appropriate clinical measures, according to the nature and severity of the symptoms, should be applied.

For management of a suspected drug overdose, contact your regional poison control centre.

6 DOSAGE FORMS, STRENGTHS, COMPOSITION AND PACKAGING

Table 1 – Dosage Forms, Strengths, Composition and Packaging

Route of Administration	Dosage Form / Strength / Composition	Non-medicinal Ingredients
Oral	Extended-release tablets 20 mg, 30 mg and 60 mg	Black iron oxide (20 and 60 mg only), cellulose acetate, hydroxypropyl cellulose, hypromellose, magnesium stearate, polyethylene glycol, polyethylene oxide, polyethylene oxide coagulant, red iron oxide, shellac, sodium chloride, talc and titanium dioxide.

The active and inactive ingredients in pms-NIFEDIPINE ER are contained within a nonabsorbable shell that has been specially designed to slowly release the drug at a constant rate over time. This shell is passed into the stool after the drug is absorbed into the body.

Availability

pms-NIFEDIPINE ER contains nifedipine in strengths of 20 mg, 30 mg and 60 mg and are available in bottles of 100 tablets and in blisters of 30 tablets.

pms-NIFEDIPINE ER 30 mg tablets are pink-coloured, film coated circular biconvex tablets, having orifice on one side and plain on other side.

pms-NIFEDIPINE ER 20 mg tablets are pink-coloured, circular biconvex, film coated tablets, having orifice and imprinted with “NF ER” in a semi-circle over “20” in black on one side of the tablet.

pms-NIFEDIPINE ER 60 mg tablets are pink-coloured, circular biconvex, film coated tablets, having orifice and imprinted with “NF ER” in a semi-circle over “60” in black on one side of the tablet.

7 WARNINGS AND PRECAUTIONS

General

Concomitant Use with Strong Inhibitors of CYP 3A4

Use of pms-NIFEDIPINE ER with drugs that result in strong inhibition of CYP 3A4, such as ketoconazole, clarithromycin, ritonavir, may lead to increased plasma levels of nifedipine and associated serious adverse events (see [9 DRUG INTERACTIONS](#)). Such concomitant use should be avoided.

An observational study demonstrated an increased risk of hospitalization with acute kidney injury when nifedipine was used concomitantly with clarithromycin in elderly patients (>65 years of age) compared to when it was used concomitantly with azithromycin, odds ratio [nifedipine: 5.33 (95% C.I. 3.39 – 8.38)].

Cardiovascular

The safety of nifedipine prolonged release tablets has not been established in patients with malignant hypertension.

Excessive Hypotension in Patients with Angina

Since nifedipine extended-release tablets lowers peripheral vascular resistance and blood pressure, pms-NIFEDIPINE ER should be used cautiously in patients with angina who are prone to develop hypotension and those with a history of cerebrovascular insufficiency. Occasionally patients have had excessive and poorly tolerated hypotension. Syncope has been reported (see 8 ADVERSE REACTIONS). These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment and may be more likely in patients on concomitant beta blockers. If excessive hypotension occurs, dosage should be lowered or the drug should be discontinued (see [2 CONTRAINDICATIONS](#)).

Severe hypotension and/or increased fluid volume requirements have been reported in patients receiving nifedipine, with a beta blocker, who underwent coronary artery bypass surgery using high dose fentanyl anesthesia. The interaction with high dose fentanyl appears to be due to the combination of nifedipine and a beta blocker, but the possibility that it may occur with nifedipine alone, with low doses of fentanyl in other surgical procedures, or with other narcotic analgesics cannot be ruled out. In nifedipine-treated patients where surgery using high dose fentanyl anesthesia is contemplated, the physician should be aware of these potential problems, and if the patient's condition permits, sufficient time (at least 36 hours) should be allowed for nifedipine to be washed out of the body prior to surgery.

The following information should be taken into account in those patients who are being treated for hypertension as well as angina.

Increased Angina and/or Myocardial Infarction

Rarely, patients, particularly those who have severe obstructive coronary artery disease have

developed well-documented increased frequency, duration and/or severity of angina or acute myocardial infarction on starting nifedipine or at the time of dosage increase. The mechanism of the response is not established.

Since there has not been a study of nifedipine extended-release tablets in acute myocardial infarction reported, similar effects of nifedipine extended-release tablets to that of immediate-release nifedipine cannot be excluded. Immediate-release nifedipine is contraindicated in acute myocardial infarction.

Beta-Blocker Withdrawal

Patients with angina recently withdrawn from beta-blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation of treatment with nifedipine extended-release tablets will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta-blocker withdrawal and initiation of nifedipine. It is important to taper beta-blockers if possible, rather than stopping them abruptly before beginning pms-NIFEDIPINE ER.

Patients with Heart Failure

There have been isolated reports of severe hypotension and lowering of cardiac output following administration of nifedipine to patients with severe heart failure. Thus, pms-NIFEDIPINE ER should be used cautiously in patients with severe heart failure. Rarely have patients receiving a beta blockers developed heart failure after beginning nifedipine therapy.

In patients with severe aortic stenosis, nifedipine will not produce its usual afterload reducing effects, and there is a possibility that an unopposed negative inotropic action of the drug may produce heart failure if the end-diastolic pressure is raised. Caution should therefore be exercised when using pms-NIFEDIPINE ER in patients with these conditions.

Hypotension/Heart Rate

Because pms-NIFEDIPINE ER (nifedipine extended-release tablets) is an arterial and arteriolar vasodilator, hypotension, and a compensatory increase in heart rate may occur. Thus, blood pressure and heart rate should be monitored carefully during nifedipine therapy. Close monitoring is especially recommended for patients who are prone to develop hypotension, those with a history of cerebrovascular insufficiency, and those who are taking medications that are known to lower blood pressure.

Peripheral Edema

Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, has been reported to occur in patients treated with nifedipine extended-release tablets (see [8 ADVERSE REACTIONS](#)). This edema occurs primarily in the lower extremities and may respond to diuretic therapy. With patients whose angina or hypertension is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Driving and Operating Machinery

Reactions to the drug, which vary in intensity from individual to individual, can impair the ability to drive or to operate machinery, particularly at the start of the treatment, upon changing the medication, or in combination with alcohol.

Gastrointestinal

Patients with Pre-existing Gastrointestinal Narrowing

Since the pms-NIFEDIPINE ER delivery system contains a non-deformable material, caution should be used when administering pms-NIFEDIPINE ER in patients with pre-existing severe gastrointestinal narrowing (pathologic or iatrogenic). There have been rare reports of obstructive symptoms in patients with known strictures in association with the ingestion of nifedipine extended-release tablets. In single cases, obstructive symptoms have been described without known history of gastrointestinal disorders. Bezoars can occur in very rare cases and may require surgical intervention. pms-NIFEDIPINE ER should be used with caution in patients with inflammatory bowel disease, Crohn's disease, or with a history of gastrointestinal obstruction, esophageal obstruction, or with decreased diameter of the gastrointestinal lumen.

When the GI narrowing is severe, the pms-NIFEDIPINE ER tablet may become obstructed within the GI tract. Therefore, pms-NIFEDIPINE ER is contraindicated in these patients (see [2 CONTRAINDICATIONS](#)).

When doing barium contrast X-ray, pms-NIFEDIPINE ER may cause false positive effects (e.g., filling defects interpreted as polyp).

Monitoring and Laboratory Tests

Hypotension/Heart Rate

Because pms-NIFEDIPINE ER is an arterial and arteriolar vasodilator, hypotension and a compensatory increase in heart rate may occur. Thus, blood pressure and heart rate should be monitored carefully during nifedipine therapy. Close monitoring is especially recommended for patients who are prone to develop hypotension, those with a history of cerebrovascular insufficiency, and those who are taking medications that are known to lower blood pressure (see [7 WARNINGS AND PRECAUTIONS, Cardiovascular](#)).

Reproductive Health: Male Potential

Male Fertility

In some cases of *in vitro* fertilization, nifedipine has been associated with reversible spermatozoal biochemical changes. *In vitro* studies have shown that nifedipine may inhibit expression of mannose-ligand receptors, thus preventing the spermatozoa from attaching to the zona pellucida and impairing sperm function. In those men who are repeatedly unsuccessful in fathering a child by *in vitro* fertilization, and where no other explanation could be found,

nifedipine should be considered as a possible cause.

7.1 Special Populations

Diabetic Patients

The use of pms-NIFEDIPINE ER in diabetic patients may require adjustment for their control.

Hepatic Insufficiency

pms-NIFEDIPINE ER should be used with caution in patients with mild impaired liver function, and a dose reduction may be required (see [10.3 Pharmacokinetics, Special Populations and Conditions, Hepatic Insufficiency](#)). Close monitoring of response and metabolic effect should apply.

The pharmacokinetics of nifedipine extended-release tablets has not been investigated in patients with severe hepatic impairment. As there is no pms-NIFEDIPINE ER formulation (< 20 mg/dose) to up-titrate patients with moderate or severe hepatic impairment, and the nifedipine formulation cannot be divided, pms-NIFEDIPINE ER should be contraindicated in patients with moderate or severe hepatic impairment (see [2 CONTRAINDICATIONS](#); 4.2 Recommended Dose and Dosage Adjustment; and [10.3 Pharmacokinetics, Special Populations and Conditions, Hepatic Insufficiency](#)).

7.1.1 Pregnant Women

The use of pms-NIFEDIPINE ER is contraindicated during pregnancy (see [2 CONTRAINDICATIONS](#)).

There are no adequate and well-controlled studies of nifedipine extended-release tablets in pregnant women. An increase in the number of fetal mortalities and resorptions occurred after the administration of 30 and 100 mg/kg nifedipine to pregnant mice, rats, and rabbits. Fetal malformations occurred after the administration of 30 and 100 mg/kg nifedipine to pregnant mice and 100 mg/kg to pregnant rats (see [2 CONTRAINDICATIONS](#)).

