

**CENTER FOR DRUG EVALUATION AND RESEARCH**

**Approval Package for:**

***APPLICATION NUMBER:***

**019766Orig1s083**

***Trade Name:*** Zocor Tablets

***Generic Name:*** simvastatin

***Sponsor:*** MSP Singapore Company, LLC

***Approval Date:*** October 6, 2011

***Indications:*** HMG-CoA reductase inhibitor (statin) drugs, labeling modification.

# CENTER FOR DRUG EVALUATION AND RESEARCH

## 019766Orig1s083

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**CENTER FOR DRUG EVALUATION AND  
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*APPLICATION NUMBER:*

**019766Orig1s083**

**APPROVAL LETTER**



NDA 19766/S-083

**SUPPLEMENT APPROVAL**

Merck Sharp & Dohme Corp.  
Attention: Carl Sparrow, Ph.D.  
Director, Worldwide Regulatory Affairs  
P.O. Box 2000, RY33-208  
Rahway, NJ 07065-0900

Dear Dr. Sparrow:

Please refer to your Supplemental New Drug Application (sNDA) dated September 20, 2011, received September 20, 2011, submitted under section 505(b) of the Federal Food, Drug, and Cosmetic Act (FDCA) for Zocor (simvastatin) Tablets.

We acknowledge receipt of your amendment dated October 3, 2011 (email).

We also refer to our letter dated August 11, 2011, requesting that sponsors of HMG-CoA reductase inhibitor (statin) drugs, modify their labeling based on our comprehensive review of clinical trial data, Adverse Event Reporting System (AERS) reports, the published literature, and the labels of other approved drugs containing information on statin coadministration.

This "Prior Approval" supplemental new drug application provides for revisions to the **WARNINGS AND PRECAUTIONS** and **DRUG INTERACTIONS** sections of the Highlights of Prescribing Information section and changes to the **DOSAGE AND ADMINISTRATION**, **WARNINGS AND PRECAUTIONS**, **ADVERSE REACTIONS**, **CLINICAL PHARMACOLOGY**, and **PATIENT COUNSELING INFORMATION** sections of the Full Prescribing Information sections of the Zocor (simvastatin) package insert.

We have completed our review of this supplemental application, as amended. It is approved, effective on the date of this letter, for use as recommended in the enclosed, agreed-upon labeling text.

**CONTENT OF LABELING**

As soon as possible, but no later than 14 days from the date of this letter, submit the content of labeling [21 CFR 314.50(1)] in structured product labeling (SPL) format using the FDA automated drug registration and listing system (eLIST), as described at <http://www.fda.gov/ForIndustry/DataStandards/StructuredProductLabeling/default.htm>. Content of labeling must be identical to the enclosed labeling (text for the package insert), with the

addition of any labeling changes in pending “Changes Being Effected” (CBE) supplements, as well as annual reportable changes not included in the enclosed labeling.

Information on submitting SPL files using eLIST may be found in the guidance for industry titled “SPL Standard for Content of Labeling Technical Qs and As” at <http://www.fda.gov/downloads/DrugsGuidanceComplianceRegulatoryInformation/Guidances/UCM072392.pdf>.

The SPL will be accessible from publicly available labeling repositories.

Also within 14 days, amend all pending supplemental applications for this NDA, including CBE supplements for which FDA has not yet issued an action letter, with the content of labeling [21 CFR 314.50(l)(1)(i)] in MS Word format, that includes the changes approved in this supplemental application, as well as annual reportable changes and annotate each change. To facilitate review of your submission, provide a highlighted or marked-up copy that shows all changes, as well as a clean Microsoft Word version. The marked-up copy should provide appropriate annotations, including supplement number(s) and annual report date(s).

### **PROMOTIONAL MATERIALS**

You may request advisory comments on proposed introductory advertising and promotional labeling. To do so, submit the following, in triplicate, (1) a cover letter requesting advisory comments, (2) the proposed materials in draft or mock-up form with annotated references, and (3) the package insert(s) to:

Food and Drug Administration  
Center for Drug Evaluation and Research  
Division of Drug Marketing, Advertising, and Communications  
5901-B Ammendale Road  
Beltsville, MD 20705-1266

You must submit final promotional materials and package insert(s), accompanied by a Form FDA 2253, at the time of initial dissemination or publication [21 CFR 314.81(b)(3)(i)]. Form FDA 2253 is available at <http://www.fda.gov/opacom/morechoices/fdaforms/cder.html>; instructions are provided on page 2 of the form. For more information about submission of promotional materials to the Division of Drug Marketing, Advertising, and Communications (DDMAC), see <http://www.fda.gov/AboutFDA/CentersOffices/CDER/ucm090142.htm>.

All promotional materials that include representations about your drug product must be promptly revised to be consistent with the labeling changes approved in this supplement, including any new safety information [21 CFR 314.70(a)(4)]. The revisions in your promotional materials should include prominent disclosure of the important new safety information that appears in the revised package labeling. Within 7 days of receipt of this letter, submit your statement of intent to comply with 21 CFR 314.70(a)(4) to the address above or by fax to 301-847-8444.

You may request advisory comments on proposed introductory advertising and promotional labeling. To do so, submit the following, in triplicate, (1) a cover letter requesting advisory comments, (2) the proposed materials in draft or mock-up form with annotated references, and (3) the package insert(s) to:

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### **REPORTING REQUIREMENTS**

We remind you that you must comply with reporting requirements for an approved NDA (21 CFR 314.80 and 314.81).

If you have any questions, call Margaret Simoneau, M.S. RPh, Regulatory Project Manager, at (301) 796-1295.

Sincerely,

*{See appended electronic signature page}*

Amy G. Egan, M.D., M.P.H.  
Deputy Director for Safety  
Division of Metabolism and Endocrinology Products  
Office of Drug Evaluation II  
Center for Drug Evaluation and Research

ENCLOSURE:  
Content of Labeling

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**This is a representation of an electronic record that was signed electronically and this page is the manifestation of the electronic signature.**  
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/s/  
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AMY G EGAN  
10/06/2011

**CENTER FOR DRUG EVALUATION AND  
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*APPLICATION NUMBER:*

**019766Orig1s083**

**LABELING**

**HIGHLIGHTS OF PRESCRIBING INFORMATION**

These highlights do not include all the information needed to use ZOCOR safely and effectively. See full prescribing information for ZOCOR.

**ZOCOR (simvastatin) Tablets**

Initial U.S. Approval: 1991

**RECENT MAJOR CHANGES**

Dosage and Administration	
Recommended Dosing (2.1)	06/2011
Restricted Dosing for 80 mg (2.2)	06/2011
Coadministration with Other Drugs (2.3)	10/2011
Patients with Homozygous Familial Hypercholesterolemia (2.4)	
Chinese Patients Taking Lipid-Modifying Doses (≥1 g/day Niacin) of Niacin-Containing Products (2.7)	06/2011
Contraindications (4)	06/2011
Warnings and Precautions	
Myopathy/Rhabdomyolysis (5.1)	10/2011
Liver Dysfunction (5.2)	10/2011
Endocrine Function (5.3)	10/2011

**INDICATIONS AND USAGE**

ZOCOR® is an HMG-CoA reductase inhibitor (statin) indicated as an adjunctive therapy to diet to:

- Reduce the risk of total mortality by reducing CHD deaths and reduce the risk of non-fatal myocardial infarction, stroke, and the need for revascularization procedures in patients at high risk of coronary events. (1.1)
- Reduce elevated total-C, LDL-C, Apo B, TG and increase HDL-C in patients with primary hyperlipidemia (heterozygous familial and nonfamilial) and mixed dyslipidemia. (1.2)
- Reduce elevated TG in patients with hypertriglyceridemia and reduce TG and VLDL-C in patients with primary dysbeta-lipoproteinemia. (1.2)
- Reduce total-C and LDL-C in adult patients with homozygous familial hypercholesterolemia. (1.2)
- Reduce elevated total-C, LDL-C, and Apo B in boys and postmenarchal girls, 10 to 17 years of age with heterozygous familial hypercholesterolemia after failing an adequate trial of diet therapy. (1.2, 1.3)

**Limitations of Use**

ZOCOR has not been studied in Fredrickson Types I and V dyslipidemias. (1.4)

**DOSAGE AND ADMINISTRATION**

- Dose range is 5 to 40 mg/day. (2.1)
- Recommended usual starting dose is 10 or 20 mg once a day in the evening. (2.1)
- Recommended starting dose for patients at high risk of CHD is 40 mg/day. (2.1)
- Due to the increased risk of myopathy, including rhabdomyolysis, use of the 80-mg dose of ZOCOR should be restricted to patients who have been taking simvastatin 80 mg chronically (e.g., for 12 months or more) without evidence of muscle toxicity. (2.2)
- Patients who are currently tolerating the 80-mg dose of ZOCOR who need to be initiated on an interacting drug that is contraindicated or is associated with a dose cap for simvastatin should be switched to an alternative statin with less potential for the drug-drug interaction. (2.2)
- Due to the increased risk of myopathy, including rhabdomyolysis, associated with the 80-mg dose of ZOCOR, patients unable to achieve their LDL-C goal utilizing the 40-mg dose of ZOCOR should not be titrated to the 80-mg dose, but should be placed on alternative LDL-C-lowering treatment(s) that provides greater LDL-C lowering. (2.2)
- Adolescents (10-17 years of age) with HeFH: starting dose is 10 mg/day; maximum recommended dose is 40 mg/day. (2.5)

**DOSAGE FORMS AND STRENGTHS**

Tablets: 5 mg; 10 mg; 20 mg; 40 mg; 80 mg (3)

**CONTRAINDICATIONS**

- Concomitant administration of strong CYP3A4 inhibitors. (4, 5.1)
- Concomitant administration of gemfibrozil, cyclosporine, or danazol. (4, 5.1)
- Hypersensitivity to any component of this medication. (4, 6.2)
- Active liver disease, which may include unexplained persistent elevations in hepatic transaminase levels. (4, 5.2)
- Women who are pregnant or may become pregnant. (4, 8.1)
- Nursing mothers. (4, 8.3)

**WARNINGS AND PRECAUTIONS**

- **Patients should be advised of the increased risk of myopathy including rhabdomyolysis with the 80-mg dose. (5.1)**
- Skeletal muscle effects (e.g., myopathy and rhabdomyolysis): Risks increase with higher doses and concomitant use of certain medicines. Predisposing factors include advanced age (≥65), female gender, uncontrolled hypothyroidism, and renal impairment. (4, 5.1, 8.5, 8.6)
- Patients should be advised to report promptly any symptoms of myopathy. Simvastatin therapy should be discontinued immediately if myopathy is diagnosed or suspected. See Drug Interaction table. (5.1)
- Liver enzyme abnormalities: Persistent elevations in hepatic transaminases can occur. Check liver enzyme tests before initiating therapy and as clinically indicated thereafter. (5.2)

**ADVERSE REACTIONS**

Most common adverse reactions (incidence ≥5.0%) are: upper respiratory infection, headache, abdominal pain, constipation, and nausea. (6.1)

To report SUSPECTED ADVERSE REACTIONS, contact Merck Sharp & Dohme Corp., a subsidiary of Merck & Co., Inc., at 1-877-888-4231 or FDA at 1-800-FDA-1088 or [www.fda.gov/medwatch](http://www.fda.gov/medwatch).

**DRUG INTERACTIONS**

**Drug Interactions Associated with Increased Risk of Myopathy/Rhabdomyolysis (2.3, 4, 5.1, 7.1, 7.2, 7.3, 12.3)**

Interacting Agents	Prescribing Recommendations
Itraconazole, ketoconazole, posaconazole, erythromycin, clarithromycin, telithromycin, HIV protease inhibitors, nefazodone, gemfibrozil, cyclosporine, danazol	Contraindicated with simvastatin
Verapamil, diltiazem	Do not exceed 10 mg simvastatin daily
Amiodarone, amlodipine, ranolazine	Do not exceed 20 mg simvastatin daily
Grapefruit juice	Avoid large quantities of grapefruit juice (>1 quart daily)

- Other Lipid-lowering Medications: Use with other fibrate products or lipid-modifying doses (≥1 g/day) of niacin increases the risk of adverse skeletal muscle effects. Caution should be used when prescribing with simvastatin. (5.1, 7.2, 7.4)
- Coumarin anticoagulants: Concomitant use with ZOCOR prolongs INR. Achieve stable INR prior to starting ZOCOR. Monitor INR frequently until stable upon initiation or alteration of ZOCOR therapy. (7.6)

**USE IN SPECIFIC POPULATIONS**

- Severe renal impairment: patients should be started at 5 mg/day and be closely monitored. (2.6, 8.6)

See 17 for PATIENT COUNSELING INFORMATION.

