

AUSTRALIAN PI – INSIG (INDAPAMIDE HEMIHYDRATE TABLETS)

1 NAME OF THE MEDICINE

Indapamide hemihydrate

2 QUALITATIVE AND QUANTITATIVE COMPOSITION

Excipients with known effect: Lactose monohydrate

For the full list of excipients, see Section 6.1 List of excipients.

3 PHARMACEUTICAL FORM

Each tablet contains 2.5 mg Indapamide hemihydrate

4 CLINICAL PARTICULARS

4.1 THERAPEUTIC INDICATIONS

Management of essential hypertension. It may be tried as a sole therapeutic agent in the treatment of mild to moderate hypertension. Normally In sig is used as the initial agent in multiple drug regimens.

4.2 DOSE AND METHOD OF ADMINISTRATION

Adults: 1 tablet (indapamide 2.5 mg) daily to be taken in the morning. The action of In sig is progressive and whilst the optimum reduction in blood pressure is usually seen after four weeks, a further small but useful reduction in blood pressure may be observed over the following four to six weeks. A larger dose than 1 tablet (2.5 mg) of In sig daily is not recommended as there is little additional antihypertensive effect, whilst the diuretic effect becomes more prominent.

A single tablet of In sig may effectively be combined with the following antihypertensive agents: β -blockers, methyldopa, clonidine, prazosin, and angiotensin converting enzyme inhibitors.

Combination with a diuretic agent is not recommended as significant electrolyte disturbances may ensue.

Indapamide has a slight but significant carry-over hypotensive effect lasting up to one to two weeks after the cessation of therapy.

Contact the Poisons Information Centre on 13 11 26 for advice on the management of an overdose.

4.3 CONTRAINDICATIONS

Anuria, Severe renal failure, progressive and severe oliguria, hepatic coma, hepatic encephalopathy or severe impairment of liver function, Hypokalaemia. Known hypersensitivity to indapamide, other sulfonamide derivatives, or to any of the excipients ingredients in In sig tablets.

4.4 SPECIAL WARNINGS AND PRECAUTIONS FOR USE

Electrolyte changes observed with indapamide become more prominent at doses above 2.5 mg / day. The daily maximum recommended dose of indapamide is 2.5 mg administered as one tablet, since doses above 2.5 mg only increase the diuretic effect and electrolyte disturbances consequent to diuresis without any further appreciable antihypertensive effect.

Hypokalaemia may occur at all doses. Symptoms of hypokalaemia include weakness, cramps, and cardiac dysrhythmias. Hypokalaemia is a particular hazard in digitalised patients; dangerous or fatal arrhythmias may be precipitated. Although indapamide 2.5 mg daily can be safely administered to hypertensive patients with impaired renal function, caution should be observed when the drug is administered to patients with severe renal impairment since the unchanged drug is excreted primarily by the renal route, and plasma concentrations are elevated (see section 5.2 Pharmacokinetic properties and section 4.4 Special warnings and precautions for use).

Uric acid

Hyperuricaemia may occur during administration of indapamide. Rarely gout has been reported. Tendency to gout attacks may be increased in patients with hyperuricaemia.

Lithium

In general, diuretics should not be given with lithium because they reduce its renal clearance and add a high risk of lithium toxicity (see section 4.5 Interactions with other medicines and other forms of interactions).

Photosensitivity

Cases of photosensitivity reactions have been reported with thiazides and thiazide-related diuretics. It is recommended to stop treatment if a photosensitivity reaction occurs during treatment. If re-administration of the diuretic is deemed necessary, it is recommended that areas exposed to the sun or to artificial UVA are protected.

Lactose

Insig tablets contain lactose. Patients with an intolerance to lactose, rare hereditary problems of galactose intolerance, the Lapp lactase deficiency or glucose-galactose malabsorption should not take this medicine.

Water and electrolyte balance

Patients receiving indapamide should be monitored for signs and symptoms of fluid or electrolyte imbalance; namely hyponatraemia, hypochloraemia and hypokalaemia. Blood urea, nitrogen and uric acid should be assessed during therapy. Hypokalaemia will be more common in association with concomitant steroid or ACTH therapy and with inadequate electrolyte intake.

