



National Agency for Food & Drug Administration & Control (NAFDAC)

Registration & Regulatory Affairs (R & R) Directorate

SUMMARY OF PRODUCT CHARACTERISTICS (SmPC)

MICRO LABS LIMITED, INDIA
SUMMARY OF PRODUCT CHARACTERISTICS
FENOFIBRATE CAPSULES 200 mg (FENROSE-200)



1. NAME OF THE MEDICINAL PRODUCT

Fenofibrate Capsules

FENROSE

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

Each Capsule contains:

Fenofibrate BP (Micronized)..... 200 mg

For the full list of excipients, see section 6.1.

3. PHARMACEUTICAL FORM

Capsules

Light blue/white colored '0' size capsule 'MICRO/MICRO' printing on capsule shell containing white powder

4. CLINICAL PARTICULARS

4.1 Therapeutic indications:

Fenofibrate capsules are indicated for:

Treatment of Hypercholesterolemia

Treatment of Hypertriglyceridemia

4.2 Posology and method of administration

Patients should be placed on an appropriate lipid-lowering diet before receiving Fenofibrate and should continue this diet during treatment with Fenofibrate. Fenofibrate should be given with meals, thereby optimizing the bioavailability of the medication.

For the treatment of adult patients with primary hypercholesterolemia or mixed hyperlipidemia, the initial dose of Fenofibrate is 200 mg per day.

For adult patients with hypertriglyceridemia, the initial dose is 67 to 200 mg per day.

Dosage should be individualized according to patient response, and should be adjusted if necessary following repeat lipid determinations at 4 to 8 week intervals. The maximum dose is 200 mg per day.

Treatment with Fenofibrate should be initiated at a dose of 67 mg/day in patients having impaired renal function, and increased only after evaluation of the effects on renal function and lipid levels at this dose.

In the elderly, the initial dose should likewise be limited to 67 mg/day.



Lipid levels should be monitored periodically and consideration should be given to reducing the dosage of Fenofibrate if lipid levels fall significantly below the targeted range.

4.3 Contraindications

- Fenofibrate is contraindicated in patients who exhibit hypersensitivity to Fenofibrate.
- Fenofibrate is contraindicated in patients with hepatic or severe renal dysfunction, including primary biliary cirrhosis, and patients with unexplained persistent liver function abnormality.
- Fenofibrate is contraindicated in patients with preexisting gallbladder disease

4.4 Special warnings and precautions for use

WARNINGS

Liver Function

Fenofibrate at doses equivalent to 134 mg to 200 mg Fenofibrate per day has been associated with increases in serum transaminases [AST (SGOT) or ALT (SGPT)]. In a pooled analysis of 10 placebo-controlled trials, increases to > 3 times the upper limit of normal occurred in 5.3% of patients taking fenofibrate versus 1.1% of patients treated with placebo. When transaminase determinations were followed either after discontinuation of treatment or during continued treatment, a return to normal limits was usually observed. The incidences of increases in transaminase related to fenofibrate therapy appear to be dose related. In an 8-week dose-ranging study, the incidence of ALT or AST elevations to at least three times the upper limit of normal was 13% in patients receiving dosages equivalent to 134 mg to 200 mg fenofibrate per day and was 0% in those receiving dosages equivalent to 34 mg or 67 mg of fenofibrate per day or placebo. Hepatocellular, chronic active and cholestatic hepatitis associated with fenofibrate therapy have been reported after exposures of weeks to several years. In extremely rare cases, cirrhosis has been reported in association with chronic active hepatitis.

Regular periodic monitoring of liver function, including serum ALT (SGPT) should be performed for the duration of therapy with fenofibrate, and therapy discontinued if enzyme levels persist above three times the normal limit.

Cholelithiasis

Fenofibrate, like clofibrate and gemfibrozil, may increase cholesterol excretion into the bile, leading to Cholelithiasis. If Cholelithiasis is suspected, gallbladder studies are indicated. Fenofibrate therapy should be discontinued if gallstones are found.

Concomitant Oral Anticoagulants



Caution should be exercised when anticoagulants are given in conjunction with fenofibrate because of the potentiation of coumarin type anticoagulants in prolonging the prothrombin time/INR. The dosage of the anticoagulant should be reduced to maintain the prothrombin time/INR at the desired level to prevent bleeding complications. Frequent prothrombin time/INR determinations are advisable until it has been definitely determined that the prothrombin time/INR has stabilized.