7.1.2 Breast-feeding

The use of pms-NIFEDIPINE ER is contraindicated during lactation (see [2 CONTRAINDICATIONS](#)).

7.1.3 Pediatrics

Pediatrics (< 18 years of age): No data are available to Health Canada; therefore, Health Canada has not authorized an indication for pediatric use.

7.1.4 Geriatrics

pms-NIFEDIPINE ER should be administered cautiously to elderly patients, especially to those with a history of hypotension or cerebral vascular insufficiency.

8 ADVERSE REACTIONS

8.1 Adverse Drug Reaction Overview

Safety information from clinical trials as well as from post-marketing surveillance and other sources is analyzed and reflected in the following section. Frequencies of occurrence are calculated from clinical trial analysis.

The most common adverse drug reactions (ADRs) are headache, edema, vasodilation, and constipation. None of these ADRs are considered severe.

The most severe reported ADRs are “agranulocytosis”, “leukopenia” and “toxic epidermal necrolysis”. These ADRs were reported from post-marketing surveillance and require immediate medical intervention.

“Angina pectoris” (chest pain) (frequency: common) and “intestinal obstruction” (frequency: unknown) require immediate medical intervention.

The ADRs “hypotension”, “syncope” (frequency: uncommon ($\geq 1/1,000$ to $< 1/100$)) and “angioedema” (frequency: unknown) require immediate medical intervention.

“Allergic reaction” (frequency: uncommon) is associated with nifedipine and might require immediate medical intervention.

8.2 Clinical Trial Adverse Drug Reactions

Clinical trials are conducted under very specific conditions. The adverse reaction rates observed in the clinical trials; therefore, may not reflect the rates observed in practice and should not be compared to the rates in the clinical trials of another drug. Adverse reaction information from clinical trials may be useful in identifying and approximating rates of adverse drug reactions in real-world use.

Angina

In 257 chronic stable angina patients treated in controlled and long-term open studies with nifedipine extended-release tablets, adverse effects were reported in 30.0% of patients and required discontinuation of therapy in 8.5% of patients.

The most common adverse effects were: edema (10.1%), headache (3.1%), angina pectoris (3.1%).

The following adverse effects were also reported. Incidences greater than 1% are given in parenthesis:

Cardiovascular: Palpitation (2.3%), tachycardia, myocardial infarction, ventricular arrhythmia, extrasystoles, dyspnea, chest pain.

In patients with angina, rarely, and possibly due to tachycardia, nifedipine has been reported to have precipitated an angina pectoris attack. In addition, more serious events were occasionally observed, not readily distinguishable from the natural history of the disease in these patients. It remains possible, however, that some or many of these events were drug related. These events include myocardial infarction, congestive heart failure or pulmonary edema, and ventricular arrhythmias or conduction disturbances.

Central Nervous System: Dizziness (2.3%), hypoesthesia (1.2%), confusion, insomnia, somnolence, nervousness, asthenia, hyperkinesia.

Gastrointestinal: Constipation (1.9%), dyspepsia (1.2%), abdominal pain (1.2%), diarrhea, nausea, melena.

Genito-urinary: Impotence, hematuria, polyuria, dysuria.

Musculo-skeletal: Leg cramps, paresthesia, myalgia, arthralgia.

Dermatologic: Rash, pruritus.

Other: Fatigue (1.2%), pain, periorbital edema.

Hypertension

In 661 hypertensive patients treated in controlled trials with nifedipine extended-release tablets, adverse effects were reported in 54.0% of patients and required discontinuation of therapy in 11.9% of patients. The majority of adverse effects reported occurred within the first three months of therapy.

The most common adverse effects reported with nifedipine extended-release tablets were edema, which was dose related and ranged in frequency from approximately 10 to 30% in the 30 to 120 mg dose range, headache (16.6%), fatigue (6.2%), dizziness (4.4%), constipation (3.5%), and nausea (3.5%).

The following adverse effects were also reported. Incidences greater than 1% are given in parenthesis:

Cardiovascular: Flushing (2.4%), palpitation (2.3%), tachycardia (1.2%), chest pain (1.1%), ventricular arrhythmia, hypotension, syncope.

Central Nervous System: Insomnia (1.8%), nervousness (1.8%), somnolence (1.5%), depression, tremor, decreased libido, migraine, vertigo, amnesia, anxiety, impaired concentration, twitching, ataxia, hypertonia, paresthesia, hypoesthesia.

Gastrointestinal: Dyspepsia (1.5%), flatulence (1.5%), abdominal pain (1.4%), dry mouth (1.1%), diarrhea, vomiting, thirst, melena, eructation, weight increase.

Genito-urinary: Impotence (1.5%), polyuria (1.5%), dysuria, nocturia, oliguria, urinary incontinence, urinary frequency, menstrual disorder.

Musculo-skeletal: Arthralgia, back pain, myalgia.

Special Senses: Abnormal vision, abnormal lacrimation, taste disturbance, conjunctivitis, tinnitus.

Dermatologic: Rash (2.3%), pruritus (1.1%), erythematous rash, alopecia.

Respiratory: Dyspnea (1.7%), bronchospasm, pharyngitis, upper respiratory tract infection, epistaxis.

Other: Leg cramps (2.7%), pain (2.7%), asthenia (2.0%), face edema, gout, allergy, fever, breast pain.

8.4 Abnormal Laboratory Findings: Hematologic, Clinical Chemistry and Other Quantitative Data

Rare, usually transient, but occasionally significant elevations of enzymes such as CPK, AST, and ALT have been noted. The relationship to drug therapy is uncertain in most cases, but probable in some. These laboratory abnormalities have rarely been associated with clinical symptoms, however, cholestasis with or without jaundice has been reported.

An increase (5.4%) in mean alkaline phosphatase was noted in patients treated with nifedipine extended-release tablets. This was an isolated finding not associated with clinical symptoms and rarely resulted in values which exceeded the upper limit of the normal range.

Serum potassium was unchanged in patients receiving nifedipine extended-release tablets in the absence of concomitant diuretic therapy, and slightly decreased in patients receiving concomitant diuretics.

Nifedipine decreases platelet aggregation *in vitro*. Limited clinical studies have demonstrated a moderate but statistically significant decrease in platelet aggregation and increase in bleeding time in some nifedipine treated patients. This is thought to be a function of inhibition of calcium transport across the platelet membrane. No clinical significance for these findings has been demonstrated.

Positive direct Coombs tests, with or without associated hemolytic anemia, have been reported

but a causal relationship between nifedipine administration and positivity of this laboratory test, including hemolysis, could not be determined.

Rare reversible elevations in BUN and serum creatinine have been reported in patients with pre-existing chronic renal insufficiency. The relationship to therapy with nifedipine extended-release tablets is uncertain in most cases, but probable in some.

8.5 Post-Market Adverse Reactions

The following adverse events have been reported with nifedipine rarely.

Rare instances of allergic hepatitis and cholestasis with or without jaundice have been reported in patients treated with nifedipine.

Gingival hyperplasia similar to that caused by diphenylhydantoin has been reported in patients treated with nifedipine. The lesions usually regressed on discontinuation of the drug. However, on occasion gingivectomy was necessary.

Gynecomastia has been observed rarely in older men on long-term therapy, but has so far always regressed completely on discontinuation of the drug.

Isolated cases of angioedema have been reported. Angioedema may be accompanied by breathing difficulty. Anaphylaxis has been reported rarely.

In post-marketing experience, there have been rare reports of exfoliative dermatitis and Stevens-Johnson Syndrome. Gastrointestinal irritation and gastrointestinal bleeding were also reported; however, the causal relationship is uncertain.

The following adverse events were identified only during post-marketing experience with a frequency that could not be estimated: agranulocytosis, epidermal photosensitivity allergic reaction, eye pain, gastro esophageal sphincter insufficiency, hyperglycemia, hypoaesthesia, jaundice, leukopenia, toxic epidermal necrolysis, somnolence, toxic palpable purpura, intestinal obstruction, bezoars.

An open, non-randomized post-marketing surveillance study (EXACT), involving 1700 mild to moderate hypertensive patients, was conducted in the offices of general practitioners across Canada. Patients were enrolled in the study if they had been previously treated with either single or dual antihypertensive therapy and the physician considered nifedipine extended-release tablets an appropriate monotherapy. Patients were to be started on nifedipine extended-release tablets 30 mg. If after 3 or 6 weeks of therapy with nifedipine extended-release tablets 30 mg, blood pressure was uncontrolled (i.e., sitting diastolic blood pressure was > 95 mmHg), then the patient was given 60 mg nifedipine extended-release tablets at the physician's discretion.

Twelve patients were started immediately on nifedipine extended-release tablets 60 mg. Patients were followed for 20 weeks. Adverse events were reported in 605/1700 patients (35.6%). These adverse events were typical of those seen with the dihydropyridine class of calcium channel blockers (edema, headache, dizziness) and are related to the vasodilatory properties of this class of compounds.

The following is a summary of adverse effects which occurred with a frequency of $\geq 1\%$ during this 20-week study.

Table 2 - Summary of adverse effects which occurred with a frequency of $\geq 1\%$ during post-marketing surveillance study (EXACT)

Adverse Effect	All Patients (n = 1,700)	
	%	(n)
Patients with ≥ 1 Adverse Effect	35.6	(605)
Headache	12.2	(207)
Peripheral Edema	8.1	(137)
Dizziness	2.9	(50)
Asthenia	2.8	(48)
Vasodilation	2.5	(43)
Constipation	2.4	(40)
Palpitations	1.7	(29)
Nausea	1.5	(26)
Anxiety	1.2	(20)
Dyspepsia	1.1	(18)
Insomnia	1.1	(18)
Tachycardia	1.0	(17)

The following table illustrates the time period during which the adverse effects in the preceding table occurred. The majority of the adverse effects occurred during the first 3 weeks that the patients received nifedipine extended-release tablets. The incidence rate of adverse effects continued to diminish as the length of exposure to nifedipine extended-release tablets increased.