The signs of electrolyte imbalance are dryness of the mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscle fatigue, hypotension, oliguria, gastrointestinal disturbances such as nausea and vomiting, tachycardia and ECG changes.

Plasma sodium

This must be measured before starting treatment, then subsequently at regular intervals. The decrease in plasma sodium may initially be asymptomatic. Regular monitoring is therefore essential and should be more frequent in the elderly and in patients with cirrhosis (see section 4.8 Adverse effects (undesirable effects) and section 4.9 Overdose). Treatment with any diuretic may cause hyponatraemia, sometimes with very serious consequences. Hyponatraemia with hypovolaemia may be responsible for dehydration and orthostatic hypotension. Concomitant loss of chloride ions may lead to secondary compensatory metabolic alkalosis.

Plasma Potassium

Potassium depletion with hypokalaemia is the major risk of thiazide and related diuretics. The risk of onset of hypokalaemia (<3.4 mmol/L) must be prevented in certain high-risk populations, i.e. the elderly, malnourished and/or polymedicated, cirrhotic patients with oedema and ascites, and patients with coronary artery disease and/or heart failure. In these patients, hypokalaemia increases the cardiac toxicity of digitalis preparations and increases the risk of arrhythmias.

Hypokalaemia will be more common when combined with a steroid or adrenocorticotrophic (ACTH) treatment and when electrolyte intake is inadequate.

Individuals with a long QT interval, whether the origin is congenital or iatrogenic, are also at increased risk as hypokalaemia and bradycardia, are predisposing factors to the onset of severe arrhythmias, in particular, potentially fatal Torsades de pointes.

Plasma potassium should be measured in the first week of treatment. More frequent monitoring of plasma potassium is required in all the situations indicated above.

Hypokalaemia, if detected, should be corrected.

Plasma calcium

Diuretic treatment should be withdrawn before the investigation of parathyroid function. Thiazide and related diuretics may decrease urinary calcium excretion and cause a slight and transitory rise in calcium. Frank hypercalcaemia may be due to previously unrecognised hyperparathyroidism.

Orthostatic hypotension may occur and may be potentiated by alcohol, barbiturates, narcotics or concurrent therapy with other antihypertensives.

When Insig is given with other non-diuretic antihypertensive agents, the effects on blood pressure are additive.

Sulfonamide derivatives have been reported to exacerbate or activate systemic lupus erythematosus. Serious allergic skin reactions (such as Stevens-Johnson syndrome) have also occasionally been reported to be associated with sulfonamides. These possibilities should be kept in mind with the use of indapamide.

Blood glucose

Monitoring of blood glucose is important in patients with diabetes, in particular in the presence of hypokalaemia.

Athletes

Insig contains indapamide which may give a positive reaction in doping tests.

Use in Renal Impairment: Although indapamide 2.5 mg daily can safely be administered to hypertensive patients with impaired renal function, the treatment should be discontinued if increasing azotemia and oliguria occur. Studies in functionally anephric patients for one month undergoing chronic haemodialysis have not shown evidence of drug accumulation, despite the fact that indapamide is not dialysable.

A study in patients with impaired renal function demonstrated that patients with severe renal impairment (creatinine clearance 11-35 mL/min) had impaired clearance of indapamide and elevated plasma levels of the drug.

Use in Hepatic Impairment: Special caution should be used in treating patients with severe hepatic disease to avoid metabolic alkalosis in cases of potassium depletion which may precipitate episodes of hepatic encephalopathy. Treatment with the diuretic must be stopped immediately if this occurs.

Use in the elderly: No data available

Paediatric use: Safety and effectiveness have not been established.

Effects on laboratory tests: Hyperuricaemia (0.4%). Hyperglycaemia (0.4%) (see section 4.8 Adverse effects (undesirable effects))

The following values represent the maximum variations from pre-treatment values in occasional patients at some stage during, but not necessarily throughout, treatment. Blood uric acid up 8.6%, blood glucose up 6%, BUN up 5.7%, blood creatinine up 3.6%.

4.5 INTERACTIONS WITH OTHER MEDICINES AND OTHER FORMS OF INTERACTIONS

Potential interactions may occur with lithium, digoxin, alcohol, narcotics and barbiturates; Refer to section 4.4 Special warnings and precautions for use for further information.