Concomitant HMG-CoA Reductase Inhibitors

The combined use of fenofibrate and HMG-CoA reductase inhibitors should be avoided unless the benefit of further alterations in lipid levels is likely to outweigh the increased risk of this drug combination.

In a single-dose drug interaction study in 23 healthy adults the concomitant administration of fenofibrate and pravastatin resulted in no clinically important difference in the pharmacokinetics of fenofibric acid, pravastatin or its active metabolite 3 α -hydroxy is pravastatin when compared to either drug given alone.

The combined use of fibric acid derivatives and HMG-CoA reductase inhibitors has been associated, in the absence of a marked pharmacokinetic interaction, in numerous case reports, with rhabdomyolysis, markedly elevated creatine kinase (CK) levels and myoglobinuria, leading in a high proportion of cases to acute renal failure.

The use of fibrates alone, including fenofibrate capsules (micronized) may occasionally be associated with myositis, myopathy, or rhabdomyolysis. Patients receiving fenofibrate and complaining of muscle pain, tenderness, or weakness should have prompt medical evaluation for myopathy, including serum creatine kinase level determination. If myopathy/myositis is suspected or diagnosed, fenofibrate therapy should be stopped.

Mortality

The effect of fenofibrate on coronary heart disease morbidity and mortality and non-cardiovascular mortality has not been established.

Other Considerations

In the Coronary Drug Project, a large study of post myocardial infarction of patients treated for 5 years with clofibrate, there was no difference in mortality seen between the clofibrate group and the placebo group. There was however, a difference in the rate of cholelithiasis and cholecystitis requiring surgery between the two groups (3.0% vs. 1.8%).



Because of chemical, pharmacological, and clinical similarities between fenofibrate, clofibrate, and gemfibrozil, the adverse findings in 4 large randomized, placebo-controlled clinical studies with these other fibrate drugs may also apply to fenofibrate.

In a study conducted by the World Health Organization (WHO), 5000 subjects without known coronary artery disease were treated with placebo or clofibrate for 5 years and followed for an additional one year. There was a statistically significant, higher age-adjusted all-cause mortality in the clofibrate group compared with the placebo group (5.70% vs. 3.96%, $p < 0.01$). Excess mortality was due to a 33% increase in non-cardiovascular causes, including malignancy, post-cholecystectomy complications, and pancreatitis. This appeared to confirm the higher risk of gallbladder disease seen in clofibrate-treated patients studied in the Coronary Drug Project.

The Helsinki Heart Study was a large ($n=4081$) study of middle-aged men without a history of coronary artery disease. Subjects received either placebo or gemfibrozil for 5 years, with a 3.5 year open extension afterward. Total mortality was numerically higher in the gemfibrozil randomization group but did not achieve statistical significance ($p=0.19$, 95% confidence interval for relative risk G:P=.91-1.64). Although cancer deaths trended higher in the gemfibrozil group ($p=0.11$), cancers (excluding basal cell carcinoma) were diagnosed with equal frequency in both study groups. Due to the limited size of the study, the relative risk of death from any cause was not shown to be different than that seen in the 9 year follow-up data from World Health Organization study (RR=1.29). Similarly, the numerical excess of gallbladder surgeries in the gemfibrozil group did not differ statistically from that observed in the WHO study. A secondary prevention component of the Helsinki Heart Study enrolled middle-aged men excluded from the primary prevention study because of known or suspected coronary heart disease. Subjects received gemfibrozil or placebo for 5 years. Although cardiac deaths trended higher in the gemfibrozil group, this was not statistically significant (hazard ratio 2.2, 95% confidence interval: 0.94-5.05).

The rate of gallbladder surgery was not statistically significant between study groups, but did trend higher in the gemfibrozil group, (1.9% vs. 0.3%, $p=0.07$).

There was a statistically significant difference in the number of appendectomies in the gemfibrozil group (6/311 vs. 0/317, $p=0.029$).

PRECAUTIONS

Initial Therapy

Laboratory studies should be done to ascertain that the lipid levels are consistently abnormal before instituting fenofibrate therapy. Every attempt should be made to control serum lipids with appropriate



diet, exercise, weight loss in obese patients, and control of any medical problems such as diabetes mellitus and hypothyroidism that are contributing to the lipid abnormalities. Medications known to exacerbate hypertriglyceridemia (beta blockers, thiazides, estrogens) should be discontinued or changed if possible prior to consideration of triglyceride-lowering drug therapy.