Adverse Effects Occurring During Each Time Period

Table 3 – Summary of adverse effects with a frequency of ≥1% during each time period in the post-marketing surveillance study (EXACT)

Adverse Events	Unknown		0-3 Weeks		3-6 Weeks		6-12 Weeks		12-20 Weeks	
	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)
Headache	7	(0.7)	148	(13.8)	41	(3.8)	22	(2.1)	6	(0.6)
Peripheral Edema	2	(0.2)	56	(5.2)	42	(3.9)	33	(3.1)	18	(1.7)
Dizziness	2	(0.2)	27	(2.5)	11	(1.0)	7	(0.7)	4	(0.4)
Asthenia	2	(0.2)	23	(2.1)	15	(1.4)	9	(0.8)	0	(0)
Vasodilatation	2	(0.2)	27	(2.5)	5	(0.5)	4	(0.4)	6	(0.6)
Constipation	0	(0)	25	(2.3)	8	(0.7)	5	(0.5)	3	(0.3)
Palpitations	1	(0.1)	17	(1.6)	6	(0.6)	2	(0.2)	4	(0.4)
Nausea	0	(0)	21	(2.0)	4	(0.4)	2	(0.2)	0	(0)
Anxiety	2	(0.2)	5	(0.5)	6	(0.6)	2	(0.2)	6	(0.6)
Dyspepsia	1	(0.1)	5	(0.5)	5	(0.5)	5	(0.5)	2	(0.2)
Insomnia	1	(0.1)	6	(0.6)	3	(0.3)	3	(0.3)	6	(0.6)
Tachycardia	1	(0.1)	5	(0.5)	3	(0.3)	6	(0.6)	3	(0.3)

9 DRUG INTERACTIONS

9.1 Serious Drug Interactions

Serious Drug Interactions

- Concomitant use of rifampicin ([2 CONTRAINDICATIONS](#); and 9.4 Drug-Drug Interactions)

9.4 Drug-Drug Interactions

As with all drugs, care should be exercised when treating patients with multiple medications. Dihydropyridine calcium channel blockers, undergo biotransformation by the cytochrome P450 system, mainly via the CYP3A4 isoenzyme. Coadministration of nifedipine with other drugs which follow the same route of biotransformation may result in altered bioavailability. Dosages of similarly metabolized drugs, particularly those of low therapeutic ratio, and especially in patients with renal and/or hepatic impairment, may require adjustment when starting or stopping concomitantly administered nifedipine to maintain optimum therapeutic blood levels. If necessary, an adjustment in the dose of nifedipine may be considered.

Cytochrome P-450 Enzyme Inducers

Enzyme inducers of the cytochrome P450 3A4 system have been shown to cause a decrease in plasma concentrations of nifedipine, e.g., *Hypericum perforatum* (Saint John's Wort) (see [9.6 Drug-Herb Interactions](#)), phenobarbital, phenytoin, and rifampicin (see [Table 4](#)).

The drugs listed in this table are based on either drug interaction case reports or studies, or potential interactions due to the expected magnitude and seriousness of the interaction (i.e., those identified as contraindicated).

Table 4 - Established or Potential Drug-drug Interactions

Proper Name		Source of Evidence	Effect	Clinical Comment
CYP3A4 Substrates	CYP3A4 substrates (e.g., cisapride, tacrolimus, benzodiazepines, imipramine, propafenone, terfenadine, warfarin)	N/A	Enzyme substrates of the cytochrome P450 3A4 (CYP3A4), when coadministered with nifedipine, may act like CYP3A4 inhibitors and cause an increase in nifedipine plasma concentrations.	Dose adjustment and monitoring may be required.
	Cisapride	CT	Simultaneous administration of cisapride and nifedipine may lead to increased plasma concentrations of nifedipine.	Upon co-administration of both drugs, blood pressure should be monitored and, if necessary, a reduction of the nifedipine dose considered.
	Tacrolimus	C	Tacrolimus has been shown to be metabolised via the cytochrome P450 3A4 system. Data indicate that the dose of tacrolimus administered simultaneously with nifedipine may be reduced in individual cases.	Upon co-administration of both drugs, tacrolimus plasma concentrations should be monitored and, if necessary, a reduction in the tacrolimus dose considered.

Proper Name		Source of Evidence	Effect	Clinical Comment
CYP3A4 Inhibitors	CYP3A4 inhibitors: (e.g., azole antifungals (ketoconazole, itraconazole, fluconazole), cimetidine, cyclosporine, erythromycin, fluoxetine, HIV protease inhibitors, nefazodone, quinidine)	N/A	Enzyme inhibitors of CYP3A4 have been shown to cause an increase in nifedipine plasma concentrations, and therefore an increased hypotensive effect of nifedipine.	Dose adjustment and monitoring may be required. Avoid concomitant administration of nifedipine with strong CYP3A4 inhibitors.
	Azole antimycotics (e.g., ketoconazole)	T	A formal interaction study investigating the potential of a drug interaction between nifedipine and certain azole antimycotics has not yet been performed. Drugs of this class are known to inhibit the cytochrome P450 3A4 system.	When administered orally together with nifedipine, a substantial increase in systemic bioavailability of nifedipine due to a decreased first pass metabolism cannot be excluded.
	Cimetidine and Ranitidine	CT	Pharmacokinetic studies have shown that concurrent administration of cimetidine or ranitidine with nifedipine results in significant increases in nifedipine plasma levels (ca. 80% with cimetidine and 70% with ranitidine).	Patients receiving either of these drugs concomitantly with nifedipine should be monitored carefully for the possible exacerbation of effects of nifedipine, such as hypotension. Adjustment of nifedipine dosage may be necessary.
	Diltiazem	CT	Diltiazem decreases the clearance of nifedipine.	The combination of both drugs should be administered with

Proper Name		Source of Evidence	Effect	Clinical Comment
				caution, and a reduction of the nifedipine dose may be considered.
	Erythromycin	T	No interaction studies have been carried out between nifedipine and macrolide antibiotics. Certain macrolide antibiotics are known to inhibit the cytochrome P450 3A4 mediated metabolism of other drugs.	The potential for an increase of nifedipine plasma concentrations upon co-administration of both drugs cannot be excluded
	Clarithromycin	T	A clinical study investigating the potential of a drug interaction between nifedipine and clarithromycin has not yet been performed. In elderly patients (>65 years of age), concomitant use of nifedipine with clarithromycin has been suggested to be associated with an increased incidence of acute kidney injury requiring hospitalization, which may have been caused by increased hypotensive reactions.	Concomitant use should be avoided.
	Fluoxetine	T	A clinical study investigating the potential of a drug interaction between nifedipine and fluoxetine has not yet	Therefore, an increase of nifedipine plasma concentrations upon co-administration of

Proper Name		Source of Evidence	Effect	Clinical Comment
			been performed. Fluoxetine has been shown to inhibit <i>in vitro</i> the cytochrome P450 3A4 mediated metabolism of nifedipine.	both drugs cannot be excluded
	HIV protease inhibitors (amprenavir, indinavir, nelfinavir, ritonavir, saquinavir)	T	A clinical study investigating the potential of a drug interaction between nifedipine and certain anti-HIV protease inhibitors has not yet been performed. Drugs of this class are known to inhibit the cytochrome P450 3A4 system. In addition, drugs of this class have been shown to inhibit <i>in vitro</i> the cytochrome P450 3A4 mediated metabolism of nifedipine.	When administered together with nifedipine, a substantial increase in plasma concentrations of nifedipine due to a decreased first pass metabolism and a decreased elimination cannot be excluded
	Nefazodone	T	A clinical study investigating the potential of a drug interaction between nifedipine and nefazodone has not yet been performed. Nefazodone is known to inhibit the cytochrome P450 3A4 mediated metabolism of other drugs.	Therefore, an increase of nifedipine plasma concentrations upon co- administration of both drugs cannot be excluded
	Quinidine	CT	The addition of nifedipine to a stable quinidine regimen may reduce the quinidine by	Patients receiving concomitant therapy of nifedipine and quinidine, or those

Proper Name		Source of Evidence	Effect	Clinical Comment
			50%, an enhanced response to nifedipine may also occur. The addition of quinidine to a stable nifedipine regimen may result in elevated nifedipine concentrations and a reduced response to quinidine. Some patients have experienced elevated quinidine levels when nifedipine was discontinued.	who had their nifedipine discontinued while still receiving quinidine, should be closely monitored, including determination of plasma levels of quinidine. Consideration should be given to dosage adjustment.
	Quinupristin/ Dalfopristin	CT	Simultaneous administration of quinupristin/dalfopristin and nifedipine may lead to increased plasma concentrations of nifedipine.	Upon coadministration of both drugs, blood pressure should be monitored and, if necessary, a reduction of the nifedipine dose should be considered
	Valproic Acid	T	No formal studies have been performed to investigate the potential interaction between nifedipine and valproic acid. As valproic acid has been shown to increase the plasma concentrations of the structurally similar calcium channel blocker nimodipine due to enzyme inhibition, an increase in nifedipine plasma concentrations and hence an increase	Caution and careful monitoring of patients on concomitant therapy is recommended.