No interactions have been reported between indapamide and oral hypoglycaemic agents, anticoagulants, uricosurics and anti-inflammatory agents.

It is recommended that the drug not be used in combination with a diuretic agent since the combination may produce hypokalaemia and hyperuricaemia.

COMBINED USE WHICH IS NOT RECOMMENDED

LITHIUM

The combined use of INSIG and lithium may result in increased plasma lithium levels and produce symptoms of overdose (due to decreased urinary lithium excretion). If diuretics are necessary, careful monitoring of plasma lithium and dose adjustment are required.

Combined use which requires special care:

TORSADES DE POINTES-INDUCING DRUGS

The combined use of INSIG and *Torsades de pointes*-inducing drugs, including the following, is not recommended due to the increased risk of ventricular arrhythmias, particularly *Torsades de pointes* (hypokalaemia is a risk factor). Medicines which induce Torsade de pointes include:

- class Ia antiarrhythmics (e.g. disopyramide)
- class III antiarrhythmics (e.g. amiodarone, sotalol)
- some antipsychotics: phenothiazines (e.g. trifluoperazine), benzamides (e.g. amisulpride, sulphiride) and butyrophenones (e.g. droperidol, haloperidol)
- others: diphemanil, erythromycin IV, pentamidine, moxifloxacin.

Monitor (using plasma electrolytes and ECG) for hypokalaemia and correct, if required, before using INSIG and a *Torsades de pointes*-inducing drug in combination.

NSAIDs (SYSTEMIC ROUTE) INCLUDING COX-2 SELECTIVE INHIBITORS, HIGH DOSE SALICYLIC ACID (≥ 3 G/DAY)

Due to the risk of acute renal failure in patients with dehydration as a result of decreased glomerular filtration, it is recommended that hydration and renal function be monitored at the start of treatment. Combined use with NSAIDs may also result in a reduction in the antihypertensive effect of INSIG.

ANGIOTENSIN CONVERTING ENZYME (ACE) INHIBITORS

Combined use with ACE inhibitors in the presence of pre-existing sodium depletion (particularly in patients with renal artery stenosis) may increase the risk of sudden hypotension and/or acute renal failure.

In patients with hypertension when prior diuretic treatment may have caused sodium depletion, it is necessary to either:

- stop the diuretic three days before starting treatment with the ACE inhibitor, and restart a hypokalaemic diuretic if necessary; or
- give low initial doses of the ACE inhibitor and increase the dose gradually.

In patients with congestive heart failure, initiation with a very low dose of ACE inhibitor, possibly after a reduction in the dose of the hypokalaemic diuretic, is recommended.

The monitoring of renal function (plasma creatinine) during the first weeks of treatment with an ACE inhibitor is recommended in all patients.

Other compounds causing hypokalaemia: amphotericin B (IV), gluco- and mineralocorticoids (systemic route), stimulant laxatives.

Due to the increased risk of hypokalaemia (additive effect):

- monitoring, and correction if required, of plasma potassium (especially during treatment with digoxin) is recommended
- the use of non-stimulant laxatives is recommended.

BACLOFEN

Due to the increased risk of antihypertensive effects, it is recommended that hydration and renal function be monitored at the start of treatment.

Digoxin

Monitoring of plasma potassium and ECG is recommended due to the increased risk of hypokalaemia following co-administration of INSIG and digoxin.

Allopurinol

Combined use with indapamide may increase the incidence of hypersensitivity reactions to allopurinol.

Combinations to be taken into consideration:

POTASSIUM-SPARING DIURETICS (AMILORIDE, SPIRONOLACTONE, TRIAMTERENE)

Due to the increased risk of either hyperkalaemia or hypokalaemia (particularly in patients with renal failure or diabetes), care should be taken when co-administering potassium-sparing diuretics. Plasma potassium and ECG should be monitored and, if necessary, treatment reviewed.

Metformin

Do not co-administer with metformin when plasma creatinine exceeds 15 mg/L (135 µmol/L) in men and 12 mg/L (110 µmol/L) in women due to the increased risk of metformin induced lactic acidosis as a result of the possibility of functional renal failure associated with diuretics and more particularly with loop diuretics.