Continued Therapy

Periodic determination of serum lipids should be obtained during initial therapy in order to establish the lowest effective dose of Fenofibrate capsules. Therapy should be withdrawn in patients who do not have an adequate response after two months of treatment with the maximum recommended dose of 200 mg per day.

Pancreatitis

Pancreatitis has been reported in patients taking fenofibrate, gemfibrozil, and clofibrate. This occurrence may represent a failure of efficacy in patients with severe hypertriglyceridemia, a direct drug effect, or a secondary phenomenon mediated through biliary tract stone or sludge formation with obstruction of the common bile duct.

Hypersensitivity Reactions

Acute hypersensitivity reactions including severe skin rashes requiring patient hospitalization and treatment with steroids have occurred very rarely during treatment with fenofibrate, including rare spontaneous reports of Stevens-Johnson syndrome, and toxic epidermal necrolysis. Urticaria was seen in 1.1 vs. 0%, and rash in 1.4 vs. 0.8% of fenofibrate and placebo patients respectively in controlled trials.

Hematologic Changes

Mild to moderate hemoglobin, hematocrit, and white blood cell decreases have been observed in patients following initiation of fenofibrate therapy. However, these levels stabilize during long-term administration. Extremely rare spontaneous reports of thrombocytopenia and agranulocytosis have been received during post-marketing surveillance outside of the U.S. Periodic blood counts are recommended during the first 12 months of fenofibrate administration.

Skeletal Muscle

The use of fibrates alone, including fenofibrate, may occasionally be associated with myopathy. Treatment with drugs of the fibrate class has been associated on rare occasions with rhabdomyolysis,



usually in patients with impaired renal function. Myopathy should be considered in any patient with diffuse myalgia's, muscle tenderness or weakness, and/or marked elevations of creatine phosphokinase levels. Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever. CPK levels should be assessed in patients reporting these symptoms, and fenofibrate therapy should be discontinued if markedly elevated CPK levels occur or myopathy is diagnosed.

4.5 Interaction with other medicinal products and other forms of interaction

Caution should be exercised when coumarin anticoagulants are given in conjunction with Fenofibrate. The dosage of the anticoagulants should be reduced to maintain the prothrombin time/inr at the desired level to prevent bleeding complications.

Frequent prothrombin time/inr determinations are advisable until it has been definitely determined that the prothrombin time/inr has stabilized.

HMG-CoA Reductase Inhibitors

The combined use of fenofibrate and HMG-CoA reductase inhibitors should be avoided unless the benefit of further alterations in lipid levels is likely to outweigh the increased risk of this drug combination.

Resins

Since bile acid sequestrants may bind other drugs given concurrently, patients should take FENOFIBRATE at least 1 hour before or 4 to 6 hours after a bile acid binding resin to avoid impeding its absorption.

Cyclosporine

Because cyclosporine can produce nephrotoxicity with decreases in creatinine clearance and rises in serum creatinine, and because renal excretion is the primary elimination route of fibrate drugs including fenofibrate, there is a risk that an interaction will lead to deterioration. The benefits and risks of using fenofibrate with immunosuppressant's and other potentially nephrotoxic agents should be carefully considered and the lowest effective dose employed.

4.6 Pregnancy and lactation

Pregnancy

There are no adequate and well-controlled studies in pregnant women. Fenofibrate should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

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Lactation:

Fenofibrate should not be used in nursing mothers. Because of the potential for tumorigenicity seen in animal studies, a decision should be made whether to discontinue nursing or to discontinue the drug.

4.7 Effects on ability to drive and use machines

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

4.8 Undesirable effects

Adverse events reported by 2% or more of patients treated with fenofibrate during the double-blind, placebo-controlled trials, regardless of causality, are listed in the table below. Adverse events led to discontinuation of treatment in 5.0% of patients treated with fenofibrate and in 3.0% treated with placebo. Increases in liver function tests were the most frequent events, causing discontinuation of fenofibrate treatment in 1.6% of patients in double-blind trials.

BODY SYSTEM Adverse Event	Fenofibrate* (N=439)	PLACEBO (N=365)
BODY AS A WHOLE		
Abdominal Pain	4.6%	4.4%
Back pain	3.4%	2.5%
Headache	3.2%	2.7%
Asthenia	2.1%	3.0%
Flu Syndrome	2.1%	2.7%
DIGESTIVE		
Liver Function Tests Abnormal	7.5%†	1.4%
Diarrhea	2.3%	4.1%
Nausea	2.3%	1.9%
Constipation	2.1%	1.4%
METABOLIC AND NUTRITIONAL DISORDERS		
SPGT Increased	3.0%	1.6%
Creatine Phosphokinase Increased	3.0%	1.4%
SGOT Increased	3.4%†	0.5%
RESPIRATORY		



Respiratory Disorder	6.2%	5.5%
Rhinitis	2.3%	1.1%

*Dosage equivalent to 200 mg FENOFIBRATE [Fenofibrate capsules (micronized)]

†Significantly different from Placebo

BODY AS A WHOLE: Chest pain, pain (unspecified), infection, malaise, allergic reaction, cyst, hernia, fever, photosensitivity reaction, and accidental injury.