Proper Name		Source of Evidence	Effect	Clinical Comment
			in efficacy cannot be excluded.	
CYP3A4 Inducers	CYP3A4 Inducers (e.g., Phenytoin, Carbamazepine, Phenobarbital, rifampicin)	N/A	Drugs that are known to induce CYP3A4 may increase the first pass effect or the clearance of nifedipine.	A pharmacodynamic interaction exists, inhibiting effective use of dihydropyridines. Need for careful clinical and laboratory monitoring of patients receiving both classes of medication.
	Phenytoin	CT	Phenytoin induces the cytochrome P450 3A4 system. Upon co-administration with phenytoin, the bioavailability of nifedipine is reduced and thus its efficacy weakened.	When both drugs are concomitantly administered, the clinical response to nifedipine should be monitored and, if necessary, an increase of the nifedipine dose considered. If the dose of nifedipine is increased during co-administration of both drugs, a reduction of the nifedipine dose should be considered when the treatment with phenytoin is discontinued.
	Carbamazepine, Phenobarbital	T	No formal studies have been performed to investigate the potential interaction between nifedipine and carbamazepine or phenobarbital. As both	Caution and careful monitoring of patients on concomitant therapy is recommended.

Proper Name		Source of Evidence	Effect	Clinical Comment
			drugs have been shown to reduce the plasma concentrations of the structurally similar calcium channel blocker, nimodipine, due to enzyme induction, a decrease in nifedipine plasma concentrations and hence a decrease in efficacy cannot be excluded.	
	Rifampicin	CT	Rifampicin strongly induces the cytochrome P450 3A4 system. Upon coadministration with rifampicin, the bioavailability of nifedipine is distinctly reduced and thus its efficacy weakened.	The use of nifedipine in combination with rifampicin is therefore contra-indicated
Non-CYP3A4 Interactions	Coumarin Anticoagulants	C	There have been rare reports of increased prothrombin time in patients taking coumarin anticoagulants to whom nifedipine was administered. However, the relationship to nifedipine therapy is uncertain.	Caution and careful monitoring of patients on concomitant therapy is recommended.
	Beta Adrenergic Blocking Agents	CT	Concomitant administration of nifedipine and beta blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that	Caution and careful monitoring of patients on concomitant therapy is recommended (see 1 INDICATIONS ; and 7 WARNINGS AND

Proper Name		Source of Evidence	Effect	Clinical Comment
			the combination may increase the likelihood of congestive heart failure, severe hypotension, or exacerbation of angina.	PRECAUTIONS, Cardiovascular).
	Digoxin	CT	Administration of nifedipine with digoxin may lead to reduced digoxin clearance and therefore an increase in the plasma digoxin level.	It is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing nifedipine to avoid possible “underdosing” or “overdosing” with digitalis.
	Long-acting Nitrates	T	Nifedipine may be safely coadministered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.	No dosage adjustment necessary.
	Theophylline	C / CT	Co-administration of nifedipine may cause alterations in theophylline levels.	When both drugs were concomitantly administered, there were no changes in clinical responsiveness of either of these drugs. Monitoring of theophylline serum levels should be considered.

Legend: C=Case Study; CT=Clinical Trial; T=Theoretical; N/A = Not Applicable

9.5 Drug-Food Interactions

Interaction with Grapefruit Juice

The inhibitory effect of grapefruit juice on CYP3A has been described in numerous publications and the corresponding effect on the pharmacokinetics of nifedipine is highly variable. Considering that the increase of AUC and C_{max} of nifedipine may be as large as two-fold, the administration of nifedipine with grapefruit juice should be avoided (see [10.3 Pharmacokinetics](#)).

9.6 Drug-Herb Interactions

Hypericum perforatum – Saint John's Wort is an inducer of CYP3A4 and has been shown to cause a decrease in plasma concentrations of nifedipine. Therefore, dosage of nifedipine may have to be increased.

9.7 Drug-Laboratory Test Interactions

Interactions with laboratory tests have not been established.

10 CLINICAL PHARMACOLOGY

10.1 Mechanism of Action

pms-NIFEDIPINE ER (nifedipine extended-release tablets) is a calcium ion influx inhibitor (calcium channel blocker or calcium ion antagonist).

pms-NIFEDIPINE ER, while similar in appearance to a conventional tablet, nonetheless consists of a semipermeable membrane surrounding an osmotically active drug core. The core itself is divided into two layers: an “active” layer containing the drug, and a “push” layer containing pharmacologically inert but osmotically active components. As water from the gastrointestinal tract enters the tablet, pressure increases in the osmotic layer and “pushes” against the drug layer, forcing drug through the orifice in the active layer.

Drug delivery is essentially constant as long as the osmotic gradient remains constant and then gradually falls to zero as drug is exhausted from the tablet. Upon swallowing, the biologically inert components of the tablet remain intact during gastrointestinal transit and are eliminated in the feces as an insoluble shell.

The antianginal and antihypertensive actions of nifedipine are believed to be related to a specific cellular action of selectively inhibiting transmembrane influx of calcium ions into cardiac muscle and vascular smooth muscle. The contractile processes of these tissues are dependent upon the movement of extracellular calcium into the cells through specific ion channels. Nifedipine selectively inhibits the transmembrane influx of calcium through the slow channel without affecting, to any significant degree, the transmembrane influx of sodium

through the fast channel. This results in a reduction of free calcium ions available within the muscle cells and an inhibition of the contractile processes. Nifedipine does not alter total serum calcium.

The specific mechanisms by which nifedipine relieves angina and reduces blood pressure have not been fully determined but are believed to be brought about largely by its vasodilatory action.

10.2 Pharmacodynamics

Nifedipine dilates the main coronary arteries and coronary arterioles both in normal and ischemic regions resulting in an increase in blood flow and hence in myocardial oxygen delivery.

Nifedipine by its vasodilatory action on peripheral arterioles, reduces the total peripheral vascular resistance. This reduces the workload of the heart and thus reduces myocardial energy consumption and oxygen requirements which probably accounts for the effectiveness of nifedipine in chronic stable angina.

The mechanism by which nifedipine reduces arterial blood pressure involves peripheral arterial vasodilation and subsequent reduction in peripheral vascular resistance. The increased peripheral vascular resistance that is an underlying cause of hypertension results from an increase in active tension in the vascular smooth muscle. Studies have demonstrated that the increase in active tension reflects an increase in cytosolic free calcium.

The negative inotropic effect of nifedipine is usually not of major clinical significance because at therapeutic doses, nifedipine's vasodilatory property evokes a baroreceptor mediated reflex tachycardia which tends to counterbalance this negative inotropic effect. Continued administration of nifedipine to hypertensive patients has shown no significant increase in heart rate.

Although nifedipine causes a slight depression of sinoatrial node function and atrioventricular conduction in isolated myocardial preparations, such effects have not been seen in studies in intact animals or in man. In formal electrophysiologic studies, predominantly in patients with normal conduction systems, nifedipine has had no tendency to prolong atrioventricular conduction or sinus node recovery time, or to slow sinus rate.

10.3 Pharmacokinetics

Absorption

Nifedipine is completely absorbed after oral administration. Plasma drug concentrations rise at a gradual, controlled rate exhibiting zero-order absorption kinetics after nifedipine extended-release tablets administration and reach a plateau at approximately six hours after the first dose. For subsequent doses, relatively constant plasma concentrations at this plateau are maintained with minimal fluctuations over the 24-hour dosing interval. About a four-fold higher

fluctuation index (ratio of peak to trough plasma concentration) was observed with the conventional immediate-release nifedipine capsule at t.i.d. dosing than with once-daily nifedipine extended-release tablets. At steady state the bioavailability of the nifedipine extended-release tablet is 86% relative to nifedipine capsules. Administration of the nifedipine extended-release tablet in the presence of food slightly alters the early rate of drug absorption but does not influence the extent of drug bioavailability. Markedly reduced GI retention time over prolonged periods (i.e., short bowel syndrome), however, may influence the pharmacokinetic profile of the drug which could potentially result in lower plasma concentrations.

Pharmacokinetics of nifedipine extended-release tablets are linear over the dose range of 30 to 180 mg in that plasma drug concentrations are proportional to dose administered. There was no evidence of dose dumping either in the presence or absence of food. The bioavailability of the 20 mg tablet is directly proportional to the 30 mg tablet.

Metabolism

Nifedipine is metabolized by the cytochrome P450 enzyme system, predominantly via CYP3A4, but also by CYP1A2 and CYP2A6 isoenzymes.

Compounds found in grapefruit juice inhibit the cytochrome P450 system, especially CYP3A4. In a grapefruit-juice-nifedipine interaction study in healthy male volunteers, pharmacokinetics of nifedipine showed significant alteration. Following administration of a single dose of nifedipine 10 mg with 250 mL grapefruit juice, the mean value of nifedipine AUC increased by 34% and the t_{max} increased from 0.8 hours to 1.2 hours as compared to water (see [9.5 Drug-Food Interactions](#)).

Elimination

Nifedipine is extensively metabolized to highly water-soluble, inactive metabolites accounting for 60 to 80% of the dose excreted in the urine. The remainder is excreted in the feces in metabolized form, most likely as a result of biliary excretion. The main metabolite (95%) is the hydroxycarboxylic acid derivative; the remaining 5% is the corresponding lactone. Only traces (less than 0.1% of the dose) of unchanged nifedipine can be detected in the urine.

Special Populations and Conditions

Hepatic Insufficiency

Since hepatic biotransformation is the predominant route for the disposition of nifedipine, the pharmacokinetics may be altered in patients with chronic liver disease. Pharmacokinetic studies in patients with hepatic cirrhosis showed a clinically significant prolongation of elimination half-life and a decrease in total clearance of nifedipine. The degree of serum protein binding of

nifedipine is high (92-98%). Protein binding may be greatly reduced in patients with hepatic impairment (see [2 CONTRAINDICATIONS](#); and [7.1 Special Populations, Hepatic Insufficiency](#)).

In a study comparing the pharmacokinetics of nifedipine in patients with mild (Child Pugh A) or moderate (Child Pugh B) hepatic impairment with those in patients with normal liver function, oral clearance of nifedipine was reduced by on average 48% (Child Pugh A) and 72% (Child Pugh B). As a result AUC and C_{max} of nifedipine increased on average by 93% and 64% (Child Pugh A) and by 253% and 171% (Child Pugh B), respectively, compared to patients with normal hepatic function. The pharmacokinetics of nifedipine has not been investigated in patients with severe hepatic impairment (see [2 CONTRAINDICATIONS](#); and [7.1 Special Populations, Hepatic Insufficiency](#)).