IODINATED CONTRAST MEDIA

Adequate hydration before administration of the iodinated compound is recommended due to an increased risk of acute renal failure resulting from dehydration, particularly when large doses of iodinated contrast media are used.

Imipramine-like antidepressants, neuroleptics

Caution is recommended with these combinations due to an increased antihypertensive effect and increased risk of orthostatic hypotension.

Calcium (salts)

Caution is recommended with this combination due to the risk of hypercalcaemia resulting from decreased urinary elimination of calcium.

Cyclosporin, tacrolimus

Caution is recommended with this combination due to the risk of increased plasma creatinine without any change in circulating cyclosporin levels, even in the absence of water/sodium depletion.

Corticosteroids, (systemic route)

Caution is recommended with this combination due to the risk of decreased antihypertensive effect (water/sodium retention due to corticosteroids).

4.6 FERTILITY, PREGNANCY AND LACTATION

Effects on fertility

A reproductive toxicity study in rats showed no impairment of male or female fertility at oral indapamide doses up to 25 mg/kg/day, however, the number of implantation sites was reduced at the highest dose.

Use in pregnancy (Category C)

Indapamide should be avoided in pregnant women and should not be used to treat oedema in pregnancy. There are limited data with the use of indapamide in pregnant women. Prolonged exposure to thiazides during the third trimester of pregnancy can reduce maternal plasma volume as well as uteroplacental blood flow, which may cause foetal-placental ischaemia and growth retardation

Animal studies do not indicate direct or indirect harmful effects with respect to reproductive toxicity

Thiazides, related diuretics and loop diuretics enter the foetal circulation and may cause electrolyte disturbances. Neonatal thrombocytopenia has been reported with thiazides and related diuretics. Loop diuretics like frusemide and bumetanide are probably also associated with this risk. During the latter part of pregnancy products of this type should only be given on sound indications, and then in the lowest effective dose. Whilst animal studies have not suggested any teratogenic effect, indapamide is not recommended for administration to pregnant women unless the expected benefit outweighs the potential risk.

Use in lactation.

Indapamide should not be used during breast-feeding. Indapamide is excreted in human breast milk and the possible effect on the newborn is unknown and cannot be excluded. Indapamide is closely related to thiazide diuretics which have associated with a decrease in, or even suppression of, lactation. Hypersensitivity to sulphonamide-derived medicines and hypokalaemia might occur.

It is therefore not recommended that the drug be given to lactating women.

4.7 EFFECTS ON ABILITY TO DRIVE AND USE MACHINES

Indapamide does not affect vigilance but different reactions related to a decrease in blood pressure may occur in individual cases, especially at the start of treatment or when another antihypertensive agent is added. Treatment with any blood pressure lowering agent may, therefore, affect the ability to drive, cross the road safely or operate machinery.

4.8 ADVERSE EFFECTS (UNDESIRABLE EFFECTS)

In general, most adverse effects are mild and transient with the most frequently reported are: hypersensitivity reactions, mainly dermatological (in subjects with a predisposition to allergic and asthmatic reactions and macropapular rashes), asthenia, dizziness, headache, fatigue, muscle cramps, and gastrointestinal disturbances, usually occurring within the first month of treatment. Other adverse reactions have been non-specific. Cutaneous rash and impotence have been occasionally reported. Percentages shown below indicate the incidence in clinical trials.

The most severe and common adverse effect is the electrolyte imbalance. Electrolyte changes reported include: hypokalaemia (plasma potassium < 3.4 mmol/L) was seen in 25% of patients and < 3.2 mmol/l in 10% of patients after four to six weeks treatment. After 12 weeks treatment, the mean fall in plasma potassium was 0.41 mmol/L. Hypochloraemia 9.4%; hyponatraemia 3.1 %. The majority of adverse reactions concerning clinical or laboratory parameters are dose-dependent. Other adverse reactions have been nonspecific. Cutaneous rash and impotence have been occasionally reported. Percentages shown below indicate the incidence in clinical trials.