CARDIOVASCULAR SYSTEM: Angina pectoris, hypertension, vasodilatation, coronary artery disorder, electrocardiogram abnormal, ventricular extra systoles, myocardial infarct, peripheral vascular disorder, migraine, varicose vein, cardiovascular disorder, hypotension, palpitation, vascular disorder, arrhythmia, phlebitis, tachycardia, extra systoles, and atrial fibrillation.

DIGESTIVE SYSTEM: Dyspepsia, flatulence, nausea, increased appetite, gastroenteritis, cholelithiasis, rectal disorder, esophagitis, gastritis, colitis, tooth disorder, vomiting, anorexia, gastrointestinal disorder, duodenal ulcer, nausea and vomiting, peptic ulcer, rectal hemorrhage, liver fatty deposit, cholecystitis, eructation, gamma glutamyl trans peptidase, and diarrhea.

ENDOCRINE SYSTEM: Diabetes mellitus.

HEMIC AND LYMPHATIC SYSTEM: Anemia, leukopenia, ecchymosis, eosinophilia, lymphadenopathy, and thrombocytopenia.

METABOLIC AND NUTRITIONAL DISORDERS: Creatinine increased, weight gain, hypoglycemia, gout, weight loss, edema, hyperuricemia, and peripheral edema.

MUSCULOSKELETAL SYSTEM: Myositis, myalgia, arthralgia, arthritis, tenosynovitis, joint disorder, arthrosis, leg cramps, bursitis, and myasthenia.

NERVOUS SYSTEM: Dizziness, insomnia, depression, vertigo, libido decreased anxiety, paresthesia, dry mouth, hypertonia, nervousness, neuralgia, and somnolence.

RESPIRATORY SYSTEM: Pharyngitis, bronchitis, coughs increased, dyspnea, asthma, pneumonia, laryngitis, and sinusitis.

SKIN AND APPENDAGES: Rash, pruritus, eczema, herpes zoster, urticaria, acne, sweating, fungal dermatitis, skin disorder, alopecia, contact dermatitis, herpes simplex, maculopapular rash, nail disorder, and skin ulcer.

SPECIAL SENSES: Conjunctivitis, eye disorder, amblyopia, ear pain, otitis media, abnormal vision, cataract specified, and refraction disorder.

UROGENITAL SYSTEM: Urinary frequency, prostatic disorder, dysuria, kidney function abnormal, urolithiasis, gynecomastia, unintended pregnancy, vaginal moniliasis, and cystitis.

**4.9 Overdose**

There is no specific treatment for overdose with fenofibrate. General supportive care of the patient is indicated, including monitoring of vital signs and observation of clinical status, should an overdose occur. If indicated, elimination of unabsorbed drug should be achieved by emesis or gastric lavage; usual precautions should be observed to maintain the airway. Because fenofibrate is highly bound to plasma proteins, hemodialysis should not be considered.

5. PHARMACOLOGICAL PROPERTIES**5.1 Pharmacodynamic properties**

A variety of clinical studies have demonstrated that elevated levels of total cholesterol (total-C), low density lipoprotein cholesterol (LDL-C), and Apo lipoprotein B (apo B), an LDL membrane complex, are associated with human atherosclerosis. Similarly, decreased levels of high density lipoprotein cholesterol (HDL-C) and its transport complex, Apo lipoprotein A (apo AI and apo AII) are associated with the development of atherosclerosis. Epidemiologic investigations have established that cardiovascular morbidity and mortality vary directly with the level of total-C, LDL-C, and triglycerides, and inversely with the level of HDL-C. The independent effect of raising HDL-C or lowering triglycerides (TG) on the risk of cardiovascular morbidity and mortality has not been determined.

Fenofibric acid, the active metabolite of fenofibrate, produces reductions in total cholesterol, LDL cholesterol, apolipoprotein B, total triglycerides and triglyceride rich lipoprotein (VLDL) in treated patients. In addition, treatment with fenofibrate results in increases in high density lipoprotein (HDL) and Apo proteins apo AI and apo AII.