Renal Insufficiency

The pharmacokinetics of nifedipine are not significantly influenced by the degree of renal impairment. Patients in hemodialysis or CAPD (continuous ambulatory peritoneal dialysis) have not reported significantly altered pharmacokinetics of nifedipine.

11 STORAGE, STABILITY AND DISPOSAL

Store between 15°C and 30°C. Protect from light and humidity.

PART II: SCIENTIFIC INFORMATION

13 PHARMACEUTICAL INFORMATION

Drug Substance

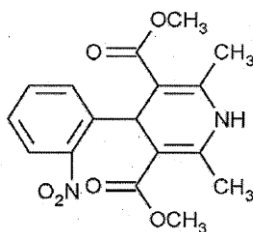
Proper name: nifedipine

Chemical name: 1,4-dihydro-2,6-dimethyl-4-(o-nitrophenyl)-3,5-pyridine- dicarboxylic acid dimethyl ester.

Molecular formula: $C_{17}H_{18}N_2O_6$

Molecular mass: 346.33 g/mol

Structural formula:



Physicochemical properties:

Nifedipine is a pyridine dicarboxylic acid dimethylester. It is a fine, yellowish powder, practically insoluble in water, but soluble in ethanol. It is light-sensitive, and when exposed, is converted to a pharmacologically inactive pyridine derivative via an intramolecular redox process.

14 CLINICAL TRIALS

14.1 Clinical Trials by Indication

Hypertension

INSIGHT Trial

Table 5 - Summary of patient demographics for clinical trials in hypertension

Study #	Study design	Study subjects (n)	Age Range
INSIGHT	Prospective double-blind trial with dynamic randomization which enrolled mainly white hypertensive men and women	6575	55-80

The International Nifedipine GITS Study Intervention as a Goal in Hypertension Treatment trial called INSIGHT was a prospective double-blind trial with dynamic randomization which enrolled mainly white hypertensive men and women. The primary endpoint was a composite of death from any cardiovascular or cerebrovascular cause, together with nonfatal stroke, myocardial infarction, and heart failure. The secondary endpoint included total mortality, death from a vascular cause, and non-fatal vascular events including transient ischemic attacks, angina (new or worsening), and renal failure. INSIGHT was designed to establish the superiority of nifedipine extended-release tablets over the diuretic combination co-amilozone (hydrochlorothiazide and amiloride). When the results of the Swedish Trial in Old Patients with Hypertension-2 study (STOP-2) became known and because these results suggested that calcium-channel blockade and diuretic treatment had similar efficacy in preventing complications, but before the patient code in INSIGHT was broken, a secondary, noninferiority analysis was added.

Study Results

INSIGHT randomized 6575 mild to moderate essential hypertensive or isolated systolic hypertensive patients, 55 – 80 years of age, with at least one other cardiovascular risk factor to nifedipine and co-amilozone. Patients were excluded if they had heart failure with low ejection fraction (<40%), unstable angina, PTCA (Percutaneous Transluminal Coronary Angioplasty) or CABG (Coronary Artery Bypass Grafting) within 6 months prior to study start, or myocardial infarction or stroke in the 12 months prior to study start. Doses of each drug were titrated to achieve a target blood pressure of 140/90 mmHg (or drop of 20/10 mmHg) and if that target was not reached additional drugs could be added (atenolol and subsequently enalapril). On average patients were treated for 3.5 years. After placebo washout, the baseline blood pressure was 173/99 mmHg and decreased to 138/82 mmHg by the end of the trial in both groups. Heart rate was not different between the groups. At the end of the study, 69% and 72%

of patients on nifedipine extended-release tablets and hydrochlorothiazide/amiloride, respectively, were on monotherapy. All endpoints were assessed and adjudicated by the Critical Events Committee. The overall results of the study show that nifedipine extended-release tablets were not inferior to the diuretic combination co-amilozide (see [Table 6](#)):

Table 6 - INSIGHT Trial Results

	Nifedipine extended-release tablets		Hydrochlorothiazide / Amiloride		Odds Ratio (95% CI)		P-value
Primary Outcomes Composite	200	(6.3%)	182	(5.8%)	1.11	(0.90-1.36)	0.34
Secondary Outcomes Composite	383	(12.1%)	397	(12.5%)	0.96	(0.83-1.12)	0.62
Total Mortality	153	(4.8%)	152	(4.8%)	1.01	(0.80-1.27)	0.95
All Adverse Events	1546	(49%)	1327	(42%)	N/A		< 0.001
Serious Adverse Events	796	(25%)	880	(28%)	N/A		0.02

14.2 Comparative Bioavailability Studies

Fasting Study

A randomized, double-blind, two-treatment, two-period, two-sequence, crossover, single dose oral bioequivalence study comparing pms-NIFEDIPINE ER 20 mg extended-release tablets (Pharmascience Inc.) and PrADALAT® XL® 20 mg extended-release tablets (Bayer Inc.) was conducted in 60 healthy, adult, Asian male subjects under fasting conditions. A summary of the comparative bioavailability data from the 54 subjects included in the statistical analysis is presented in the following table:

SUMMARY TABLE OF THE COMPARATIVE BIOAVAILABILITY DATA

Nifedipine (1 x 20 mg) Geometric Mean Arithmetic Mean (CV %)				
Parameter	Test ¹	Reference ²	% Ratio of Geometric Means	90% Confidence Interval
AUC _T (ng·h/mL)	359.93 433.84 (55.7)	385.75 447.80 (58.2)	93.0	81.9 – 105.7
AUC _I (ng·h/mL)	369.37 458.20 (65.3)	402.97 491.01 (73.3)	92.9	81.3 – 106.1
C _{max} (ng/mL)	19.49 21.44 (42.6)	19.71 21.78 (46.0)	98.6	90.7 – 107.2
T _{max} ³ (h)	13.25 (4.00 – 36.02)	13.50 (5.00 – 36.00)		
T _{1/2} ⁴ (h)	6.55 (49.1)	7.27 (93.4)		

¹ pms-NIFEDIPINE ER (nifedipine) extended-release tablets, 20 mg (Pharmascience Inc.)

² PrADALAT® XL® (nifedipine) extended-release tablets, 20 mg (Bayer Inc., Canada)

³ Expressed as the median (range) only

⁴ Expressed as the arithmetic mean (CV %) only

Fed Study

A randomized, double-blind, two-treatment, two-period, two-sequence, crossover, single dose oral bioequivalence study comparing pms-NIFEDIPINE ER 20 mg extended-release tablets (Pharmascience Inc.) and PrADALAT® XL® 20 mg extended-release tablets (Bayer Inc.) was conducted in 60 healthy, adult, Asian male subjects under high-fat, high-calorie fed conditions. A summary of the comparative bioavailability data from the 53 subjects included in the statistical analysis is presented in the following table:

SUMMARY TABLE OF THE COMPARATIVE BIOAVAILABILITY DATA

Nifedipine (1 x 20 mg) Geometric Mean Arithmetic Mean (CV %)				
Parameter	Test ¹	Reference ²	% Ratio of Geometric Means	90% Confidence Interval
AUC _T (ng·h/mL)	377.62 459.99 (61.8)	387.47 448.09 (56.3)	98.2	89.1 – 108.3
AUC _I (ng·h/mL)	390.16 480.61 (65.3)	397.18 465.95 (60.4)	99.0	89.7 – 109.3
C _{max} (ng/mL)	23.14 26.13 (50.1)	23.80 25.61 (39.5)	97.5	91.3 – 104.2
T _{max} ³ (h)	8.50 (5.00 – 24.00)	7.00 (5.00 – 24.00)		
T _{1/2} ⁴ (h)	6.19 (50.4)	5.95 (47.6)		

¹ pms-NIFEDIPINE ER (nifedipine) extended-release tablets, 20 mg (Pharmascience Inc.)

² PrADALAT® XL® (nifedipine) extended-release tablets, 20 mg (Bayer Inc., Canada)

³ Expressed as the median (range) only

⁴ Expressed as the arithmetic mean (CV %) only

Fasting Study

A randomized, double-blind, two-treatment, two-period, two-sequence, crossover, single dose oral bioequivalence study comparing pms-NIFEDIPINE ER 30 mg extended-release tablets (Pharmascience Inc.) and PrADALAT® XL® 30 mg extended-release tablets (Bayer Inc.) was conducted in 40 healthy, adult, Asian male subjects under fasting conditions. A summary of the comparative bioavailability data from the 36 subjects included in the statistical analysis is presented in the following table:

SUMMARY TABLE OF THE COMPARATIVE BIOAVAILABILITY DATA

Nifedipine (1 x 30 mg) Geometric Mean Arithmetic Mean (CV %)				
Parameter	Test ¹	Reference ²	% Ratio of Geometric Means	90% Confidence Interval
AUC _T (ng·h/mL)	590.69 702.01 (49.8)	613.27 704.32 (51.3)	96.3	81.6 – 113.6
AUC _I (ng·h/mL)	611.47 739.89 (52.9)	631.71 735.39 (55.1)	96.8	81.0 – 115.6
C _{max} (ng/mL)	30.90 34.29 (45.7)	28.45 30.93 (40.3)	108.6	96.7 – 122.1
T _{max} ³ (h)	13.50 (5.00 – 24.00)	20.00 (5.00 - 36.00)		
T _{1/2} ⁴ (h)	7.31 (70.8)	6.57 (44.2)		

¹ pms-NIFEDIPINE ER (nifedipine) extended-release tablets, 30 mg (Pharmascience Inc.)