Revised: 10/2011

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\*Sections or subsections omitted from the full prescribing information are not listed.

**FULL PRESCRIBING INFORMATION**

**1 INDICATIONS AND USAGE**

Therapy with lipid-altering agents should be only one component of multiple risk factor intervention in individuals at significantly increased risk for atherosclerotic vascular disease due to hypercholesterolemia. Drug therapy is indicated as an adjunct to diet when the response to a diet restricted in saturated fat and cholesterol and other nonpharmacologic measures alone has been inadequate. In patients with coronary heart disease (CHD) or at high risk of CHD, ZOCOR<sup>1</sup> can be started simultaneously with diet.

**1.1 Reductions in Risk of CHD Mortality and Cardiovascular Events**

In patients at high risk of coronary events because of existing coronary heart disease, diabetes, peripheral vessel disease, history of stroke or other cerebrovascular disease, ZOCOR is indicated to:

- Reduce the risk of total mortality by reducing CHD deaths.
- Reduce the risk of non-fatal myocardial infarction and stroke.
- Reduce the need for coronary and non-coronary revascularization procedures.

**1.2 Hyperlipidemia**

ZOCOR is indicated to:

- Reduce elevated total cholesterol (total-C), low-density lipoprotein cholesterol (LDL-C), apolipoprotein B (Apo B), and triglycerides (TG), and to increase high-density lipoprotein cholesterol (HDL-C) in patients with primary hyperlipidemia (Fredrickson type IIa, heterozygous familial and nonfamilial) or mixed dyslipidemia (Fredrickson type IIb).
- Reduce elevated TG in patients with hypertriglyceridemia (Fredrickson type IV hyperlipidemia).
- Reduce elevated TG and VLDL-C in patients with primary dysbetalipoproteinemia (Fredrickson type III hyperlipidemia).

<sup>1</sup> Registered trademark of Merck Sharp & Dohme Corp., a subsidiary of Merck & Co., Inc.  
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- Reduce total-C and LDL-C in patients with homozygous familial hypercholesterolemia as an adjunct to other lipid-lowering treatments (e.g., LDL apheresis) or if such treatments are unavailable.

### 1.3 Adolescent Patients with Heterozygous Familial Hypercholesterolemia (HeFH)

ZOCOR is indicated as an adjunct to diet to reduce total-C, LDL-C, and Apo B levels in adolescent boys and girls who are at least one year post-menarche, 10-17 years of age, with HeFH, if after an adequate trial of diet therapy the following findings are present:

1. LDL cholesterol remains  $\geq 190$  mg/dL; or
2. LDL cholesterol remains  $\geq 160$  mg/dL and
  - There is a positive family history of premature cardiovascular disease (CVD) or
  - Two or more other CVD risk factors are present in the adolescent patient.

The minimum goal of treatment in pediatric and adolescent patients is to achieve a mean LDL-C  $< 130$  mg/dL. The optimal age at which to initiate lipid-lowering therapy to decrease the risk of symptomatic adulthood CAD has not been determined.

### 1.4 Limitations of Use

ZOCOR has not been studied in conditions where the major abnormality is elevation of chylomicrons (i.e., hyperlipidemia Fredrickson types I and V).

## 2 DOSAGE AND ADMINISTRATION

### 2.1 Recommended Dosing

The usual dosage range is 5 to 40 mg/day. In patients with CHD or at high risk of CHD, ZOCOR can be started simultaneously with diet. The recommended usual starting dose is 10 or 20 mg once a day in the evening. For patients at high risk for a CHD event due to existing CHD, diabetes, peripheral vessel disease, history of stroke or other cerebrovascular disease, the recommended starting dose is 40 mg/day. Lipid determinations should be performed after 4 weeks of therapy and periodically thereafter.

### 2.2 Restricted Dosing for 80 mg

Due to the increased risk of myopathy, including rhabdomyolysis, particularly during the first year of treatment, use of the 80-mg dose of ZOCOR should be restricted to patients who have been taking simvastatin 80 mg chronically (e.g., for 12 months or more) without evidence of muscle toxicity [see *Warnings and Precautions (5.1)*].

Patients who are currently tolerating the 80-mg dose of ZOCOR who need to be initiated on an interacting drug that is contraindicated or is associated with a dose cap for simvastatin should be switched to an alternative statin with less potential for the drug-drug interaction.

Due to the increased risk of myopathy, including rhabdomyolysis, associated with the 80-mg dose of ZOCOR, patients unable to achieve their LDL-C goal utilizing the 40-mg dose of ZOCOR should not be titrated to the 80-mg dose, but should be placed on alternative LDL-C-lowering treatment(s) that provides greater LDL-C lowering.

### 2.3 Coadministration with Other Drugs

#### *Patients taking Verapamil or Diltiazem*

- The dose of ZOCOR should not exceed 10 mg/day [see *Warnings and Precautions (5.1)*, *Drug Interactions (7.3)*, and *Clinical Pharmacology (12.3)*].

#### *Patients taking Amiodarone, Amlodipine or Ranolazine*

- The dose of ZOCOR should not exceed 20 mg/day [see *Warnings and Precautions (5.1)*, *Drug Interactions (7.3)*, and *Clinical Pharmacology (12.3)*].

### 2.4 Patients with Homozygous Familial Hypercholesterolemia

The recommended dosage is 40 mg/day in the evening [see *Dosage and Administration, Restricted Dosing for 80 mg (2.2)*]. ZOCOR should be used as an adjunct to other lipid-lowering treatments (e.g., LDL apheresis) in these patients or if such treatments are unavailable.

### 2.5 Adolescents (10-17 years of age) with Heterozygous Familial Hypercholesterolemia

The recommended usual starting dose is 10 mg once a day in the evening. The recommended dosing range is 10 to 40 mg/day; the maximum recommended dose is 40 mg/day. Doses should be

individualized according to the recommended goal of therapy [see NCEP Pediatric Panel Guidelines<sup>2</sup> and *Clinical Studies (14.2)*]. Adjustments should be made at intervals of 4 weeks or more.

## 2.6 Patients with Renal Impairment

Because ZOCOR does not undergo significant renal excretion, modification of dosage should not be necessary in patients with mild to moderate renal impairment. However, caution should be exercised when ZOCOR is administered to patients with severe renal impairment; such patients should be started at 5 mg/day and be closely monitored [see *Warnings and Precautions (5.1)* and *Clinical Pharmacology (12.3)*].

## 2.7 Chinese Patients Taking Lipid-Modifying Doses ( $\geq 1$ g/day Niacin) of Niacin-Containing Products

Because of an increased risk for myopathy in Chinese patients taking simvastatin 40 mg coadministered with lipid-modifying doses ( $\geq 1$  g/day niacin) of niacin-containing products, caution should be used when treating Chinese patients with simvastatin doses exceeding 20 mg/day coadministered with lipid-modifying doses of niacin-containing products. Because the risk for myopathy is dose-related, Chinese patients should not receive simvastatin 80 mg coadministered with lipid-modifying doses of niacin-containing products. The cause of the increased risk of myopathy is not known. It is also unknown if the risk for myopathy with coadministration of simvastatin with lipid-modifying doses of niacin-containing products observed in Chinese patients applies to other Asian patients. [See *Warnings and Precautions (5.1)*.]

## 3 DOSAGE FORMS AND STRENGTHS

- Tablets ZOCOR 5 mg are buff, oval, film-coated tablets, coded MSD 726 on one side and ZOCOR 5 on the other.
- Tablets ZOCOR 10 mg are peach, oval, film-coated tablets, coded MSD 735 on one side and plain on the other.
- Tablets ZOCOR 20 mg are tan, oval, film-coated tablets, coded MSD 740 on one side and plain on the other.
- Tablets ZOCOR 40 mg are brick red, oval, film-coated tablets, coded MSD 749 on one side and plain on the other.
- Tablets ZOCOR 80 mg are brick red, capsule-shaped, film-coated tablets, coded 543 on one side and 80 on the other.

## 4 CONTRAINDICATIONS

ZOCOR is contraindicated in the following conditions:

- Concomitant administration of strong CYP3A4 inhibitors (e.g., itraconazole, ketoconazole, posaconazole, HIV protease inhibitors, erythromycin, clarithromycin, telithromycin and nefazodone) [see *Warnings and Precautions (5.1)*].
- Concomitant administration of gemfibrozil, cyclosporine, or danazol [see *Warnings and Precautions (5.1)*].
- Hypersensitivity to any component of this medication [see *Adverse Reactions (6.2)*].
- Active liver disease, which may include unexplained persistent elevations in hepatic transaminase levels [see *Warnings and Precautions (5.2)*].
- Women who are pregnant or may become pregnant. Serum cholesterol and triglycerides increase during normal pregnancy, and cholesterol or cholesterol derivatives are essential for fetal development. Because HMG-CoA reductase inhibitors (statins) decrease cholesterol synthesis and possibly the synthesis of other biologically active substances derived from cholesterol, ZOCOR may cause fetal harm when administered to a pregnant woman. Atherosclerosis is a chronic process and the discontinuation of lipid-lowering drugs during pregnancy should have little impact on the outcome

<sup>2</sup> National Cholesterol Education Program (NCEP): Highlights of the Report of the Expert Panel on Blood Cholesterol Levels in Children and Adolescents. *Pediatrics*. 89(3):495-501. 1992.

of long-term therapy of primary hypercholesterolemia. There are no adequate and well-controlled studies of use with ZOCOR during pregnancy; however, in rare reports congenital anomalies were observed following intrauterine exposure to statins. In rat and rabbit animal reproduction studies, simvastatin revealed no evidence of teratogenicity. **ZOCOR should be administered to women of childbearing age only when such patients are highly unlikely to conceive.** If the patient becomes pregnant while taking this drug, ZOCOR should be discontinued immediately and the patient should be apprised of the potential hazard to the fetus [see *Use in Specific Populations (8.1)*].

- Nursing mothers. It is not known whether simvastatin is excreted into human milk; however, a small amount of another drug in this class does pass into breast milk. Because statins have the potential for serious adverse reactions in nursing infants, women who require treatment with ZOCOR should not breastfeed their infants [see *Use in Specific Populations (8.3)*].

## 5 WARNINGS AND PRECAUTIONS

### 5.1 Myopathy/Rhabdomyolysis

Simvastatin occasionally causes myopathy manifested as muscle pain, tenderness or weakness with creatine kinase (CK) above ten times the upper limit of normal (ULN). Myopathy sometimes takes the form of rhabdomyolysis with or without acute renal failure secondary to myoglobinuria, and rare fatalities have occurred. The risk of myopathy is increased by high levels of statin activity in plasma. Predisposing factors for myopathy include advanced age ( $\geq 65$  years), female gender, uncontrolled hypothyroidism, and renal impairment.

**The risk of myopathy, including rhabdomyolysis, is dose related.** In a clinical trial database in which 41,413 patients were treated with ZOCOR, 24,747 (approximately 60%) of whom were enrolled in studies with a median follow-up of at least 4 years, the incidence of myopathy was approximately 0.03% and 0.08% at 20 and 40 mg/day, respectively. The incidence of myopathy with 80 mg (0.61%) was disproportionately higher than that observed at the lower doses. In these trials, patients were carefully monitored and some interacting medicinal products were excluded.

In a clinical trial in which 12,064 patients with a history of myocardial infarction were treated with ZOCOR (mean follow-up 6.7 years), the incidence of myopathy (defined as unexplained muscle weakness or pain with a serum creatine kinase [CK]  $>10$  times upper limit of normal [ULN]) in patients on 80 mg/day was approximately 0.9% compared with 0.02% for patients on 20 mg/day. The incidence of rhabdomyolysis (defined as myopathy with a CK  $>40$  times ULN) in patients on 80 mg/day was approximately 0.4% compared with 0% for patients on 20 mg/day. The incidence of myopathy, including rhabdomyolysis, was highest during the first year and then notably decreased during the subsequent years of treatment. In this trial, patients were carefully monitored and some interacting medicinal products were excluded.