The effects of fenofibric acid seen in clinical practice have been explained in vivo in transgenic mice and in vitro in human hepatocyte cultures by the activation of peroxisome proliferator activated receptor α (PPAR α). Through this mechanism, fenofibrate increases lipolysis and elimination of triglyceride-rich particles from plasma by activating lipoprotein lipase and reducing production of apoproteins C-III (an inhibitor of lipoprotein lipase activity). The resulting fall in triglycerides produces an alteration in the size and composition of LDL from small, dense particles (which are thought to be atherogenic due to their susceptibility to oxidation), to large buoyant particles. These larger particles have a greater affinity for cholesterol receptors and are catabolized rapidly. Activation of PPAR α also induces an increase in the synthesis of apoproteins A-I, A-II and HDL-cholesterol.

Fenofibrate also reduces serum uric acid levels in hyperuricemic and normal individuals by increasing the urinary excretion of uric acid.

**5.2 Pharmacokinetic properties**

Clinical experience has been obtained with two different formulations of fenofibrate: a “micronized” and “non-micronized” formulation, which has been demonstrated to be bioequivalent. Comparisons of blood levels following oral administration of both formulations in healthy volunteers demonstrate that a single capsule containing 67 mg of the “micronized” formulation is bioequivalent to 100 mg of the “non-micronized” formulation. Three capsules containing 67 mg Fenofibrate are bioequivalent to a single 200 mg Fenofibrate capsule.

Absorption

The absolute bioavailability of fenofibrate cannot be determined as the compound is virtually insoluble in aqueous media suitable for injection. However, fenofibrate is well absorbed from the gastrointestinal tract. Following oral administration in healthy volunteers, approximately 60% of a single dose of radiolabelled fenofibrate appeared in urine, primarily as fenofibric acid and its glucuronate conjugate, and 25% was excreted in the feces. Peak plasma levels of fenofibric acid occur within 6 to 8 hours after administration.

The absorption of fenofibrate is increased when administered with food. With micronized fenofibrate, the absorption is increased by approximately 35% under fed as compared to fasting conditions.

Distribution

In healthy volunteers, steady-state plasma levels of fenofibric acid were shown to be achieved within 5 days of dosing with single oral doses equivalent to 67 mg fenofibrate and did not demonstrate accumulation across time following multiple dose administration. Serum protein binding was approximately 99% in normal and hyperlipidemia subjects.

Metabolism

Following oral administration, fenofibrate is rapidly hydrolyzed by esterases to the active metabolite, fenofibric acid; no unchanged fenofibrate is detected in plasma.

Fenofibric acid is primarily conjugated with glucuronic acid and then excreted in urine. A small amount of fenofibric acid is reduced at the carbonyl moiety to a benzhydrol metabolite which is, in turn, conjugated with glucuronic acid and excreted in urine.

In vivo metabolism data indicate that neither fenofibrate nor fenofibric acid undergo oxidative metabolism (e.g., cytochrome P450) to a significant extent.



Excretion

After absorption, fenofibrate is mainly excreted in the urine in the form of metabolites, primarily fenofibric acid and fenofibric acid glucuronide. After administration of radiolabelled fenofibrate, approximately 60% of the dose appeared in the urine and 25% was excreted in the feces.

Fenofibric acid is eliminated with a half-life of 20 hours, allowing once daily administration in a clinical setting.

Special Populations

Geriatrics

In elderly volunteers 77 to 87 years of age, the oral clearance of fenofibric acid following a single oral dose of fenofibrate was 1.2 L/h, which compares to 1.1 L/h in young adults. This indicates that a similar dosage regimen can be used in the elderly, without increasing accumulation of the drug or metabolites.

Pediatrics

Fenofibrate has not been investigated in adequate and well-controlled trials in pediatric patients.

Gender

No pharmacokinetic difference between males and females has been observed for fenofibrate.

Race

The influence of race on the pharmacokinetics of fenofibrate has not been studied however fenofibrate is not metabolized by enzymes known for exhibiting inter-ethnic variability. Therefore, inter-ethnic pharmacokinetic differences are very unlikely.

Renal Insufficiency

In a study in patients with severe renal impairment (creatinine clearance < 50 mL/min), the rate of clearance of fenofibric acid was greatly reduced, and the compound accumulated during chronic dosage. However, in patients having moderate renal impairment (creatinine clearance of 50 to 90 mL/min), the oral clearance and the oral volume of distribution of fenofibric acid are increased compared to healthy adults (2.1 L/h and 95 L versus 1.1 L/h and 30 L, respectively). Therefore, the dosage of fenofibrate should be minimized in patients who have severe renal impairment, while no modification of dosage is required in patients having moderate renal impairment.