² PrADALAT® XL® (nifedipine) extended-release tablets, 30 mg (Bayer Inc., Canada)

³ Expressed as the median (range)

⁴ Expressed as the arithmetic mean (CV %) only

Fed Study

A randomized, double-blind, two-treatment, two-period, two-sequence, crossover, single dose oral bioequivalence study comparing pms-NIFEDIPINE ER 30 mg extended-release tablets (Pharmascience Inc.) and PrADALAT® XL® 30 mg extended-release tablets (Bayer Inc.) was conducted in 50 healthy, adult, Asian male subjects under high-fat, high-calorie fed conditions. A summary of the comparative bioavailability data from the 47 subjects included in the statistical analysis is presented in the following table:

SUMMARY TABLE OF THE COMPARATIVE BIOAVAILABILITY DATA

Nifedipine (1 x 30 mg) Geometric Mean Arithmetic Mean (CV %)				
Parameter	Test ¹	Reference ²	% Ratio of Geometric Means	90% Confidence Interval
AUC _T (ng·h/mL)	599.22 705.24 (55.2)	633.88 722.71 (48.6)	94.6	85.2 – 105.1
AUC _I (ng·h/mL)	617.79 737.61 (59.4)	684.63 955.09 (161.2)	90.9	79.7 – 103.7
C _{max} (ng/mL)	36.56 41.11 (45.8)	37.11 40.58 (44.5)	98.6	89.5 – 108.7
T _{max} ³ (h)	10.00 (6.00 – 36.00)	8.50 (5.00 – 24.00)		
T _{1/2} ⁴ (h)	6.51 (37.5)	10.78 (269.4)		

¹ pms-NIFEDIPINE ER (nifedipine) extended-release tablets, 30 mg (Pharmascience Inc.)

² PrADALAT® XL® (nifedipine) extended-release tablets, 30 mg (Bayer Inc., Canada)

³ Expressed as the median (range)

⁴ Expressed as the arithmetic mean (CV %) only

Fasting Study

A randomized, double-blind, two-treatment, two-period, two-sequence, crossover, single dose oral bioequivalence study comparing pms-NIFEDIPINE ER 60 mg extended-release tablets (Pharmascience Inc.) and PrADALAT® XL® 60 mg extended-release tablets (Bayer Inc.) was conducted in 40 healthy, adult, Asian male subjects under fasting conditions. A summary of the comparative bioavailability data from the 36 subjects included in the statistical analysis is presented in the following table:

SUMMARY TABLE OF THE COMPARATIVE BIOAVAILABILITY DATA

Nifedipine (1 x 60 mg) Geometric Mean Arithmetic Mean (CV %)				
Parameter	Test ¹	Reference ²	% Ratio of Geometric Means	90% Confidence Interval
AUC _T (ng·h/mL)	1274.05 1495.45 (56.7)	1354.72 1507.14 (42.6)	94.0	84.7 – 104.4
AUC _I (ng·h/mL)	1460.41 2046.44 (101.8)	1553.89 1791.02 (51.7)	94.0	78.1 – 113.2
C _{max} (ng/mL)	60.86 66.78 (42.7)	57.33 61.48 (35.3)	106.1	99.2 – 113.6
T _{max} ³ (h)	16.00 (5.00 – 30.00)	20.00 (5.00 – 30.00)		
T _{1/2} ⁴ (h)	11.83 (137.7)	11.83 (82.4)		

¹ pms-NIFEDIPINE ER (nifedipine) extended-release tablets, 60 mg (Pharmascience Inc.)

² PrADALAT® XL® (nifedipine) extended-release tablets, 60 mg (Bayer Inc., Canada.)

³ Expressed as the median (range) only

⁴ Expressed as the arithmetic mean (CV %) only

Fed Study

A randomized, double-blind, two-treatment, two-period, two-sequence, crossover, single dose oral bioequivalence study comparing pms-NIFEDIPINE ER 60 mg extended-release tablets (Pharmascience Inc.) and PrADALAT® XL® 60 mg extended-release tablets (Bayer Inc.) was conducted in 35 healthy, adult male subjects under high-fat, high-calorie fed conditions. A summary of the comparative bioavailability data from the 31 subjects included in the statistical analysis is presented in the following table:

SUMMARY TABLE OF THE COMPARATIVE BIOAVAILABILITY DATA

Nifedipine (1 x 60 mg) Geometric Mean Arithmetic Mean (CV %)				
Parameter	Test ¹	Reference ²	% Ratio of Geometric Means	90% Confidence Interval
AUC _T (ng·h/mL)	752.12 827.62 (46.5)	748.92 844.87 (49.7)	100.2	91.9 – 109.3
AUC _I (ng·h/mL)	770.02 847.44 (46.8)	765.93 877.20 (55.2)	98.6	90.2 – 107.7
C _{max} (ng/mL)	43.77 47.45 (40.9)	38.04 41.21 (40.5)	114.8	106.7 – 123.6
T _{max} ³ (h)	9.50 (5.00 – 24.00)	11.00 (5.00 – 36.00)		
T _{1/2} ⁴ (h)	5.89 (29.3)	8.89 (79.6)		

¹ pms-NIFEDIPINE ER (nifedipine) extended-release tablets, 60 mg (Pharmascience Inc.)

² PrADALAT® XL® (nifedipine) extended-release tablets, 60 mg (Bayer Inc., Canada.)

³ Expressed as the median (range) only

⁴ Expressed as the arithmetic mean (CV %) only

15 MICROBIOLOGY

No microbiological information is required for this drug product.

16 NON-CLINICAL TOXICOLOGY

General Toxicology

Acute Toxicity

Signs of toxicity were usually observed from 5 to 10 minutes after oral administration and immediately after intravenous administration. These include a reduction of spontaneous motility and apathy in association with increased frequency of respiration usually seen at the

lower dosages, with saltatory and clonic spasm, cyanosis and death at the higher dosages. Post-mortem examinations revealed pulmonary edema in rats and cats.

Table 7 - LD₅₀ in Animal Studies

Species	Dose Range (mg/kg)		LD ₅₀ (mg/kg)	
	Oral	Intravenous	Oral	Intravenous
Mouse	294-882	3-5	494 (421-572)	4.2 (3.8-4.6)
Rat	588-1323	10-25	1022 (950-1087)	15.5 (13.7-17.5)
Rabbit	100-500	1-4	250-500	2-3
Cat	50-250	0.5-8	100	0.5-8
Dog	250-2000	0.5-3	>250	2-3

Subacute Toxicity

In rats, oral doses of 0.5 to 100 mg/kg/day nifedipine for 13 weeks did not induce significant adverse effects.

Similar results were obtained in dogs treated with 0.5 to 50 mg/kg/day nifedipine for thirteen weeks.

Carcinogenicity

Nifedipine was administered orally to dogs at doses of 2.5, 20, and 100 mg/kg/day for 52 weeks. No indication of toxic damage caused by nifedipine was found.

In a two-year study, nifedipine was administered orally to male and female rats in the diet at doses of 5-9, 29-39, and 156-210 mg/kg/day. In the lowest dose group, nifedipine was without toxic effects. The higher doses led to dose-dependent, significant weight losses. An increased mortality was found in the 156-210 mg/kg dose group, especially in the females. The pathological-anatomical examination of the dead animals showed a hypotonia or atonia of the musculature of the small intestine. An increase in the weight of the adrenal glands of male rats was also observed in this dose group. Histopathological examinations revealed no organ damage related to treatment.

At the end of the study, all rats were examined histopathologically with regard to tumourigenesis. Although the animals in the highest dose group showed no uncommon tumour incidence, this group was considered not suitable for comparison with the other treatment groups because of the high mortality rate. No significant differences were found between the controls and the remaining two groups with respect to the frequency, nature, and localization of tumours.

Reproductive and Developmental Toxicology

Pregnant mice, rats, and rabbits were treated orally with 10, 30, and 100 mg/kg nifedipine from Day 6 to Day 15 of gestation.

In the mouse, at doses of 30 and 100 mg/kg, there was an increase in the number of fetal resorptions. Fetal malformations in the form of cleft palate and rib deformities occurred at all dose levels in a dose-related fashion (cleft palate occurred in 5/218 controls, 13/190 at 10 mg/kg, 22/112 at 30 mg/kg and 3/3 at 100 mg/kg).

In the rat, the dose of 30 mg/kg was not toxic to pregnant dams, but caused reduced fetal weight and increased fetal loss. The dose of 100 mg/kg produced malformations in the fetuses from 20% of the mother animals. In a total of 11 fetuses, 10 showed malformation of the front or hind paws (ectrodactyly, oligodactyly, and adactyly) and one developed a severe malformation of the sinciput.

In the rabbit, there was dose-dependent anorexia and weight loss in mothers during the dosing period. At 30 and 100 mg/kg reduced litter size and weight and increased fetal loss were evident.

Studies on pregnant Rhesus monkeys with oral doses of 2 (1 animal) or 6 mg/kg/day (4 animals) revealed no teratogenic effects. The placentas were poorly developed in these animals.

Pre-natal and post-natal studies on rats with daily doses of 3, 10, 30, and 100 mg/kg showed that nifedipine caused significant prolongation of the gestation period at dosages of 10 mg/kg upwards and a decrease in litter size. The post-natal development of the newborn animals was impaired when doses of 30 mg/kg or more had been administered. All offspring in the 100 mg/kg group died.

Mutagenesis

In the Dominant Lethal test, the oral administration of nifedipine to mice at a dose of 100 mg/kg for five consecutive days did not affect fertility rate or post-implantation loss.

In the Micronucleus test, two doses of 50 mg/kg or 100 mg/kg nifedipine given orally to mice also did not produce any mutagenic effect. Furthermore, the formation of erythrocytes was not impaired as shown by the polychromatic: normochromatic erythrocyte ratio.

In the Ames' Salmonella/microsome test, nifedipine at doses of up to 12,500 mcg per plate did not cause any bacteriotoxic effects. Also, a dose-dependent and biologically relevant increase in the number of mutants to a level double that of the negative control was not noted.