The following adverse effects have been observed with indapamide during treatment ranked according to the following frequencies: very common ($\geq 1/10$); common ($\geq 1/100$, < 1/10); uncommon ($\geq 1/1.000$, < 1/100); rare ($\geq 1/10.000$); very rare (<1/10.000); not known (cannot be estimated from the available data):

MedDRA System Organ Class	Adverse Effects	Frequency
Blood and the lymphatic System Disorders	Agranulocytosis	Very rare
	Aplastic anaemia	Very rare
	Haemolytic anaemia	Very rare
	Leucopenia	Very rare
	Thrombocytopenia	Very rare
Metabolism and Nutrition Disorders	Hypercalcaemia	Very rare
	Potassium depletion with hypokalaemia, particularly serious in certain high risk populations (see section 4.3 <i>CONTRAINDICATIONS and section 4.4 SPECIAL WARNINGS AND PRECAUTIONS FOR USE</i>)	Not known
	Hyponatraemia [†] (see section 4.4 <i>SPECIAL WARNINGS AND PRECAUTIONS FOR USE</i>)	Not known
Nervous System disorders	Vertigo	Rare
	Fatigue	Common
	Headache	Common
	Dizziness	Common

	Paresthesia	Rare
	Syncope [§]	Not known
	Drowsiness	Uncommon
	Sleepiness	Uncommon
	Insomnia	Uncommon
	Anxiety	Uncommon
	Weakness	Uncommon
Eye disorders	Myopia [§]	Not known
	Blurred vision [§]	Not known
	Visual impairment	Uncommon
Cardiac Disorders	Arrhythmia	Very rare
	Torsade de pointes (potentially fatal) [§] (see section 4.4 SPECIAL WARNINGS AND PRECAUTIONS FOR USE and see section 4.5 INTERACTIONS WITH OTHER MEDICINES AND OTHER FORMS OF INTERACTIONS)	Not known
	Palpitations	Very rare
	Chest pain	Very rare
Vascular Disorders	Hypotension	Very rare
Gastrointestinal Disorders	Vomiting	Uncommon
	Dyspepsia	Uncommon
	Abdominal pain	Uncommon
	Nausea	Rare
	Constipation	Rare
	Dry mouth	Rare
	Pancreatitis	Very rare
Hepatobiliary Disorders	Abnormal hepatic function	Very rare
	Possibility of onset of hepatic encephalopathy in case of hepatic insufficiency [§] (see SECTION 4.3 CONTRAINDICATIONS and see section 4.4 SPECIAL WARNINGS AND PRECAUTIONS FOR USE)	Not known
	Hepatitis [§]	Not known
Skin and Subcutaneous Tissue Disorder	Hypersensitivity reactions, mainly dermatological, in subjects with a predisposition to allergic and asthmatic reactions	Common
	Maculopapular rashes	Common
	Purpura	Uncommon
	Pruritis	Uncommon
	Angioedema	Very rare

	Urticaria	Very rare
	Toxic epidermic necrolysis	Very rare
	Stevens-Johnson Syndrome	Very rare
	Possible worsening of pre-existing acute disseminated lupus erythematosus [§]	Not known
	Photosensitivity reactions [§] (see <i>section 4.4 SPECIAL WARNINGS AND PRECAUTIONS FOR USE</i>)	Not known
Musculoskeletal Disorders	Muscle cramps	Common
Renal and Urinary Disorders	Renal failure	Very rare
	Cystitis	Uncommon
Investigations	Electrocardiogram QT prolonged [§] (see <i>section 4.4 SPECIAL WARNINGS AND PRECAUTIONS FOR USE and section 4.5 INTERACTIONS WITH OTHER MEDICINES AND OTHER FORMS OF INTERACTIONS</i>)	Not known
	Blood glucose increased ^{§‡} (see <i>section 4.4 SPECIAL WARNINGS AND PRECAUTIONS FOR USE</i>)	Not known
	Blood uric acid increased ^{§‡} (see <i>section 4.4 SPECIAL WARNINGS AND PRECAUTIONS FOR USE</i>)	Not known
	Elevated liver enzyme levels [§]	Not known

† Reported in clinical studies with the immediate release formulation of indapamide, and not seen in INSIG SR studies.

§ Reported for indapamide as a Post-Marketing Adverse Effect

‡ Appropriateness of treatment with INSIG must be very carefully weighed in patients with gout or diabetes.

Other adverse reactions, reported in clinical studies with the immediate release formulation of indapamide include the following:

Central Nervous System: lethargy, asthenia, Visual disturbance.