**The risk of myopathy, including rhabdomyolysis, is greater in patients on simvastatin 80 mg compared with other statin therapies with similar or greater LDL-C-lowering efficacy and compared with lower doses of simvastatin. Therefore, the 80-mg dose of ZOCOR should be used only in patients who have been taking simvastatin 80 mg chronically (e.g., for 12 months or more) without evidence of muscle toxicity [see *Dosage and Administration, Restricted Dosing for 80 mg (2.2)*].** If, however, a patient who is currently tolerating the 80-mg dose of ZOCOR needs to be initiated on an interacting drug that is contraindicated or is associated with a dose cap for simvastatin, that patient should be switched to an alternative statin with less potential for the drug-drug interaction. Patients should be advised of the increased risk of myopathy, including rhabdomyolysis, and to report promptly any unexplained muscle pain, tenderness or weakness. **If symptoms occur, treatment should be discontinued immediately.** [See *Warnings and Precautions (5.2)*.]

**All patients starting therapy with simvastatin, or whose dose of simvastatin is being increased, should be advised of the risk of myopathy, including rhabdomyolysis, and told to report promptly any unexplained muscle pain, tenderness or weakness. Simvastatin therapy should be discontinued immediately if myopathy is diagnosed or suspected.** In most cases, muscle symptoms and CK increases resolved when treatment was promptly discontinued. Periodic CK determinations may

be considered in patients starting therapy with simvastatin or whose dose is being increased, but there is no assurance that such monitoring will prevent myopathy.

Many of the patients who have developed rhabdomyolysis on therapy with simvastatin have had complicated medical histories, including renal insufficiency usually as a consequence of long-standing diabetes mellitus. Such patients merit closer monitoring. ZOCOR therapy should be discontinued if markedly elevated CPK levels occur or myopathy is diagnosed or suspected. ZOCOR therapy should also be temporarily withheld in any patient experiencing an acute or serious condition predisposing to the development of renal failure secondary to rhabdomyolysis, e.g., sepsis; hypotension; major surgery; trauma; severe metabolic, endocrine, or electrolyte disorders; or uncontrolled epilepsy.

#### *Drug Interactions*

The risk of myopathy and rhabdomyolysis is increased by high levels of statin activity in plasma. Simvastatin is metabolized by the cytochrome P450 isoform 3A4. Certain drugs which inhibit this metabolic pathway can raise the plasma levels of simvastatin and may increase the risk of myopathy. These include itraconazole, ketoconazole, and posaconazole, the macrolide antibiotics erythromycin and clarithromycin, and the ketolide antibiotic telithromycin, HIV protease inhibitors, the antidepressant nefazodone, or large quantities of grapefruit juice (>1 quart daily). Combination of these drugs with simvastatin is contraindicated. If treatment with itraconazole, ketoconazole, posaconazole, erythromycin, clarithromycin or telithromycin is unavoidable, therapy with simvastatin must be suspended during the course of treatment. [See *Contraindications (4) and Drug Interactions (7.1).*] *In vitro* studies have demonstrated a potential for voriconazole to inhibit the metabolism of simvastatin. Adjustment of the simvastatin dose may be needed to reduce the risk of myopathy, including rhabdomyolysis, if voriconazole must be used concomitantly with simvastatin. [See *Drug Interactions (7.1).*]

The combined use of simvastatin with gemfibrozil, cyclosporine, or danazol is contraindicated [see *Contraindications (4) and Drug Interactions (7.1 and 7.2)*].

Caution should be used when prescribing other fibrates with simvastatin, as these agents can cause myopathy when given alone and the risk is increased when they are co-administered [see *Drug Interactions (7.2)*].

Cases of myopathy, including rhabdomyolysis, have been reported with simvastatin coadministered with colchicine, and caution should be exercised when prescribing simvastatin with colchicine [see *Drug Interactions (7.7)*].

The benefits of the combined use of simvastatin with the following drugs should be carefully weighed against the potential risks of combinations: other lipid-lowering drugs (other fibrates or  $\geq 1$  g/day of niacin), amiodarone, verapamil, diltiazem, amlodipine, or ranolazine [see *Drug Interactions (7.3) and Table 3 in Clinical Pharmacology (12.3)*].

Cases of myopathy, including rhabdomyolysis, have been observed with simvastatin coadministered with lipid-modifying doses ( $\geq 1$  g/day niacin) of niacin-containing products. In an ongoing, double-blind, randomized cardiovascular outcomes trial, an independent safety monitoring committee identified that the incidence of myopathy is higher in Chinese compared with non-Chinese patients taking simvastatin 40 mg coadministered with lipid-modifying doses of a niacin-containing product. Caution should be used when treating Chinese patients with simvastatin in doses exceeding 20 mg/day coadministered with lipid-modifying doses of niacin-containing products. Because the risk for myopathy is dose-related, Chinese patients should not receive simvastatin 80 mg coadministered with lipid-modifying doses of niacin-containing products. It is unknown if the risk for myopathy with coadministration of simvastatin with lipid-modifying doses of niacin-containing products observed in Chinese patients applies to other Asian patients [see *Drug Interactions (7.4)*].

Prescribing recommendations for interacting agents are summarized in Table 1 [see also *Dosage and Administration (2.3), Drug Interactions (7), Clinical Pharmacology (12.3)*].

TABLE 1  
Drug Interactions Associated with Increased  
Risk of Myopathy/Rhabdomyolysis

Interacting Agents	Prescribing Recommendations
Itraconazole Ketoconazole Posaconazole Erythromycin Clarithromycin Telithromycin HIV protease inhibitors Nefazodone Gemfibrozil Cyclosporine Danazol	Contraindicated with simvastatin
Verapamil Diltiazem	Do not exceed 10 mg simvastatin daily
Amiodarone Amlodipine Ranolazine	Do not exceed 20 mg simvastatin daily
Grapefruit juice	Avoid large quantities of grapefruit juice (>1 quart daily)

## 5.2 Liver Dysfunction

**Persistent increases (to more than 3X the ULN) in serum transaminases have occurred in approximately 1% of patients who received simvastatin in clinical studies.** When drug treatment was interrupted or discontinued in these patients, the transaminase levels usually fell slowly to pretreatment levels. The increases were not associated with jaundice or other clinical signs or symptoms. There was no evidence of hypersensitivity.

In the Scandinavian Simvastatin Survival Study (4S) [see *Clinical Studies (14.1)*], the number of patients with more than one transaminase elevation to >3X ULN, over the course of the study, was not significantly different between the simvastatin and placebo groups (14 [0.7%] vs. 12 [0.6%]). Elevated transaminases resulted in the discontinuation of 8 patients from therapy in the simvastatin group (n=2,221) and 5 in the placebo group (n=2,223). Of the 1,986 simvastatin treated patients in 4S with normal liver function tests (LFTs) at baseline, 8 (0.4%) developed consecutive LFT elevations to >3X ULN and/or were discontinued due to transaminase elevations during the 5.4 years (median follow-up) of the study. Among these 8 patients, 5 initially developed these abnormalities within the first year. All of the patients in this study received a starting dose of 20 mg of simvastatin; 37% were titrated to 40 mg.

In 2 controlled clinical studies in 1,105 patients, the 12-month incidence of persistent hepatic transaminase elevation without regard to drug relationship was 0.9% and 2.1% at the 40- and 80-mg dose, respectively. No patients developed persistent liver function abnormalities following the initial 6 months of treatment at a given dose.

**It is recommended that liver function tests be performed before the initiation of treatment, and thereafter when clinically indicated.** There have been rare postmarketing reports of fatal and non-fatal hepatic failure in patients taking statins, including simvastatin. If serious liver injury with clinical symptoms and/or hyperbilirubinemia or jaundice occurs during treatment with ZOCOR, promptly interrupt therapy. If an alternate etiology is not found do not restart ZOCOR. Note that ALT may emanate from muscle, therefore ALT rising with CK may indicate myopathy [see *Warnings and Precautions (5.1)*].

The drug should be used with caution in patients who consume substantial quantities of alcohol and/or have a past history of liver disease. Active liver diseases or unexplained transaminase elevations are contraindications to the use of simvastatin.

As with other lipid-lowering agents, moderate (less than 3X ULN) elevations of serum transaminases have been reported following therapy with simvastatin. These changes appeared soon after initiation of therapy with simvastatin, were often transient, were not accompanied by any symptoms and did not require interruption of treatment.

### 5.3 Endocrine Function

Increases in HbA1c and fasting serum glucose levels have been reported with HMG-CoA reductase inhibitors, including ZOCOR.

## 6 ADVERSE REACTIONS

### 6.1 Clinical Trials Experience

Because clinical studies are conducted under widely varying conditions, adverse reaction rates observed in the clinical studies of a drug cannot be directly compared to rates in the clinical studies of another drug and may not reflect the rates observed in practice.

In the pre-marketing controlled clinical studies and their open extensions (2,423 patients with median duration of follow-up of approximately 18 months), 1.4% of patients were discontinued due to adverse reactions. The most common adverse reactions that led to treatment discontinuation were: gastrointestinal disorders (0.5%), myalgia (0.1%), and arthralgia (0.1%). The most commonly reported adverse reactions (incidence  $\geq 5\%$ ) in simvastatin controlled clinical trials were: upper respiratory infections (9.0%), headache (7.4%), abdominal pain (7.3%), constipation (6.6%), and nausea (5.4%).

#### *Scandinavian Simvastatin Survival Study*

In 4S involving 4,444 (age range 35-71 years, 19% women, 100% Caucasians) treated with 20-40 mg/day of ZOCOR (n=2,221) or placebo (n=2,223) over a median of 5.4 years, adverse reactions reported in  $\geq 2\%$  of patients and at a rate greater than placebo are shown in Table 2.

TABLE 2  
Adverse Reactions Reported Regardless of Causality by  $\geq 2\%$  of Patients Treated  
with ZOCOR and Greater than Placebo in 4S

	ZOCOR (N = 2,221) %	Placebo (N = 2,223) %
<i>Body as a Whole</i>		
Edema/swelling	2.7	2.3
Abdominal pain	5.9	5.8
<i>Cardiovascular System Disorders</i>		
Atrial fibrillation	5.7	5.1
<i>Digestive System Disorders</i>		
Constipation	2.2	1.6
Gastritis	4.9	3.9
<i>Endocrine Disorders</i>		
Diabetes mellitus	4.2	3.6
<i>Musculoskeletal Disorders</i>		
Myalgia	3.7	3.2
<i>Nervous System/ Psychiatric Disorders</i>		
Headache	2.5	2.1
Insomnia	4.0	3.8
Vertigo	4.5	4.2
<i>Respiratory System Disorders</i>		
Bronchitis	6.6	6.3
Sinusitis	2.3	1.8
<i>Skin / Skin Appendage Disorders</i>		
Eczema	4.5	3.0
<i>Urogenital System Disorders</i>		
Infection, urinary tract	3.2	3.1

#### *Heart Protection Study*

In the Heart Protection Study (HPS), involving 20,536 patients (age range 40-80 years, 25% women, 97% Caucasians, 3% other races) treated with ZOCOR 40 mg/day (n=10,269) or placebo (n=10,267) over a mean of 5 years, only serious adverse reactions and discontinuations due to any adverse reactions were recorded. Discontinuation rates due to adverse reactions were 4.8% in patients treated with ZOCOR compared with 5.1% in patients treated with placebo. The incidence of myopathy/rhabdomyolysis was  $< 0.1\%$  in patients treated with ZOCOR.