Animal Pharmacology

In Vitro Animal Pharmacology

Inhibition of Transmembrane Ca⁺⁺ Influx

Nifedipine has been shown in isolated preparations to restrict the transmembrane calcium ion influx during excitation-contraction coupling in both cardiac and vascular smooth muscles.

In the cat papillary muscle under voltage clamp conditions, nifedipine at a concentration of 10^{-7} to 10^{-5} M did not influence the fast Na^+ inward current, but depressed the slow Ca^{++} inward current in a dose-dependent manner without altering the kinetic control mechanism (gating mechanism).

In isolated rabbit ears perfused with tyrode solution, nifedipine has been shown to cause immediate vasodilation, loss of vascular tone and a lack of response to increases in perfusion pressure. However, subsequent neutralization of the drug effect could be achieved by an 8-fold increase in the extracellular Ca^{++} concentration.

Studies *in vitro* using rat thoracic aorta and superior mesenteric artery preparations have shown that nifedipine inhibits contractions induced by potassium and noradrenaline. Tracing the movement of $^{45}\text{Ca}^{++}$ in these preparations showed that nifedipine 3×10^{-6} M reduced the calcium influx triggered by noradrenaline or depolarization. The influx could not be completely blocked and $^{45}\text{Ca}^{++}$ efflux remained unaffected.

Electrophysiologic Effect

In the isolated guinea-pig atria, the prolongation of the functional refractory period by nifedipine was not very pronounced, although there was a marked decrease in contractility. Even at high concentrations, nifedipine did not affect myocardial excitability.

In the conscious dog, nifedipine produced a moderate, dose-dependent PQ shortening. Only injection of large doses (0.3 to 30 mcg) of nifedipine into the posterior septal artery induced a dose-dependent increase in AV conduction. The increase in blood flow through the posterior septal artery required only 1/10 of the dose necessary to affect AV conduction.

These electrophysiologic properties of nifedipine explain in part the lack of antiarrhythmic activity of the drug.

In Vivo Animal Pharmacology

Cardiovascular Effects

In dogs under opiate analgesia (thereby maintaining practically intact regulation of the circulation), nifedipine administered sublingually at dosages of 10-1000 mcg/kg caused a dose-dependent increase in coronary flow, resulting in an increased oxygen supply to the heart. The peripheral flow, measured in the femoral artery, also increased in a dose-dependent manner. At low doses (10-31.5 mcg/kg) the cardiac contractility, measured by left ventricular dp/dt, and the end-diastolic pressure were reduced or unaffected, while at higher doses (100-1000 mcg/kg) there was an increase in dp/dt dependent on the increase in heart rate. Thus, low doses of nifedipine may produce a negative inotropic effect, but higher doses produce greater peripheral vasodilation, and the direct negative inotropic effect is modified by the baroreceptor mediated reflex, positive inotropic response and tachycardia.

In further hemodynamic investigations conducted in conscious dogs with implanted aortic flow-

probes, a reduction in total peripheral resistance was observed with nifedipine doses of only 10 mcg/kg sublingually, which did not appreciably lower the mean blood pressure. However, a decrease in the mean blood pressure occurred when doses were raised to 31.5 or 100 mcg/kg. In the higher dose range there were significant decreases in peripheral resistance, with concomitant increases in heart rate, stroke volume and cardiac output as a result of compensatory mechanisms. The drop in peripheral resistance associated with the increase in cardiac output results in a partial transformation of the pressure workload of the heart into a volume workload which is considered to be less oxygen consuming. Lowering of the peripheral resistance also indicated that nifedipine reduces the afterload.

Antihypertensive Effects

In male spontaneously hypertensive rats, nifedipine was administered in single oral doses of 0.3, 1, 3, 6, or 9 mg/kg and compared to hydralazine 2.5, 6, or 7.5 mg/kg (5 animals/group). This was followed by oral administration once a day for ten weeks of nifedipine 1, 3, 6, or 9 mg/kg/day or hydralazine 6 mg/kg/day (5-7 animals/group). No changes in blood pressure were seen after nifedipine 0.3 mg/kg but the 1 and 3 mg/kg doses caused maximal decrease in blood pressure 1-4 hours after administration. Maximal effects of the higher (6 and 9 mg/kg) doses of nifedipine were seen after 15 minutes with a slightly longer duration following 9 mg/kg. The hydralazine dose of 2.5 mg/kg was not observed to have an antihypertensive effect. Significant decreases in blood pressure were seen after 6 and 7.5 mg/kg with maximal effect after 2-4 hours. In the ten- week study, nifedipine at doses of 3 mg/kg/day and above produced significant decreases in blood pressure in the first week and throughout the subsequent weeks to the end of administration. The effect of nifedipine 9 mg/kg/day was comparable to that of hydralazine 6 mg/kg/day.

17 SUPPORTING PRODUCT MONOGRAPHS

1. ADALAT® XL®, tablet, 30 mg, submission control 270254, Product Monograph, Bayer Inc., June 29, 2023.

PATIENT MEDICATION INFORMATION

READ THIS FOR SAFE AND EFFECTIVE USE OF YOUR MEDICINE

pms-NIFEDIPINE ER Nifedipine Extended-Release Tablets

Read this carefully before you start taking **pms-NIFEDIPINE ER** and each time you get a refill. This leaflet is a summary and will not tell you everything about this drug. Talk to your healthcare professional about your medical condition and treatment and ask if there is any new information about **pms-NIFEDIPINE ER**.

What is pms-NIFEDIPINE ER used for?

pms-NIFEDIPINE is used in adults to control:

- chest pain that most often occurs with physical activity or emotional stress (chronic stable angina). It can be used with other chest pain medicines when those medicines do not provide enough benefit on their own. pms-NIFEDIPINE ER is normally used in patients who have tried beta blockers and/or nitrates for their chest pain, but did not receive benefits, or had bad side effects.
- mild to moderate high blood pressure.

How does pms-NIFEDIPINE ER work?

pms-NIFEDIPINE ER belongs to the group of medicines called “calcium channel blockers” or “calcium antagonists”. It works by:

- relaxing and expanding the blood vessels. This makes the blood flow more easily and lowers blood pressure. Lower blood pressure reduces the strain on your heart.
- relaxing and expanding the arteries supplying the heart. This allows more blood and oxygen to reach the heart and decreases the strain on it. Your angina attacks (chest pain) will be less severe and less frequent if there is less strain on the heart.

What are the ingredients in pms-NIFEDIPINE?

Medicinal ingredients: Nifedipine

Non-medicinal ingredients: Black iron oxide (20 and 60 mg only), cellulose acetate, hydroxypropyl cellulose, hypromellose, magnesium stearate, polyethylene glycol, polyethylene oxide, polyethylene oxide coagulant, red iron oxide, shellac, sodium chloride, talc and titanium dioxide.

pms-NIFEDIPINE ER comes in the following dosage forms:

Extended-release tablets: 20 mg, 30 mg and 60 mg

Do not use pms-NIFEDIPINE ER if:

- you are allergic to nifedipine or any of the other ingredients in pms-NIFEDIPINE ER.

- you are allergic to medicines that are similar to pms-NIFEDIPINE ER (i.e., dihydropyridines calcium antagonists) such as amlodipine, clevidipine, felodipine, isradipine, and nimodipine.
- you have very low blood pressure.
- you are going into cardiogenic shock (your heart suddenly cannot pump enough blood and oxygen to the brain and other vital organs).
- you are pregnant or plan to become pregnant.
- you are a woman of child-bearing potential, unless you and your healthcare professional have decided you should take pms-NIFEDIPINE ER.
- you are breastfeeding or plan to breastfeed.
- you are taking rifampicin (used to treat bacterial infections, including tuberculosis).
- you have a Kock pouch (a pouch or reservoir created inside the abdomen with a portion of the small intestines for which a tube or catheter can be inserted through the abdominal wall to drain the reservoir).
- you have moderate to severe liver disease.
- you have severe intestinal obstruction (blockage that stops or impairs the passage of contents through the intestines).

To help avoid side effects and ensure proper use, talk to your healthcare professional before you take pms-NIFEDIPINE ER. Talk about any health conditions or problems you may have, including if you:

- have mild liver disease.
- have diabetes.
- have very high blood pressure that comes on suddenly and quickly.
- have a history of or are prone to low blood pressure.
- have a history of poor blood circulation in the brain.
- have had or will have surgery under general anaesthesia.
- had a recent heart attack.
- have a severe heart condition such as heart failure or aortic stenosis (narrowing of a valve in your heart).
- have obstructive coronary artery disease (gradual narrowing or closing of arteries that supply the heart with blood due to plaque buildup).
- have severe narrowing of the intestines, or an inflammatory bowel disease such as Crohn's disease, or a history of intestinal or esophageal obstruction (blockage that stops or impairs the passage of contents through the intestines or esophagus).
- have unstable angina (sudden chest pain that occurs at rest and gets increasingly worse).
- have angina (chest pain) and recently stopped taking beta blockers (medicines used to treat high blood pressure and other circulatory problems). You may experience withdrawal symptoms, including increased chest pain. Starting treatment with pms-NIFEDIPINE ER may not prevent these withdrawal symptoms and may even make them worse.
- are a man and are planning or currently trying to father a child by in vitro fertilization.