Hepatic Insufficiency

No pharmacokinetic studies have been conducted in patients having hepatic insufficiency.

***Drug-drug Interactions***

In vitro studies using human liver microsomes indicate that fenofibrate and fenofibric acid are not inhibitors of cytochrome (CYP) P450 isoforms CYP3A4, CYP2D6, CYP2E1, or CYP1A2. They are weak inhibitors of CYP2C19 and CYP2A6, and mild-to moderate inhibitors of CYP2C9 at therapeutic concentrations. Potentiation of coumarin-type anti-coagulants has been observed with prolongation of the prothrombin time/INR. Bile acid sequestrants have been shown to bind other drugs given concurrently. Therefore, fenofibrate should be taken at least 1 hour before or 4 to 6 hours after a bile acid binding resin to avoid impeding its absorption..

5.3 Preclinical safety data

In a 24-month study in rats (10, 45, and 200 mg/kg; 0.3, 1, and 6 times the maximum recommended human dose on the basis of mg/meter² of surface area), the incidence of liver carcinoma was significantly increased at 6 times the maximum recommended human dose in males and females. A statistically significant increase in pancreatic carcinomas occurred in males at 1 and 6 times the maximum recommended human dose; there were also increases in pancreatic adenomas and benign testicular interstitial cell tumors at 6 times the maximum recommended human dose in males. In a second 24-month study in a different strain of rats (doses of 10 and 60 mg/kg; 0.3 and 2 times the maximum recommended human dose based on mg/meter² surface area), there were significant increases in the incidence of pancreatic acinar adenomas in both sexes and increases in interstitial cell tumors of the testes at 2 times the maximum recommended human dose.

A comparative carcinogenicity study was done in rats comparing three drugs: fenofibrate (10 and 70 mg/kg; 0.3 and 1.6 times the maximum recommended human dose), clofibrate (400 mg/kg; 1.6 times the human dose), and gemfibrozil (250 mg/kg; 1.7 times the human dose) (multiples based on mg/meter² surface area). Pancreatic acinar adenomas were increased in males and females on fenofibrate; hepatocellular carcinoma and pancreatic acinar adenomas were increased in males and hepatic neoplastic nodules in females treated with clofibrate; hepatic neoplastic nodules were increased in males and females treated with gemfibrozil while testicular interstitial cell tumors were increased in males on all three drugs. In a 21-month study in mice at doses of 10, 45, and 200 mg/kg (approximately 0.2, 0.7 and 3 times the maximum recommended human dose on the basis of mg/meter² surface area), there were statistically significant increases in liver carcinoma at 3 times the maximum recommended human dose in both males and females. In a second 18-month study at the same doses, there was a significant increase in liver carcinoma in male mice and liver adenoma in female mice at 3 times the maximum recommended human dose.



Electron microscopy studies have demonstrated peroxisomal proliferation following fenofibrate administration to the rat. An adequate study to test for peroxisome proliferation in humans has not been done, but changes in peroxisome morphology and numbers have been observed in humans after treatment with other members of the fibrate class when liver biopsies were compared before and after treatment in the same individual. Fenofibrate has been demonstrated to be devoid of mutagenic potential in the following tests: Ames, mouse lymphoma, chromosomal aberration and unscheduled DNA synthesis.

6. Pharmaceutical Particulars

6.1 List of excipients:

Pharmatose DCL 21

Pregelatinised starch

Sodium lauryl sulphate

Cross Povidone

Talc

Magnesium stearate

Colloidal silicon dioxide

HEG CAPS Size '0' Blue/White

6.2 Incompatibilities:

Not applicable

6.3 Shelf life:

36 Months from the date of Manufacturing.

6.4 Special precautions for storage:

Store below 30°C. Keep out from the reach of children

6.5 Nature and contents of container:

Blister Pack of 10 Capsules

6.6 Special precautions for disposal and other handling

No special requirements.

MICRO LABS LIMITED, INDIA
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FENOFIBRATE CAPSULES 200 mg (FENROSE-200)



7. Marketing Authorization Holder:

MICRO LABS LIMITED
#31, Race Course Road
Bangalore-560001
INDIA

8. Marketing Authorization Numbers

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9. Date of first authorization

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10. Date of revision of text

July 2021