#### *Other Clinical Studies*

In a clinical trial in which 12,064 patients with a history of myocardial infarction were treated with ZOCOR (mean follow-up 6.7 years), the incidence of myopathy (defined as unexplained muscle weakness or pain with a serum creatine kinase [CK]  $> 10$  times upper limit of normal [ULN]) in patients on

80 mg/day was approximately 0.9% compared with 0.02% for patients on 20 mg/day. The incidence of rhabdomyolysis (defined as myopathy with a CK >40 times ULN) in patients on 80 mg/day was approximately 0.4% compared with 0% for patients on 20 mg/day. The incidence of myopathy, including rhabdomyolysis, was highest during the first year and then notably decreased during the subsequent years of treatment. In this trial, patients were carefully monitored and some interacting medicinal products were excluded.

Other adverse reactions reported in clinical trials were: diarrhea, rash, dyspepsia, flatulence, and asthenia.

#### *Laboratory Tests*

Marked persistent increases of hepatic transaminases have been noted [see *Warnings and Precautions (5.2)*]. Elevated alkaline phosphatase and  $\gamma$ -glutamyl transpeptidase have also been reported. About 5% of patients had elevations of CK levels of 3 or more times the normal value on one or more occasions. This was attributable to the noncardiac fraction of CK. [See *Warnings and Precautions (5.1)*.]

#### *Adolescent Patients (ages 10-17 years)*

In a 48-week, controlled study in adolescent boys and girls who were at least 1 year post-menarche, 10-17 years of age (43.4% female, 97.7% Caucasians, 1.7% Hispanics, 0.6% Multiracial) with heterozygous familial hypercholesterolemia (n=175), treated with placebo or ZOCOR (10-40 mg daily), the most common adverse reactions observed in both groups were upper respiratory infection, headache, abdominal pain, and nausea [see *Use in Specific Populations (8.4)* and *Clinical Studies (14.2)*].

## **6.2 Post-Marketing Experience**

Because the below reactions are reported voluntarily from a population of uncertain size, it is generally not possible to reliably estimate their frequency or establish a causal relationship to drug exposure. The following additional adverse reactions have been identified during postapproval use of simvastatin: pruritus, alopecia, a variety of skin changes (e.g., nodules, discoloration, dryness of skin/mucous membranes, changes to hair/nails), dizziness, muscle cramps, myalgia, pancreatitis, paresthesia, peripheral neuropathy, vomiting, anemia, erectile dysfunction, interstitial lung disease, rhabdomyolysis, hepatitis/jaundice, fatal and non-fatal hepatic failure, and depression.

An apparent hypersensitivity syndrome has been reported rarely which has included some of the following features: anaphylaxis, angioedema, lupus erythematosus-like syndrome, polymyalgia rheumatica, dermatomyositis, vasculitis, purpura, thrombocytopenia, leukopenia, hemolytic anemia, positive ANA, ESR increase, eosinophilia, arthritis, arthralgia, urticaria, asthenia, photosensitivity, fever, chills, flushing, malaise, dyspnea, toxic epidermal necrolysis, erythema multiforme, including Stevens-Johnson syndrome.

There have been rare postmarketing reports of cognitive impairment (e.g., memory loss, forgetfulness, amnesia, memory impairment, confusion) associated with statin use. These cognitive issues have been reported for all statins. The reports are generally nonserious, and reversible upon statin discontinuation, with variable times to symptom onset (1 day to years) and symptom resolution (median of 3 weeks).

## **7 DRUG INTERACTIONS**

### **7.1 Strong CYP3A4 Inhibitors, cyclosporine, or danazol**

Strong CYP3A4 inhibitors: Simvastatin, like several other inhibitors of HMG-CoA reductase, is a substrate of CYP3A4. Simvastatin is metabolized by CYP3A4 but has no CYP3A4 inhibitory activity; therefore it is not expected to affect the plasma concentrations of other drugs metabolized by CYP3A4.

Elevated plasma levels of HMG-CoA reductase inhibitory activity increases the risk of myopathy and rhabdomyolysis, particularly with higher doses of simvastatin. [See *Warnings and Precautions (5.1)* and *Clinical Pharmacology (12.3)*.] Concomitant use of drugs labeled as having a strong inhibitory effect on CYP3A4 is contraindicated [see *Contraindications (4)*]. If treatment with itraconazole, ketoconazole, posaconazole, erythromycin, clarithromycin or telithromycin is unavoidable, therapy with simvastatin must be suspended during the course of treatment.

Although not studied clinically, voriconazole has been shown to inhibit lovastatin metabolism *in vitro* (human liver microsomes). Therefore, voriconazole is likely to increase the plasma concentration of

simvastatin. It is recommended that dose adjustment of simvastatin be considered during concomitant use of voriconazole and simvastatin to reduce the risk of myopathy, including rhabdomyolysis. [see *Warnings and Precautions (5.1)*]

Cyclosporine or Danazol: The risk of myopathy, including rhabdomyolysis is increased by concomitant administration of cyclosporine or danazol. Therefore, concomitant use of these drugs is contraindicated. [see *Contraindications (4), Warnings and Precautions (5.1) and Clinical Pharmacology (12.3)*].

## **7.2 Lipid-Lowering Drugs That Can Cause Myopathy When Given Alone**

Gemfibrozil: Contraindicated with simvastatin [see *Contraindications (4) and Warnings and Precautions (5.1)*].

Other fibrates: Caution should be used when prescribing with simvastatin [see *Warnings and Precautions (5.1)*].

## **7.3 Amiodarone, Ranolazine, or Calcium Channel Blockers**

The risk of myopathy, including rhabdomyolysis, is increased by concomitant administration of amiodarone, ranolazine, or calcium channel blockers such as verapamil, diltiazem, or amlodipine [see *Dosage and Administration (2.3) and Warnings and Precautions (5.1), and Table 3 in Clinical Pharmacology (12.3)*].

## **7.4 Niacin**

Cases of myopathy/rhabdomyolysis have been observed with simvastatin coadministered with lipid-modifying doses ( $\geq 1$  g/day niacin) of niacin-containing products. In particular, caution should be used when treating Chinese patients with simvastatin doses exceeding 20 mg/day coadministered with lipid-modifying doses of niacin-containing products. Because the risk for myopathy is dose-related, Chinese patients should not receive simvastatin 80 mg coadministered with lipid-modifying doses of niacin-containing products. [See *Warnings and Precautions (5.1) and Clinical Pharmacology (12.3)*].

## **7.5 Digoxin**

In one study, concomitant administration of digoxin with simvastatin resulted in a slight elevation in digoxin concentrations in plasma. Patients taking digoxin should be monitored appropriately when simvastatin is initiated [see *Clinical Pharmacology (12.3)*].

## **7.6 Coumarin Anticoagulants**

In two clinical studies, one in normal volunteers and the other in hypercholesterolemic patients, simvastatin 20-40 mg/day modestly potentiated the effect of coumarin anticoagulants: the prothrombin time, reported as International Normalized Ratio (INR), increased from a baseline of 1.7 to 1.8 and from 2.6 to 3.4 in the volunteer and patient studies, respectively. With other statins, clinically evident bleeding and/or increased prothrombin time has been reported in a few patients taking coumarin anticoagulants concomitantly. In such patients, prothrombin time should be determined before starting simvastatin and frequently enough during early therapy to ensure that no significant alteration of prothrombin time occurs. Once a stable prothrombin time has been documented, prothrombin times can be monitored at the intervals usually recommended for patients on coumarin anticoagulants. If the dose of simvastatin is changed or discontinued, the same procedure should be repeated. Simvastatin therapy has not been associated with bleeding or with changes in prothrombin time in patients not taking anticoagulants.

## **7.7 Colchicine**

Cases of myopathy, including rhabdomyolysis, have been reported with simvastatin coadministered with colchicine, and caution should be exercised when prescribing simvastatin with colchicine.

# **8 USE IN SPECIFIC POPULATIONS**

## **8.1 Pregnancy**

*Pregnancy Category X [See Contraindications (4).]*

ZOCOR is contraindicated in women who are or may become pregnant. Lipid lowering drugs offer no benefit during pregnancy, because cholesterol and cholesterol derivatives are needed for normal fetal development. Atherosclerosis is a chronic process, and discontinuation of lipid-lowering drugs during pregnancy should have little impact on long-term outcomes of primary hypercholesterolemia therapy. There are no adequate and well-controlled studies of use with ZOCOR during pregnancy; however, there

are rare reports of congenital anomalies in infants exposed to statins *in utero*. Animal reproduction studies of simvastatin in rats and rabbits showed no evidence of teratogenicity. Serum cholesterol and triglycerides increase during normal pregnancy, and cholesterol or cholesterol derivatives are essential for fetal development. Because statins decrease cholesterol synthesis and possibly the synthesis of other biologically active substances derived from cholesterol, ZOCOR may cause fetal harm when administered to a pregnant woman. If ZOCOR is used during pregnancy or if the patient becomes pregnant while taking this drug, the patient should be apprised of the potential hazard to the fetus.

There are rare reports of congenital anomalies following intrauterine exposure to statins. In a review<sup>3</sup> of approximately 100 prospectively followed pregnancies in women exposed to simvastatin or another structurally related statin, the incidences of congenital anomalies, spontaneous abortions, and fetal deaths/stillbirths did not exceed those expected in the general population. However, the study was only able to exclude a 3- to 4-fold increased risk of congenital anomalies over the background rate. In 89% of these cases, drug treatment was initiated prior to pregnancy and was discontinued during the first trimester when pregnancy was identified.

Simvastatin was not teratogenic in rats or rabbits at doses (25, 10 mg/kg/day, respectively) that resulted in 3 times the human exposure based on mg/m<sup>2</sup> surface area. However, in studies with another structurally-related statin, skeletal malformations were observed in rats and mice.

Women of childbearing potential, who require treatment with ZOCOR for a lipid disorder, should be advised to use effective contraception. For women trying to conceive, discontinuation of ZOCOR should be considered. If pregnancy occurs, ZOCOR should be immediately discontinued.

### 8.3 Nursing Mothers

It is not known whether simvastatin is excreted in human milk. Because a small amount of another drug in this class is excreted in human milk and because of the potential for serious adverse reactions in nursing infants, women taking simvastatin should not nurse their infants. A decision should be made whether to discontinue nursing or discontinue drug, taking into account the importance of the drug to the mother [see *Contraindications (4)*].

### 8.4 Pediatric Use

Safety and effectiveness of simvastatin in patients 10-17 years of age with heterozygous familial hypercholesterolemia have been evaluated in a controlled clinical trial in adolescent boys and in girls who were at least 1 year post-menarche. Patients treated with simvastatin had an adverse reaction profile similar to that of patients treated with placebo. **Doses greater than 40 mg have not been studied in this population.** In this limited controlled study, there was no significant effect on growth or sexual maturation in the adolescent boys or girls, or on menstrual cycle length in girls. [See *Dosage and Administration (2.5)*, *Adverse Reactions (6.1)*, *Clinical Studies (14.2)*.] Adolescent females should be counseled on appropriate contraceptive methods while on simvastatin therapy [see *Contraindications (4)* and *Use in Specific Populations (8.1)*]. Simvastatin has not been studied in patients younger than 10 years of age, nor in pre-menarchal girls.

### 8.5 Geriatric Use

Of the 2,423 patients who received ZOCOR in Phase III clinical studies and the 10,269 patients in the Heart Protection Study who received ZOCOR, 363 (15%) and 5,366 (52%), respectively were ≥65 years old. In HPS, 615 (6%) were ≥75 years old. No overall differences in safety or effectiveness were observed between these subjects and younger subjects, and other reported clinical experience has not identified differences in responses between the elderly and younger patients, but greater sensitivity of some older individuals cannot be ruled out. Since advanced age (≥65 years) is a predisposing factor for myopathy, ZOCOR should be prescribed with caution in the elderly. [See *Clinical Pharmacology (12.3)*.]

A pharmacokinetic study with simvastatin showed the mean plasma level of statin activity to be approximately 45% higher in elderly patients between 70-78 years of age compared with patients between 18-30 years of age. In 4S, 1,021 (23%) of 4,444 patients were 65 or older. Lipid-lowering efficacy was at least as great in elderly patients compared with younger patients, and ZOCOR significantly reduced total mortality and CHD mortality in elderly patients with a history of CHD. In HPS,

<sup>3</sup> Manson, J.M., Freyssinges, C., Ducrocq, M.B., Stephenson, W.P., Postmarketing Surveillance of Lovastatin and Simvastatin Exposure During Pregnancy, *Reproductive Toxicology*, 10(6):439-446, 1996.