Other warnings you should know about:

pms-NIFEDIPINE ER can cause serious side effects, including:

- **Hypotension** (low blood pressure): This can occur after your first dose or after your dose is increased. Your risk may be greater if you also take beta blockers (medicines used to treat high blood pressure or other circulatory problems). Tell your healthcare professional if you experience excessive symptoms of low blood pressure, including fainting. They may adjust your dose or stop your treatment with pms-NIFEDIPINE ER altogether.
- **Angina pectoris** (chest pain) and **Myocardial infarction** (heart attack): In rare cases, pms-NIFEDIPINE ER can cause chest pain that is new or worse after your first dose or after your dose is increased. Heart attack can also occur. The risk is greater if you have severe heart disease. If you experience chest pain, stop taking pms-NIFEDIPINE ER and seek medical help **right away**.
- **Intestinal obstruction** (blockage that stops or impairs passage of contents through the intestines): The outer shell of pms-NIFEDIPINE ER tablets does not dissolve in the intestines. Although rare, this may increase your risk of intestinal obstruction, especially if you have or have had severe bowel problems. If you experience symptoms of intestinal obstruction, stop taking pms-NIFEDIPINE ER and seek medical help **right away**. In some cases, surgery may be required.

See the **Serious side effects and what to do about them table**, below, for more information on these and other serious side effects.

Diabetes: If you have diabetes, pms-NIFEDIPINE ER may affect your blood sugar control. Closely monitor your blood sugar while taking pms-NIFEDIPINE ER. Tell your healthcare professional if you notice that you have difficulty controlling your blood sugar levels during your treatment. They may adjust your dose of pms-NIFEDIPINE ER.

Fertility (male): pms-NIFEDIPINE ER may affect your chance to father a child. Talk to your healthcare professional if this is important to you.

Driving and using machines: pms-NIFEDIPINE ER can decrease your blood pressure causing light-headedness, dizziness and fainting. These can occur more often after your first dose, when your dose is increased, or in combination with alcohol. Before you drive or do tasks that require special attention, wait until you know how you respond to pms-NIFEDIPINE ER.

Check-ups and testing: You will have regular visits with your healthcare professional while you are taking pms-NIFEDIPINE ER to monitor your blood pressure and heart rate. If you have mild liver disease, they may also do blood tests to monitor the health of your liver during treatment.

Tell your healthcare professional about all the medicines you take, including any drugs, vitamins, minerals, natural supplements, or alternative medicines.

Serious Drug Interactions

Do not take pms-NIFEDIPINE ER if:

- you are taking rifampicin (used to treat bacterial infections, including tuberculosis) as you may have serious side effects.

The following may also interact with pms-NIFEDIPINE ER:

- other medicines used to treat high blood pressure and/or chest pain, including calcium channel blockers (e.g., amlodipine, clevidipine, felodipine, isradipine, nimodipine, diltiazem) and beta blockers (e.g., atenolol, metoprolol, labetalol, propranolol)
- medicines used to treat seizures (e.g., phenobarbital, phenytoin, valproic acid, carbamazepine)
- medicines used to treat fungal infections with a name ending in “azole” (e.g., ketoconazole, itraconazole, fluconazole)
- medicines used to treat bacterial infections (e.g., erythromycin, clarithromycin, quinupristin/dalfopristin). Taking clarithromycin with pms-NIFEDIPINE ER may increase your risk of kidney problems if you are elderly.
- medicines used to suppress the immune system (e.g., tacrolimus, cyclosporine)
- medicines used to treat depression (e.g., imipramine, fluoxetine, nefazodone)
- medicines used to treat HIV/AIDS (e.g., amprenavir, indinavir, nelfinavir, ritonavir, saquinavir)
- medicines used to treat an irregular heartbeat (e.g., propafenone, quinidine)
- medicines used to treat ulcers of the stomach and intestines (e.g., cimetidine, ranitidine)
- benzodiazepines, used to treat anxiety, seizures and insomnia
- terfenadine, used to treat allergies
- warfarin, used to treat or prevent blood clots
- digoxin, used to treat various heart conditions
- theophylline, used to treat asthma and other lung diseases
- St. John’s Wort, a herbal remedy
- grapefruit or grapefruit juice. Do not eat grapefruit or drink grapefruit juice while taking pms-NIFEDIPINE ER.
- alcohol

How to take pms-NIFEDIPINE ER:

- Take pms-NIFEDIPINE ER exactly as directed by your healthcare professional.
- **You must swallow pms-NIFEDIPINE ER tablets whole. DO NOT bite, chew, divide or crush the tablets. Doing so can release all of the medicine at once, increasing the risk of side effects.**
- Do not change your dose or stop taking pms-NIFEDIPINE ER without talking with your healthcare professional first.
- Never share your medicine with anyone.

Usual dose:

The dose of pms-NIFEDIPINE ER prescribed to you will depend on your condition.

- **To treat chest pain (chronic stable angina):** The usual starting dose is 30 mg once a day.
- **To treat high blood pressure:** The usual starting dose is 20 mg to 30 mg once a day.
The usual maintenance dose is 30 mg to 60 mg once a day.

Your healthcare professional may slowly increase your dose (over 7 to 14 days) to find the dose that works best for you. Follow their instructions carefully.

The maximum daily dose is 90 mg.

Overdose:

Signs of an overdose with pms-NIFEDIPINE ER may include:

- low blood pressure that can lead to shock (rapid breathing, pale skin cold and sweaty skin).
It can be accompanied with a buildup of fluids in the lungs (difficulty breathing, especially while lying down).
- high blood sugar (increased thirst, dry mouth, needing to pee frequently).
- buildup of acid in the body (confusion, rapid heartbeat, feeling sick, headache, long and deep breaths).
- low levels of oxygen in your body tissues (shortness of breath, headache, confusion or restlessness).
- slow or rapid heartbeat.
- decreased consciousness or coma.

If you think you, or a person you are caring for, have taken too much pms-NIFEDIPINE ER, contact a healthcare professional, hospital emergency department, or regional poison control centre immediately, even if there are no symptoms.

Missed Dose:

If you have forgotten or missed a dose, take it as soon as you remember. However, if it is almost time for your next dose, skip the missed dose and take your next dose at the usual time. Do not double the doses.

What are the possible side effects from using pms-NIFEDIPINE ER?

These are not all the possible side effects you may have when taking pms-NIFEDIPINE ER. If you experience any side effects not listed here, tell your healthcare professional.

Side effects may include:

- headaches, anxiety, loss of sensation in a body part, burning or prickling sensation in the hands, arms, legs or feet, confusion, insomnia, nervousness, weakness, excessive muscle movement
- dizziness, fatigue
- nausea, upset stomach, indigestion, dry mouth

- enlargement of the gums
- muscle or joint pain, leg cramps, back pain
- rash, itch, sensitivity to the sun
- impotence, breast enlargement in men, menstrual disorder for women
- abnormally large production of urine, the need to urinate at night, lack of urine or incontinence
- eye pain

If any of these affects you severely, tell your healthcare professional.

pms-NIFEDIPINE ER can cause abnormal blood test results. Your healthcare professional will decide when to perform blood tests and will interpret the results.

Serious side effects and what to do about them			
Symptom / effect	Talk to your healthcare professional		Stop taking drug and get immediate medical help
	Only if severe	In all cases	
COMMON			
Wheezing or trouble breathing			✓
Angina pectoris (not enough oxygen to the heart muscle): pain or pressure in the chest, discomfort in the shoulder, arms, back, throat jaw or teeth.			✓
Edema: swelling of the hands, ankles, feet or legs	✓		
Abdominal cramps		✓	
Vomiting		✓	
Diarrhea		✓	
Irregular or fast heartbeat			✓
UNCOMMON			
Constipation		✓	
Allergic reaction/Angioedema: difficulty breathing or swallowing, rash or hives (redness, intense itching and burning), swelling of the face, throat, tongue, lips, eyes, hands, feet, ankles, or lower legs			✓
Hypotension (low blood pressure): dizziness, fainting, light-headedness, blurred vision, nausea, vomiting, fatigue (may occur when you go from lying or sitting to standing up)		✓	

Serious side effects and what to do about them			
Symptom / effect	Talk to your healthcare professional		Stop taking drug and get immediate medical help
	Only if severe	In all cases	
UNKNOWN FREQUENCY			
Liver disorder (including hepatitis and cholestasis): yellowing of the skin or eyes (jaundice), dark urine, pale stools, abdominal pain, nausea, vomiting, loss of appetite		✓	
Myocardial infarction (heart attack): pressure or squeezing pain between the shoulder blades, in the chest, jaw, left arm or upper abdomen, shortness of breath, dizziness, fatigue, light-headedness, clammy skin, sweating, indigestion, anxiety, feeling faint and possible irregular heartbeat.			✓
Toxic Epidermal Necrolysis (TEN) (severe skin reaction): redness, blistering and/or peeling of large areas of the skin, especially in the mouth and eyes			✓
Intestinal obstruction (blockage that stops or impairs passage of contents of intestines): cramping pain in abdomen that may begin suddenly, bloating, loss of appetite, pain that comes and goes but will then last, nausea and vomiting, constipation or diarrhea			✓

If you have a troublesome symptom or side effect that is not listed here or becomes bad enough to interfere with your daily activities, tell your healthcare professional.

Reporting Side Effects

You can report any suspected side effects associated with the use of health products to Health Canada by:

- Visiting the Web page on Adverse Reaction Reporting (<https://www.canada.ca/en/health-canada/services/drugs-health-products/medeffect-canada/adverse-reaction-reporting.html>) for information on how to report online, by mail or by fax; or
- Calling toll-free at 1-866-234-2345.

Note: Contact your health professional if you need information about how to manage your side effects. The Canada Vigilance Program does not provide medical advice.

Storage:

- Store between 15°C and 30°C. Protect from light and humidity.
- Keep out of reach and sight of children.
- Ask your healthcare professional about the best way to dispose of any expired medicine or medicine no longer needed.

If you want more information about pms-NIFEDIPINE ER:

- Talk to your healthcare professional.
- Find the full product monograph that is prepared for healthcare professionals and includes this Patient Medication Information by visiting the Health Canada website (<https://www.canada.ca/en/health-canada/services/drugs-health-products/drug-products/drug-product-database.html>); the manufacturer's website www.pharmascience.com, or by calling 1-888-550-6060.

This leaflet was prepared by Pharmascience Inc.

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