Gastrointestinal: anorexia, gastralgia, diarrhoea.

Musculoskeletal: joint pain, back pain, weakness of legs.

Cardiac disorders: tachycardia, ECG changes (nonspecific ST-T changes, U waves, left ventricular strain).

Vascular disorders: orthostatic hypotension

Urogenital: modification of libido, polyuria.

Endocrine: gout.

Skin and Subcutaneous Tissue Disorder: Rash

Other: tinnitus, malaise/fainting, sweat.

Laboratory abnormalities: BUN increase, blood creatinine increase

Reporting suspected adverse effects:

Reporting suspected adverse reactions after registration of this medicinal product is important. It allows continued monitoring of the benefit-risk balance of this medicinal product. Healthcare professionals are asked to report any suspected adverse reactions at <https://www.tga.gov.au/reporting-problems>.

4.9 OVERDOSE

Symptoms.

There have been no reports of overdosage. Based on the pharmacological activities of indapamide, overdosage may lead to excessive diuresis with electrolyte depletion. In cirrhotic patients, overdosage might precipitate hepatic coma.

Treatment.

There is no specific antidote. Treatment is symptomatic and supportive. Discontinue drug; induce emesis or perform gastric lavage; correct dehydration, electrolyte imbalance, hepatic coma and hypotension by established procedures.

For information on the management of overdose, contact the Poisons Information Centre on 13 11 16 (Australia).

5 PHARMACOLOGICAL PROPERTIES

5.1 PHARMACODYNAMIC PROPERTIES

Mechanism of action

Indapamide is an oral antihypertensive agent. The mechanism whereby indapamide exerts its antihypertensive action has not been completely elucidated; both vascular and renal actions have been implicated.

At a dose of 2.5 mg the renal effects of indapamide are minimal and the antihypertensive effect of indapamide has been attributed to a reduction in vascular reactivity to pressor amines. The finding that indapamide retains its antihypertensive activity in functionally anephric patients lends support to the hypothesis. The renal site of action of indapamide is the proximal segment of the distal tubule. Indapamide appears to have natriuretic properties (sodium and chloride being excreted in equivalent amounts) with less effect on kaliuresis or uric acid excretion. Only at doses greater than 2.5 mg / day is an appreciable increase in urinary volume observed in humans. No significant changes in plasma sodium levels have been observed in clinical studies. Significant hypokalaemia (plasma potassium <3.2 mmols / l has been reported in some 10% of patients.

Indapamide (2.5 mg daily) does not adversely affect serum triglycerides, LDL cholesterol, the LDL-HDL cholesterol ratio, or glucose tolerance.

Clinical trials

No data available

5.2 PHARMACOKINETIC PROPERTIES

Absorption

Possibly related to its high lipid solubility, absorption of indapamide from the gastrointestinal tract is rapid (within 0.5 to 1 hour after an oral dose) and complete. Bioavailability of the tablet formulation is 100% and is virtually unchanged with food or antacids.

Distribution

Indapamide is widely distributed throughout the body, with extensive binding to some specific sites. In blood, it is highly bound to red blood cells (80%) and, more specifically, to carbonic acid anhydrase (98%) without having any significant inhibiting activity on this enzyme. In plasma, it is relatively highly bound to plasma proteins (79%). It is also taken up to a significant degree in the vascular compartment, the drug has a relatively low apparent volume of distribution (approximately 60 L) and 40% of the dose is located in the blood one hour after administration.

Metabolism

After a single oral dose of 2.5 mg, as well as after repeated administration of 2.5 mg daily for 15 days, plasma elimination half-life of unchanged indapamide is biphasic with half-lives of 14 and 25 hours, indicating that once daily dosing is possible and that no change in kinetics occurs after repeated dosing. Both single and multiple dose data indicate that indapamide's kinetics are linear. Steady state plasma levels are reached within three to four days after starting treatment, and the drug does not accumulate in hypertensive patients with various degrees of renal insufficiency.

Indapamide is extensively metabolised in the liver.

Excretion

Following radioactivity studies using carbon-14, the main route of elimination is the urine, but only 5 to 7% of the dose is excreted into the urine as unchanged drug; 20 to 23% of total radioactivity is eliminated into the faeces. Renal clearance of indapamide (as unchanged drug) is approximately 5 mL / minute, representing less than 10% of systemic clearance.