52% of patients were elderly (4,891 patients 65-69 years and 5,806 patients 70 years or older). The relative risk reductions of CHD death, non-fatal MI, coronary and non-coronary revascularization procedures, and stroke were similar in older and younger patients [see *Clinical Studies (14.1)*]. In HPS, among 32,145 patients entering the active run-in period, there were 2 cases of myopathy/rhabdomyolysis; these patients were aged 67 and 73. Of the 7 cases of myopathy/rhabdomyolysis among 10,269 patients allocated to simvastatin, 4 were aged 65 or more (at baseline), of whom one was over 75. There were no overall differences in safety between older and younger patients in either 4S or HPS.

Because advanced age ( $\geq 65$  years) is a predisposing factor for myopathy, including rhabdomyolysis, ZOCOR should be prescribed with caution in the elderly. In a clinical trial of patients treated with simvastatin 80 mg/day, patients  $\geq 65$  years of age had an increased risk of myopathy, including rhabdomyolysis, compared to patients  $< 65$  years of age. [See *Warnings and Precautions (5.1)* and *Clinical Pharmacology (12.3)*.]

### 8.6 Renal Impairment

Caution should be exercised when ZOCOR is administered to patients with severe renal impairment. [See *Dosage and Administration (2.6)*.]

### 8.7 Hepatic Impairment

ZOCOR is contraindicated in patients with active liver disease which may include unexplained persistent elevations in hepatic transaminase levels [see *Contraindications (4)* and *Warnings and Precautions (5.2)*].

## 10 OVERDOSAGE

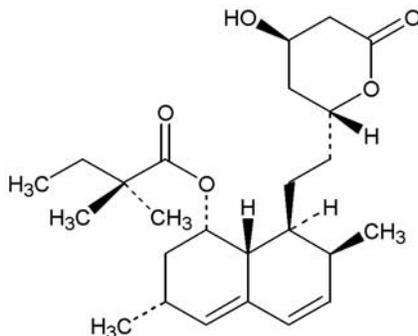
Significant lethality was observed in mice after a single oral dose of 9 g/m<sup>2</sup>. No evidence of lethality was observed in rats or dogs treated with doses of 30 and 100 g/m<sup>2</sup>, respectively. No specific diagnostic signs were observed in rodents. At these doses the only signs seen in dogs were emesis and mucoid stools.

A few cases of overdosage with ZOCOR have been reported; the maximum dose taken was 3.6 g. All patients recovered without sequelae. Supportive measures should be taken in the event of an overdose. The dialyzability of simvastatin and its metabolites in man is not known at present.

## 11 DESCRIPTION

ZOCOR (simvastatin) is a lipid-lowering agent that is derived synthetically from a fermentation product of *Aspergillus terreus*. After oral ingestion, simvastatin, which is an inactive lactone, is hydrolyzed to the corresponding  $\beta$ -hydroxyacid form. This is an inhibitor of 3-hydroxy-3-methylglutaryl-coenzyme A (HMG-CoA) reductase. This enzyme catalyzes the conversion of HMG-CoA to mevalonate, which is an early and rate-limiting step in the biosynthesis of cholesterol.

Simvastatin is butanoic acid, 2,2-dimethyl-,1,2,3,7,8,8a-hexahydro-3,7-dimethyl-8-[2-(tetrahydro-4-hydroxy-6-oxo-2H-pyran-2-yl)-ethyl]-1-naphthalenyl ester, [1S-[1 $\alpha$ ,3 $\alpha$ ,7 $\beta$ ,8 $\beta$ (2S\*,4S\*),-8a $\beta$ ]]. The empirical formula of simvastatin is C<sub>25</sub>H<sub>38</sub>O<sub>5</sub> and its molecular weight is 418.57. Its structural formula is:



Simvastatin is a white to off-white, nonhygroscopic, crystalline powder that is practically insoluble in water, and freely soluble in chloroform, methanol and ethanol.

Tablets ZOCOR for oral administration contain either 5 mg, 10 mg, 20 mg, 40 mg or 80 mg of simvastatin and the following inactive ingredients: ascorbic acid, citric acid, hydroxypropyl cellulose, hypromellose, iron oxides, lactose, magnesium stearate, microcrystalline cellulose, starch, talc, and titanium dioxide. Butylated hydroxyanisole is added as a preservative.

## 12 CLINICAL PHARMACOLOGY

### 12.1 Mechanism of Action

Simvastatin is a prodrug and is hydrolyzed to its active  $\beta$ -hydroxyacid form, simvastatin acid, after administration. Simvastatin is a specific inhibitor of 3-hydroxy-3-methylglutaryl-coenzyme A (HMG-CoA) reductase, the enzyme that catalyzes the conversion of HMG-CoA to mevalonate, an early and rate limiting step in the biosynthetic pathway for cholesterol. In addition, simvastatin reduces VLDL and TG and increases HDL-C.

### 12.2 Pharmacodynamics

Epidemiological studies have demonstrated that elevated levels of total-C, LDL-C, as well as decreased levels of HDL-C are associated with the development of atherosclerosis and increased cardiovascular risk. Lowering LDL-C decreases this risk. However, the independent effect of raising HDL-C or lowering TG on the risk of coronary and cardiovascular morbidity and mortality has not been determined.

### 12.3 Pharmacokinetics

Simvastatin is a lactone that is readily hydrolyzed *in vivo* to the corresponding  $\beta$ -hydroxyacid, a potent inhibitor of HMG-CoA reductase. Inhibition of HMG-CoA reductase is the basis for an assay in pharmacokinetic studies of the  $\beta$ -hydroxyacid metabolites (active inhibitors) and, following base hydrolysis, active plus latent inhibitors (total inhibitors) in plasma following administration of simvastatin.

Following an oral dose of  $^{14}\text{C}$ -labeled simvastatin in man, 13% of the dose was excreted in urine and 60% in feces. Plasma concentrations of total radioactivity (simvastatin plus  $^{14}\text{C}$ -metabolites) peaked at 4 hours and declined rapidly to about 10% of peak by 12 hours postdose. Since simvastatin undergoes extensive first-pass extraction in the liver, the availability of the drug to the general circulation is low (<5%).

Both simvastatin and its  $\beta$ -hydroxyacid metabolite are highly bound (approximately 95%) to human plasma proteins. Rat studies indicate that when radiolabeled simvastatin was administered, simvastatin-derived radioactivity crossed the blood-brain barrier.

The major active metabolites of simvastatin present in human plasma are the  $\beta$ -hydroxyacid of simvastatin and its 6'-hydroxy, 6'-hydroxymethyl, and 6'-exomethylene derivatives. Peak plasma concentrations of both active and total inhibitors were attained within 1.3 to 2.4 hours postdose. While the recommended therapeutic dose range is 5 to 40 mg/day, there was no substantial deviation from linearity of AUC of inhibitors in the general circulation with an increase in dose to as high as 120 mg. Relative to the fasting state, the plasma profile of inhibitors was not affected when simvastatin was administered immediately before an American Heart Association recommended low-fat meal.

In a study including 16 elderly patients between 70 and 78 years of age who received ZOCOR 40 mg/day, the mean plasma level of HMG-CoA reductase inhibitory activity was increased approximately 45% compared with 18 patients between 18-30 years of age. Clinical study experience in the elderly (n=1522), suggests that there were no overall differences in safety between elderly and younger patients [see *Use in Specific Populations* (8.5)].

Kinetic studies with another statin, having a similar principal route of elimination, have suggested that for a given dose level higher systemic exposure may be achieved in patients with severe renal insufficiency (as measured by creatinine clearance).

Although the mechanism is not fully understood, cyclosporine has been shown to increase the AUC of statins. The increase in AUC for simvastatin acid is presumably due, in part, to inhibition of CYP3A4.

The risk of myopathy is increased by high levels of HMG-CoA reductase inhibitory activity in plasma. Inhibitors of CYP3A4 can raise the plasma levels of HMG-CoA reductase inhibitory activity and increase the risk of myopathy [see *Warnings and Precautions (5.1) and Drug Interactions (7.1)*].

TABLE 3  
Effect of Coadministered Drugs or Grapefruit Juice on Simvastatin Systemic Exposure

Coadministered Drug or Grapefruit Juice	Dosing of Coadministered Drug or Grapefruit Juice	Dosing of Simvastatin	Geometric Mean Ratio (Ratio* with / without coadministered drug) No Effect = 1.00		
			AUC	C <sub>max</sub>	
<b>Contraindicated with simvastatin</b> [see <i>Contraindications (4) and Warnings and Precautions (5.1)</i> ]					
Telithromycin <sup>†</sup>	200 mg QD for 4 days	80 mg	simvastatin acid <sup>‡</sup> simvastatin	12 8.9	15 5.3
Nelfinavir <sup>†</sup>	1250 mg BID for 14 days	20 mg QD for 28 days	simvastatin acid <sup>‡</sup> simvastatin	6	6.2
Itraconazole <sup>†</sup>	200 mg QD for 4 days	80 mg	simvastatin acid <sup>‡</sup> simvastatin		13.1 13.1
Posaconazole	100 mg (oral suspension) QD for 13 days	40 mg	simvastatin acid simvastatin	7.3 10.3	9.2 9.4
	200 mg (oral suspension) QD for 13 days	40 mg	simvastatin acid simvastatin	8.5 10.6	9.5 11.4
Gemfibrozil	600 mg BID for 3 days	40 mg	simvastatin acid	2.85	2.18
			simvastatin	1.35	0.91
<b>Avoid &gt;1 quart of grapefruit juice with simvastatin</b> [see <i>Warnings and Precautions (5.1)</i> ]					
Grapefruit Juice <sup>§</sup> (high dose)	200 mL of double-strength TID <sup>¶</sup>	60 mg single dose	simvastatin acid simvastatin	7 16	
Grapefruit Juice <sup>§</sup> (low dose)	8 oz (about 237mL) of single-strength <sup>#</sup>	20 mg single dose	simvastatin acid simvastatin	1.3 1.9	
<b>Avoid taking with &gt;10 mg simvastatin</b> , based on clinical and/or post-marketing experience [see <i>Warnings and Precautions (5.1)</i> ]					
Verapamil SR	240 mg QD Days 1-7 then 240 mg BID on Days 8-10	80 mg on Day 10	simvastatin acid	2.3	2.4
			simvastatin	2.5	2.1
Diltiazem	120 mg BID for 10 days	80 mg on Day 10	simvastatin acid	2.69	2.69
			simvastatin	3.10	2.88
Diltiazem	120 mg BID for 14 days	20 mg on Day 14	simvastatin	4.6	3.6
<b>Avoid taking with &gt;20 mg simvastatin</b> , based on clinical and/or post-marketing experience [see <i>Warnings and Precautions (5.1)</i> ]					
Amiodarone	400 mg QD for 3 days	40 mg on Day 3	simvastatin acid	1.75	1.72
			simvastatin	1.76	1.79
Amlodipine	10 mg QD x 10 days	80 mg on Day 10	simvastatin acid	1.58	1.56
			simvastatin	1.77	1.47
Ranolazine SR	1000 mg BID for 7 days	80 mg on Day 1 and Day 6-9	simvastatin acid simvastatin	2.26 1.86	2.28 1.75
<b>No dosing adjustments required for the following:</b>					
Fenofibrate	160 mg QD X 14 days	80 mg QD on Days 8-14	simvastatin acid	0.64	0.89
			simvastatin	0.89	0.83
Niacin extended-release <sup>b</sup>	2 g single dose	20 mg single dose	simvastatin acid simvastatin	1.6 1.4	1.84 1.08
Propranolol	80 mg single dose	80 mg single dose	total inhibitor	0.79	↓ from 33.6 to 21.1 ng-eq/mL
			active inhibitor	0.79	↓ from 7.0 to 4.7 ng-eq/mL

\* Results based on a chemical assay except results with propranolol as indicated.

<sup>†</sup> Results could be representative of the following CYP3A4 inhibitors: ketoconazole, erythromycin, clarithromycin, HIV protease inhibitors, and nefazodone.

<sup>‡</sup> Simvastatin acid refers to the β-hydroxyacid of simvastatin.

<sup>§</sup> The effect of amounts of grapefruit juice between those used in these two studies on simvastatin pharmacokinetics has not been studied.

<sup>¶</sup> Double-strength: one can of frozen concentrate diluted with one can of water. Grapefruit juice was administered TID for 2 days, and 200 mL together with single dose simvastatin and 30 and 90 minutes following single dose simvastatin on Day 3.

<sup>#</sup> Single-strength: one can of frozen concentrate diluted with 3 cans of water. Grapefruit juice was administered with breakfast for 3 days, and simvastatin was administered in the evening on Day 3.

<sup>p</sup> Because Chinese patients have an increased risk for myopathy with simvastatin coadministered with lipid-modifying doses ( $\geq 1$  gram/day niacin) of niacin-containing products, and the risk is dose-related, Chinese patients should not receive simvastatin 80 mg coadministered with lipid-modifying doses of niacin-containing products [see *Warnings and Precautions* (5.1) and *Drug Interactions* (7.4)].

In a study of 12 healthy volunteers, simvastatin at the 80-mg dose had no effect on the metabolism of the probe cytochrome P450 isoform 3A4 (CYP3A4) substrates midazolam and erythromycin. This indicates that simvastatin is not an inhibitor of CYP3A4, and, therefore, is not expected to affect the plasma levels of other drugs metabolized by CYP3A4.

Coadministration of simvastatin (40 mg QD for 10 days) resulted in an increase in the maximum mean levels of cardioactive digoxin (given as a single 0.4 mg dose on day 10) by approximately 0.3 ng/mL.

## 13 NONCLINICAL TOXICOLOGY

### 13.1 Carcinogenesis, Mutagenesis, Impairment of Fertility

In a 72-week carcinogenicity study, mice were administered daily doses of simvastatin of 25, 100, and 400 mg/kg body weight, which resulted in mean plasma drug levels approximately 1, 4, and 8 times higher than the mean human plasma drug level, respectively (as total inhibitory activity based on AUC) after an 80-mg oral dose. Liver carcinomas were significantly increased in high-dose females and mid- and high-dose males with a maximum incidence of 90% in males. The incidence of adenomas of the liver was significantly increased in mid- and high-dose females. Drug treatment also significantly increased the incidence of lung adenomas in mid- and high-dose males and females. Adenomas of the Harderian gland (a gland of the eye of rodents) were significantly higher in high-dose mice than in controls. No evidence of a tumorigenic effect was observed at 25 mg/kg/day.

In a separate 92-week carcinogenicity study in mice at doses up to 25 mg/kg/day, no evidence of a tumorigenic effect was observed (mean plasma drug levels were 1 times higher than humans given 80 mg simvastatin as measured by AUC).

In a two-year study in rats at 25 mg/kg/day, there was a statistically significant increase in the incidence of thyroid follicular adenomas in female rats exposed to approximately 11 times higher levels of simvastatin than in humans given 80 mg simvastatin (as measured by AUC).

A second two-year rat carcinogenicity study with doses of 50 and 100 mg/kg/day produced hepatocellular adenomas and carcinomas (in female rats at both doses and in males at 100 mg/kg/day). Thyroid follicular cell adenomas were increased in males and females at both doses; thyroid follicular cell carcinomas were increased in females at 100 mg/kg/day. The increased incidence of thyroid neoplasms appears to be consistent with findings from other statins. These treatment levels represented plasma drug levels (AUC) of approximately 7 and 15 times (males) and 22 and 25 times (females) the mean human plasma drug exposure after an 80 milligram daily dose.

No evidence of mutagenicity was observed in a microbial mutagenicity (Ames) test with or without rat or mouse liver metabolic activation. In addition, no evidence of damage to genetic material was noted in an *in vitro* alkaline elution assay using rat hepatocytes, a V-79 mammalian cell forward mutation study, an *in vitro* chromosome aberration study in CHO cells, or an *in vivo* chromosomal aberration assay in mouse bone marrow.

There was decreased fertility in male rats treated with simvastatin for 34 weeks at 25 mg/kg body weight (4 times the maximum human exposure level, based on AUC, in patients receiving 80 mg/day); however, this effect was not observed during a subsequent fertility study in which simvastatin was administered at this same dose level to male rats for 11 weeks (the entire cycle of spermatogenesis including epididymal maturation). No microscopic changes were observed in the testes of rats from either study. At 180 mg/kg/day, (which produces exposure levels 22 times higher than those in humans taking 80 mg/day based on surface area, mg/m<sup>2</sup>), seminiferous tubule degeneration (necrosis and loss of spermatogenic epithelium) was observed. In dogs, there was drug-related testicular atrophy, decreased spermatogenesis, spermatocytic degeneration and giant cell formation at 10 mg/kg/day, (approximately 2 times the human exposure, based on AUC, at 80 mg/day). The clinical significance of these findings is unclear.

### 13.2 Animal Toxicology and/or Pharmacology

#### *CNS Toxicity*

Optic nerve degeneration was seen in clinically normal dogs treated with simvastatin for 14 weeks at 180 mg/kg/day, a dose that produced mean plasma drug levels about 12 times higher than the mean plasma drug level in humans taking 80 mg/day.

A chemically similar drug in this class also produced optic nerve degeneration (Wallerian degeneration of retinogeniculate fibers) in clinically normal dogs in a dose-dependent fashion starting at 60 mg/kg/day, a dose that produced mean plasma drug levels about 30 times higher than the mean plasma drug level in humans taking the highest recommended dose (as measured by total enzyme inhibitory activity). This same drug also produced vestibulocochlear Wallerian-like degeneration and retinal ganglion cell chromatolysis in dogs treated for 14 weeks at 180 mg/kg/day, a dose that resulted in a mean plasma drug level similar to that seen with the 60 mg/kg/day dose.

CNS vascular lesions, characterized by perivascular hemorrhage and edema, mononuclear cell infiltration of perivascular spaces, perivascular fibrin deposits and necrosis of small vessels were seen in dogs treated with simvastatin at a dose of 360 mg/kg/day, a dose that produced mean plasma drug levels that were about 14 times higher than the mean plasma drug levels in humans taking 80 mg/day. Similar CNS vascular lesions have been observed with several other drugs of this class.

There were cataracts in female rats after two years of treatment with 50 and 100 mg/kg/day (22 and 25 times the human AUC at 80 mg/day, respectively) and in dogs after three months at 90 mg/kg/day (19 times) and at two years at 50 mg/kg/day (5 times).

## 14 CLINICAL STUDIES

### 14.1 Clinical Studies in Adults

#### *Reductions in Risk of CHD Mortality and Cardiovascular Events*

In 4S, the effect of therapy with ZOCOR on total mortality was assessed in 4,444 patients with CHD and baseline total cholesterol 212-309 mg/dL (5.5-8.0 mmol/L). In this multicenter, randomized, double-blind, placebo-controlled study, patients were treated with standard care, including diet, and either ZOCOR 20-40 mg/day (n=2,221) or placebo (n=2,223) for a median duration of 5.4 years. Over the course of the study, treatment with ZOCOR led to mean reductions in total-C, LDL-C and TG of 25%, 35%, and 10%, respectively, and a mean increase in HDL-C of 8%. ZOCOR significantly reduced the risk of mortality by 30% (p=0.0003, 182 deaths in the ZOCOR group vs 256 deaths in the placebo group). The risk of CHD mortality was significantly reduced by 42% (p=0.00001, 111 vs 189 deaths). There was no statistically significant difference between groups in non-cardiovascular mortality. ZOCOR significantly decreased the risk of having major coronary events (CHD mortality plus hospital-verified and silent non-fatal myocardial infarction [MI]) by 34% (p<0.00001, 431 vs 622 patients with one or more events). The risk of having a hospital-verified non-fatal MI was reduced by 37%. ZOCOR significantly reduced the risk for undergoing myocardial revascularization procedures (coronary artery bypass grafting or percutaneous transluminal coronary angioplasty) by 37% (p<0.00001, 252 vs 383 patients). ZOCOR significantly reduced the risk of fatal plus non-fatal cerebrovascular events (combined stroke and transient ischemic attacks) by 28% (p=0.033, 75 vs 102 patients). ZOCOR reduced the risk of major coronary events to a similar extent across the range of baseline total and LDL cholesterol levels. Because there were only 53 female deaths, the effect of ZOCOR on mortality in women could not be adequately assessed. However, ZOCOR significantly lessened the risk of having major coronary events by 34% (60 vs 91 women with one or more event). The randomization was stratified by angina alone (21% of each treatment group) or a previous MI. Because there were only 57 deaths among the patients with angina alone at baseline, the effect of ZOCOR on mortality in this subgroup could not be adequately assessed. However, trends in reduced coronary mortality, major coronary events and revascularization procedures were consistent between this group and the total study cohort. Additionally, ZOCOR resulted in similar decreases in relative risk for total mortality, CHD mortality, and major coronary events in elderly patients (≥65 years), compared with younger patients.

The Heart Protection Study (HPS) was a large, multi-center, placebo-controlled, double-blind study with a mean duration of 5 years conducted in 20,536 patients (10,269 on ZOCOR 40 mg and 10,267 on

placebo). Patients were allocated to treatment using a covariate adaptive method<sup>4</sup> which took into account the distribution of 10 important baseline characteristics of patients already enrolled and minimized the imbalance of those characteristics across the groups. Patients had a mean age of 64 years (range 40-80 years), were 97% Caucasian and were at high risk of developing a major coronary event because of existing CHD (65%), diabetes (Type 2, 26%; Type 1, 3%), history of stroke or other cerebrovascular disease (16%), peripheral vessel disease (33%), or hypertension in males  $\geq 65$  years (6%). At baseline, 3,421 patients (17%) had LDL-C levels below 100 mg/dL, of whom 953 (5%) had LDL-C levels below 80 mg/dL; 7,068 patients (34%) had levels between 100 and 130 mg/dL; and 10,047 patients (49%) had levels greater than 130 mg/dL.

The HPS results showed that ZOCOR 40 mg/day significantly reduced: total and CHD mortality; non-fatal MI, stroke, and revascularization procedures (coronary and non-coronary) (see Table 4).