The high lipid solubility of the indoline moiety confers to indapamide its highly localised binding to structures in the cardiovascular system.

5.3 PRECLINICAL SAFETY DATA

Genotoxicity – Indapamide was negative in mutagenicity tests in bacteria, and bone marrow micronucleus tests in mice. There was a decrease in weight gain of the F1 generation from rats treated orally at 2.5 mg/kg/day. Galactopoiesis was affected in the F1 generation from rats treated orally at 0.5 mg/kg/day and this led to increased mortality of the F2 generation during the first 48 hours of life. No embryo-foetal toxicity or teratogenic potential were seen in rats (up to 150 mg/kg/day) and in rabbits (up to 180 mg/kg/day).

Carcinogenicity – Carcinogenicity studies in mice and rats showed no evidence of tumourigenicity when indapamide was administered in the diet at levels up to 100mg/kg/day.

6 PHARMACEUTICAL PARTICULARS

6.1 LIST OF EXCIPIENTS

The Other ingredients of Insig tablets are lactose monohydrate, maize starch, magnesium stearate, povidone, OPASEAL Pharmaceutical Enteric - Phthalavin (Pvap) Solution P-2-0300G clear, purified talc, calcium carbonate, acacia, titanium dioxide, sucrose and OPAGLOS tablet core sealant product OPAGLOS 6000P OFF-WHITE.

6.2 INCOMPATIBILITIES

Incompatibilities were either not assessed or not identified as part of the registration of this medicine.

6.3 SHELF LIFE

In Australia, information on the shelf-life can be found on the public summary of the Australian Register of Therapeutic Goods (ARTG). The expiry date can be found on the packaging.

6.4 SPECIAL PRECAUTIONS FOR STORAGE

Store below 25°C, protect from light and moisture

6.5 NATURE AND CONTENTS OF CONTAINER

Insig are white, biconvex, sugar coated tablets

Insig are available in PVC/PVDC/Aluminium blisters of 60* and 90 tablets.

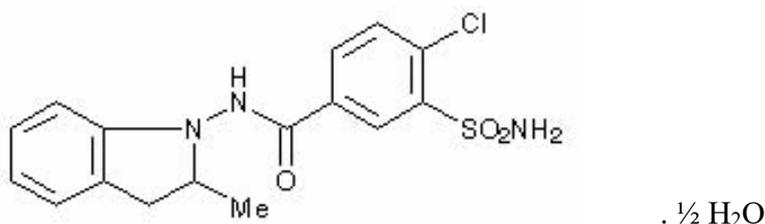
6.6 SPECIAL PRECAUTIONS FOR DISPOSAL

In Australia, any unused medicine or waste material should be disposed of by taking to your local pharmacy.

6.7 PHYSICOCHEMICAL PROPERTIES

Indapamide hemihydrate is a non-thiazide indole derivative of chlorosulfonamide. It is a white crystalline lipophilic powder, soluble in methanol, ethanol, acetic acid and ethyl acetate, very slightly soluble in ether, chloroform and benzene and practically insoluble in water.

Chemical structure



Chemical name: 4-chloro-N-(2-methyl-1-indolizinyl)-3-sulfamoyl benzamide hemihydrate.

Molecular weight: 374.85.

Molecular Formula: C₁₆H₁₆ClN₃O₃S, ½H₂O

CAS Number: [26807-65-8].

7 MEDICINE SCHEDULE (POISONS STANDARD)

S4 – Prescription only medicine

8 SPONSOR

Arrow Pharma Pty Ltd

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Australia

www.arrowpharma.com.au

9 DATE OF FIRST APPROVAL

7 January 2014

10 DATE OF REVISION

02 November 2018

SUMMARY TABLE OF CHANGES

Section Changed	Summary of new information
4.3	SRR added to Contraindications
4.4	SRR added to Special warnings and precautions for use
4.5	SRR added to Interactions with other medicines and other forms of interactions.
4.8	SRR added to adverse effects
4.6	SRR added to effects on fertility, use in pregnancy and use in lactation.
4.7	SRR added to effects on ability to drive and use machines
5.3	SRR added to Genotoxicity and carcinogenicity
2	Excipients with known effect added