TABLE 4  
Summary of Heart Protection Study Results

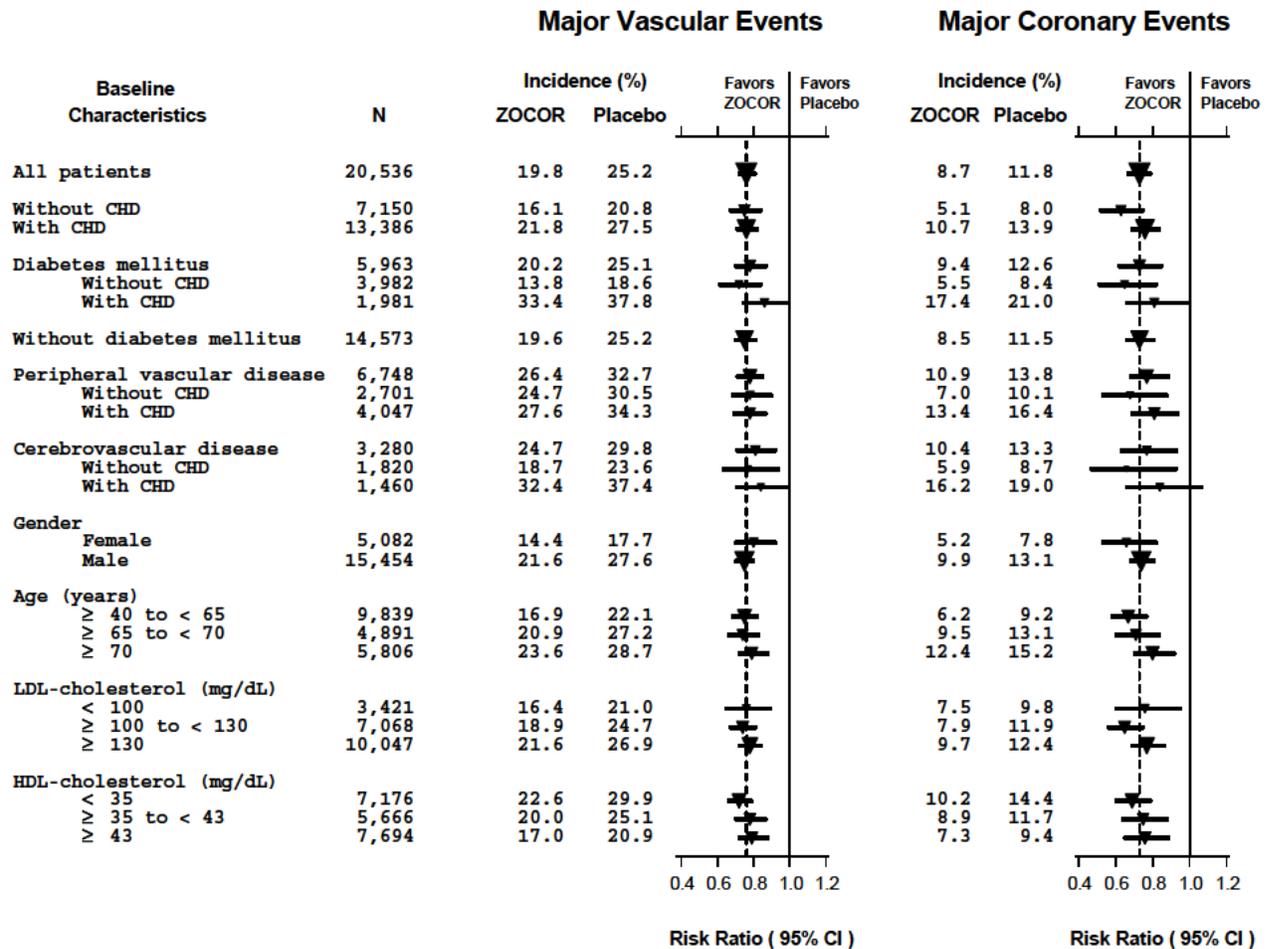
Endpoint	ZOCOR (N=10,269) n (%) <sup>†</sup>	Placebo (N=10,267) n (%) <sup>†</sup>	Risk Reduction (%) (95% CI)	p-Value
<b>Primary</b>				
Mortality	1,328 (12.9)	1,507 (14.7)	13 (6-19)	p=0.0003
CHD mortality	587 (5.7)	707 (6.9)	18 (8-26)	p=0.0005
<b>Secondary</b>				
Non-fatal MI	357 (3.5)	574 (5.6)	38 (30-46)	p<0.0001
Stroke	444 (4.3)	585 (5.7)	25 (15-34)	p<0.0001
<b>Tertiary</b>				
Coronary revascularization	513 (5)	725 (7.1)	30 (22-38)	p<0.0001
Peripheral and other non-coronary revascularization	450 (4.4)	532 (5.2)	16 (5-26)	p=0.006

<sup>†</sup> n = number of patients with indicated event

Two composite endpoints were defined in order to have sufficient events to assess relative risk reductions across a range of baseline characteristics (see Figure 1). A composite of major coronary events (MCE) was comprised of CHD mortality and non-fatal MI (analyzed by time-to-first event; 898 patients treated with ZOCOR had events and 1,212 patients on placebo had events). A composite of major vascular events (MVE) was comprised of MCE, stroke and revascularization procedures including coronary, peripheral and other non-coronary procedures (analyzed by time-to-first event; 2,033 patients treated with ZOCOR had events and 2,585 patients on placebo had events). Significant relative risk reductions were observed for both composite endpoints (27% for MCE and 24% for MVE, p<0.0001). Treatment with ZOCOR produced significant relative risk reductions for all components of the composite endpoints. The risk reductions produced by ZOCOR in both MCE and MVE were evident and consistent regardless of cardiovascular disease related medical history at study entry (i.e., CHD alone; or peripheral vascular disease, cerebrovascular disease, diabetes or treated hypertension, with or without CHD), gender, age, creatinine levels up to the entry limit of 2.3 mg/dL, baseline levels of LDL-C, HDL-C, apolipoprotein B and A-1, baseline concomitant cardiovascular medications (i.e., aspirin, beta blockers, or calcium channel blockers), smoking status, alcohol intake, or obesity. Diabetics showed risk reductions for MCE and MVE due to ZOCOR treatment regardless of baseline HbA1c levels or obesity with the greatest effects seen for diabetics without CHD.

<sup>4</sup> D.R. Taves, Minimization: a new method of assigning patients to treatment and control groups. Clin. Pharmacol. Ther. 15 (1974), pp. 443-453

Figure 1  
The Effects of Treatment with ZOCOR on Major Vascular Events and Major Coronary Events in HPS



N = number of patients in each subgroup. The inverted triangles are point estimates of the relative risk, with their 95% confidence intervals represented as a line. The area of a triangle is proportional to the number of patients with MVE or MCE in the subgroup relative to the number with MVE or MCE, respectively, in the entire study population. The vertical solid line represents a relative risk of one. The vertical dashed line represents the point estimate of relative risk in the entire study population.

**Angiographic Studies**

In the Multicenter Anti-Atheroma Study, the effect of simvastatin on atherosclerosis was assessed by quantitative coronary angiography in hypercholesterolemic patients with CHD. In this randomized, double-blind, controlled study, patients were treated with simvastatin 20 mg/day or placebo. Angiograms were evaluated at baseline, two and four years. The co-primary study endpoints were mean change per-patient in minimum and mean lumen diameters, indicating focal and diffuse disease, respectively. ZOCOR significantly slowed the progression of lesions as measured in the Year 4 angiogram by both parameters, as well as by change in percent diameter stenosis. In addition, simvastatin significantly decreased the proportion of patients with new lesions and with new total occlusions.

**Modifications of Lipid Profiles**

*Primary Hyperlipidemia (Fredrickson type IIa and IIb)*

ZOCOR has been shown to be effective in reducing total-C and LDL-C in heterozygous familial and non-familial forms of hyperlipidemia and in mixed hyperlipidemia. Maximal to near maximal response is generally achieved within 4-6 weeks and maintained during chronic therapy. ZOCOR consistently and

significantly decreased total-C, LDL-C, total-C/HDL-C ratio, and LDL-C/HDL-C ratio; ZOCOR also decreased TG and increased HDL-C (see Table 5).

TABLE 5  
Mean Response in Patients with Primary Hyperlipidemia and Combined (mixed) Hyperlipidemia  
(Mean Percent Change from Baseline After 6 to 24 Weeks)

TREATMENT	N	TOTAL-C	LDL-C	HDL-C	TG <sup>†</sup>
<u>Lower Dose Comparative Study</u> <sup>‡</sup> (Mean % Change at Week 6)					
ZOCOR 5 mg q.p.m.	109	-19	-26	10	-12
ZOCOR 10 mg q.p.m.	110	-23	-30	12	-15
<u>Scandinavian Simvastatin Survival Study</u> <sup>§</sup> (Mean % Change at Week 6)					
Placebo	2223	-1	-1	0	-2
ZOCOR 20 mg q.p.m.	2221	-28	-38	8	-19
<u>Upper Dose Comparative Study</u> <sup>  </sup> (Mean % Change Averaged at Weeks 18 and 24)					
ZOCOR 40 mg q.p.m.	433	-31	-41	9	-18
ZOCOR 80 mg q.p.m. <sup>¶</sup>	664	-36	-47	8	-24
<u>Multi-Center Combined Hyperlipidemia Study</u> <sup>††</sup> (Mean % Change at Week 6)					
Placebo	125	1	2	3	-4
ZOCOR 40 mg q.p.m.	123	-25	-29	13	-28
ZOCOR 80 mg q.p.m.	124	-31	-36	16	-33

<sup>†</sup> median percent change

<sup>‡</sup> mean baseline LDL-C 244 mg/dL and median baseline TG 168 mg/dL

<sup>§</sup> mean baseline LDL-C 188 mg/dL and median baseline TG 128 mg/dL

<sup>||</sup> mean baseline LDL-C 226 mg/dL and median baseline TG 156 mg/dL

<sup>¶</sup> 21% and 36% median reduction in TG in patients with TG ≤200 mg/dL and TG >200 mg/dL, respectively. Patients with TG >350 mg/dL were excluded

<sup>††</sup> mean baseline LDL-C 156 mg/dL and median baseline TG 391 mg/dL.

#### Hypertriglyceridemia (Fredrickson type IV)

The results of a subgroup analysis in 74 patients with type IV hyperlipidemia from a 130-patient, double-blind, placebo-controlled, 3-period crossover study are presented in Table 6.

TABLE 6  
Six-week, Lipid-lowering Effects of Simvastatin in Type IV Hyperlipidemia  
Median Percent Change (25<sup>th</sup> and 75<sup>th</sup> percentile) from Baseline<sup>†</sup>

TREATMENT	N	Total-C	LDL-C	HDL-C	TG	VLDL-C	Non-HDL-C
Placebo	74	+2 (-7, +7)	+1 (-8, +14)	+3 (-3, +10)	-9 (-25, +13)	-7 (-25, +11)	+1 (-9, +8)
ZOCOR 40 mg/day	74	-25 (-34, -19)	-28 (-40, -17)	+11 (+5, +23)	-29 (-43, -16)	-37 (-54, -23)	-32 (-42, -23)
ZOCOR 80 mg/day	74	-32 (-38, -24)	-37 (-46, -26)	+15 (+5, +23)	-34 (-45, -18)	-41 (-57, -28)	-38 (-49, -32)

<sup>†</sup> The median baseline values (mg/dL) for the patients in this study were: total-C = 254, LDL-C = 135, HDL-C = 36, TG = 404, VLDL-C = 83, and non-HDL-C = 215.

*Dysbetalipoproteinemia (Fredrickson type III)*

The results of a subgroup analysis in 7 patients with type III hyperlipidemia (dysbetalipoproteinemia) (apo E2/2) (VLDL-C/TG>0.25) from a 130-patient, double-blind, placebo-controlled, 3-period crossover study are presented in Table 7.

TABLE 7  
Six-week, Lipid-lowering Effects of Simvastatin in Type III Hyperlipidemia  
Median Percent Change (min, max) from Baseline<sup>†</sup>

TREATMENT	N	Total-C	LDL-C + IDL	HDL-C	TG	VLDL-C + IDL	Non-HDL-C
Placebo	7	-8 (-24, +34)	-8 (-27, +23)	-2 (-21, +16)	+4 (-22, +90)	-4 (-28, +78)	-8 (-26, -39)
ZOCOR 40 mg/day	7	-50 (-66, -39)	-50 (-60, -31)	+7 (-8, +23)	-41 (-74, -16)	-58 (-90, -37)	-57 (-72, -44)
ZOCOR 80 mg/day	7	-52 (-55, -41)	-51 (-57, -28)	+7 (-5, +29)	-38 (-58, +2)	-60 (-72, -39)	-59 (-61, -46)

<sup>†</sup> The median baseline values (mg/dL) were: total-C = 324, LDL-C = 121, HDL-C = 31, TG = 411, VLDL-C = 170, and non-HDL-C = 291.

*Homozygous Familial Hypercholesterolemia*

In a controlled clinical study, 12 patients 15-39 years of age with homozygous familial hypercholesterolemia received simvastatin 40 mg/day in a single dose or in 3 divided doses, or 80 mg/day in 3 divided doses. In 11 patients with reductions in LDL-C, the mean LDL-C changes for the 40- and 80-mg doses were 14% (range 8% to 23%, median 12%) and 30% (range 14% to 46%, median 29%), respectively. One patient had an increase of 15% in LDL-C. Another patient with absent LDL-C receptor function had an LDL-C reduction of 41% with the 80-mg dose.

*Endocrine Function*

In clinical studies, simvastatin did not impair adrenal reserve or significantly reduce basal plasma cortisol concentration. Small reductions from baseline in basal plasma testosterone in men were observed in clinical studies with simvastatin, an effect also observed with other statins and the bile acid sequestrant cholestyramine. There was no effect on plasma gonadotropin levels. In a placebo-controlled, 12-week study there was no significant effect of simvastatin 80 mg on the plasma testosterone response to human chorionic gonadotropin. In another 24-week study, simvastatin 20-40 mg had no detectable effect on spermatogenesis. In 4S, in which 4,444 patients were randomized to simvastatin 20-40 mg/day or placebo for a median duration of 5.4 years, the incidence of male sexual adverse events in the two treatment groups was not significantly different. Because of these factors, the small changes in plasma testosterone are unlikely to be clinically significant. The effects, if any, on the pituitary-gonadal axis in premenopausal women are unknown.

**14.2 Clinical Studies in Adolescents**

In a double-blind, placebo-controlled study, 175 patients (99 adolescent boys and 76 post-menarchal girls) 10-17 years of age (mean age 14.1 years) with heterozygous familial hypercholesterolemia (HeFH) were randomized to simvastatin (n=106) or placebo (n=67) for 24 weeks (base study). Inclusion in the study required a baseline LDL-C level between 160 and 400 mg/dL and at least one parent with an LDL-C level >189 mg/dL. The dosage of simvastatin (once daily in the evening) was 10 mg for the first 8 weeks, 20 mg for the second 8 weeks, and 40 mg thereafter. In a 24-week extension, 144 patients elected to continue therapy with simvastatin 40 mg or placebo.

ZOCOR significantly decreased plasma levels of total-C, LDL-C, and Apo B (see Table 8). Results from the extension at 48 weeks were comparable to those observed in the base study.

TABLE 8  
Lipid-Lowering Effects of Simvastatin in Adolescent Patients with Heterozygous Familial Hypercholesterolemia  
(Mean Percent Change from Baseline)

Dosage	Duration	N		Total-C	LDL-C	HDL-C	TG <sup>†</sup>	Apo B
Placebo	24 Weeks	67	% Change from Baseline (95% CI)	1.6 (-2.2, 5.3)	1.1 (-3.4, 5.5)	3.6 (-0.7, 8.0)	-3.2 (-11.8, 5.4)	-0.5 (-4.7, 3.6)
			Mean baseline, mg/dL (SD)	278.6 (51.8)	211.9 (49.0)	46.9 (11.9)	90.0 (50.7)	186.3 (38.1)
ZOCOR	24 Weeks	106	% Change from Baseline (95% CI)	-26.5 (-29.6, -23.3)	-36.8 (-40.5, -33.0)	8.3 (4.6, 11.9)	-7.9 (-15.8, 0.0)	-32.4 (-35.9, -29.0)
			Mean baseline, mg/dL (SD)	270.2 (44.0)	203.8 (41.5)	47.7 (9.0)	78.3 (46.0)	179.9 (33.8)

<sup>†</sup> median percent change

After 24 weeks of treatment, the mean achieved LDL-C value was 124.9 mg/dL (range: 64.0-289.0 mg/dL) in the ZOCOR 40 mg group compared to 207.8 mg/dL (range: 128.0-334.0 mg/dL) in the placebo group.

The safety and efficacy of doses above 40 mg daily have not been studied in children with HeFH. The long-term efficacy of simvastatin therapy in childhood to reduce morbidity and mortality in adulthood has not been established.

## 16 HOW SUPPLIED/STORAGE AND HANDLING

No. 8360 — Tablets ZOCOR 5 mg are buff, oval, film-coated tablets, coded MSD 726 on one side and ZOCOR 5 on the other. They are supplied as follows:

**NDC 0006-0726-31** unit of use bottles of 30

**NDC 0006-0726-54** unit of use bottles of 90.

No. 8146 — Tablets ZOCOR 10 mg are peach, oval, film-coated tablets, coded MSD 735 on one side and plain on the other. They are supplied as follows:

**NDC 0006-0735-31** unit of use bottles of 30

**NDC 0006-0735-54** unit of use bottles of 90

**NDC 0006-0735-82** bottles of 1000.

No. 8147 — Tablets ZOCOR 20 mg are tan, oval, film-coated tablets, coded MSD 740 on one side and plain on the other. They are supplied as follows:

**NDC 0006-0740-31** unit of use bottles of 30

**NDC 0006-0740-54** unit of use bottles of 90

**NDC 0006-0740-82** bottles of 1000.

No. 8148 — Tablets ZOCOR 40 mg are brick red, oval, film-coated tablets, coded MSD 749 on one side and plain on the other. They are supplied as follows:

**NDC 0006-0749-31** unit of use bottles of 30

**NDC 0006-0749-54** unit of use bottles of 90

**NDC 0006-0749-82** bottles of 1000.

No. 6577 — Tablets ZOCOR 80 mg are brick red, capsule-shaped, film-coated tablets, coded 543 on one side and 80 on the other. They are supplied as follows:

**NDC 0006-0543-31** unit of use bottles of 30

**NDC 0006-0543-54** unit of use bottles of 90

**NDC 0006-0543-28** unit dose packages of 100

**NDC 0006-0543-82** bottles of 1000.

### Storage

Store between 5-30°C (41-86°F).

### Storage of 1,000 count bottles

Dispense in a tightly-closed container.

## 17 PATIENT COUNSELING INFORMATION

Patients should be advised to adhere to their National Cholesterol Education Program (NCEP)-recommended diet, a regular exercise program, and periodic testing of a fasting lipid panel.

**Patients should be advised about substances they should not take concomitantly with simvastatin [see Contraindications (4) and Warnings and Precautions (5.1)]. Patients should also be advised to inform other healthcare professionals prescribing a new medication or increasing the dose of an existing medication that they are taking ZOCOR.**

### 17.1 Muscle Pain

All patients starting therapy with ZOCOR should be advised of the risk of myopathy, including rhabdomyolysis, and told to report promptly any unexplained muscle pain, tenderness or weakness. **Patients using the 80-mg dose should be informed that the risk of myopathy, including rhabdomyolysis, is increased with use of the 80-mg dose.** The risk of myopathy, including rhabdomyolysis, occurring with use of ZOCOR is increased when taking certain types of medication or consuming larger quantities of grapefruit juice. Patients should discuss all medication, both prescription and over the counter, with their healthcare professional.

### 17.2 Liver Enzymes

It is recommended that liver function tests be performed before the initiation of ZOCOR, and thereafter when clinically indicated. All patients treated with ZOCOR should be advised to report promptly any symptoms that may indicate liver injury, including fatigue, anorexia, right upper abdominal discomfort, dark urine or jaundice.

### 17.3 Pregnancy

Women of childbearing age should be advised to use an effective method of birth control to prevent pregnancy while using ZOCOR. Discuss future pregnancy plans with your patients, and discuss when to stop taking ZOCOR if they are trying to conceive. Patients should be advised that if they become pregnant they should stop taking ZOCOR and call their healthcare professional.

### 17.4 Breastfeeding

Women who are breastfeeding should not use ZOCOR. Patients who have a lipid disorder and are breastfeeding should be advised to discuss the options with their healthcare professional.

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Manuf. for: Merck Sharp & Dohme Corp., a subsidiary of  
 **MERCK & CO., INC.**, Whitehouse Station, NJ 08889, USA

By:  
MERCK SHARP & DOHME LTD.  
Cramlington, Northumberland, UK NE23 3JU

Revised: 10/2011

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**This is a representation of an electronic record that was signed electronically and this page is the manifestation of the electronic signature.**  
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/s/  
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AMY G EGAN  
10/06/2011

**CENTER FOR DRUG EVALUATION AND  
RESEARCH**

*APPLICATION NUMBER:*

**019766Orig1s083**

**MEDICAL REVIEW(S)**

## **Clinical Review for Statin Class Labeling Changes**

**February 15, 2012**

**Amy G. Egan, M.D., M.P.H.**

On August 11, 2011 the Division of Metabolism and Endocrinology Products (DMEP) issued supplement request letters to the sponsors of all HMG-CoA reductase inhibitor (statin) drugs requesting changes to the labeling so as to furnish adequate information for the safe and effective use of their statin. These labeling changes were based on FDA's comprehensive review of the statin class of drugs, including clinical trial data, Adverse Event Reporting System (AERS) reports, the published literature, and the labels of other approved drugs containing information on statin co-administration. This review will serve to summarize the safety issues and the sources and reviews of the data.

### **1. Liver enzyme abnormalities – TSI #57**

On March 19, 2007 DMEP opened Tracked Safety Issue (TSI) #57 to evaluate hepatotoxicity associated with the statin class of drugs. This was based on articles in the published literature which suggested that FDA should re-evaluate current recommendations in statin labeling for routine periodic monitoring of liver enzyme tests.

In March 2008, DMEP issued Information Request letters to the statin sponsors requesting the following:

- a. Does <<APPLICANT>> have an opinion or recommendation regarding the utility of baseline and/or periodic monitoring of serum aminotransferase activity prior to and/or during treatment with <<STATIN>>? Please address this question for subjects with normal liver function and for those with asymptomatic liver disease (e.g., NAFLD, hepatitis C).
- b. Upon what clinical evidence or other consideration are these opinions or recommendations based?
- c. Please provide the number of phase 2 and 3 trials conducted with <<STATIN>> for which you have access to the raw data.

The table below summarizes the sponsors' responses to the first question:

Table 10. Overview of Industry responses to FDA questions on hepatotoxicity of statins			
Sponsor	Product	Text suggests interest in withdrawal of monitoring	caveats
Andrx	Lovastatin ER	No	none
AstraZeneca	rosuvastatin	Yes	none
Bristol-Myers Squibb	pravastatin	N/A	No text to delete
Merck	lovastatin	No	None
Merck	simvastatin	No	None
Novartis	fluvastatin	No	None
Pfizer	atorvastatin	Yes	10 mg dose only

In general, most sponsors agreed that liver enzyme testing prior to initiation of statin therapy was appropriate, but acknowledged that there appeared to be limited utility to routine liver biochemistry monitoring during treatment. One sponsor commented on the recommendations of the Liver Expert Panel convened by the National Lipid Association which stated that “because there is no evidence that a relation exists between elevated serum aminotransferase levels and significant liver injury, or that routine monitoring of liver biochemistries will identify individuals likely to develop rare cases of idiosyncratic liver failure, the requirement for routine liver biochemistry monitoring in patients receiving any of the currently marketed statin therapies should be re-examined.” Another sponsor noted that “nearly 50% of hyperlipidemic patients have coexisting non-alcoholic fatty liver disease (NAFLD) and it is well known that LFT levels fluctuate in NAFLD.”

In conjunction with the request to statin sponsors, DMEP requested that the Office of Surveillance and Epidemiology (OSE) conduct a review to characterize the risk of clinically serious hepatotoxicity in association with statins and assist in a determination if the statin class labeling for liver enzyme monitoring should be retained, revised, or removed. OSE had conducted 5 postmarket reviews of statins and hepatotoxicity between 2000 and 2009. Those reviews had consistently noted that reporting of statin-associated serious liver injury to AERS was extremely low (reporting rate of  $\leq 2$  per one million patient-years).

The OSE review of AERS was completed May 13, 2011. The review focused on cases of severe liver injury, defined as a 4 (severe liver injury) or a 5 (death or liver transplant) using the Drug Induced Liver Injury Network (DILIN) liver injury severity scale. Cases meeting those criteria were further assessed for causality. Seventy-five cases (27 with a severity score of 4 and 48 with a severity score of 5 [37 deaths and 11 liver transplants]) were assessed for causality, 30 of which (14 deaths, 7 liver transplantations, and 9 severe liver injury) were assessed as possibly (25-49% likelihood) or probably (50-74% likelihood) associated with

statin therapy. No cases were assessed as highly likely (75-95% likelihood) or definitely (>95% likelihood) associated with statin therapy. OSE noted that “despite rising use of statins as a class since the late 1990s, there has not been a detectable uptick in the annual rates of fatal (deaths or liver transplant) or severe liver injury possibly or probably causally associated cases.” The cases are summarized in the table below:

<b>Table 6. Characteristics of U.S. AERS Cases With A Liver Injury Severity Score of 4 (Severe) or 5 (Death or Transplant) and Causally Associated* With Statin Therapy. Source: AERS, marketing through January 1, 2009</b>			
<b>Liver Injury Severity Score</b>	<b>5 (Death)</b>	<b>5 (Transplant)</b>	<b>4 (Severe)</b>
<b># of Cases</b>	14	7	9
<b>Median Age in Years (range)</b>	66 (51-89)	48 (40-71)	58 (47-71)
<b>Percent Female</b>	79% (11/14)	71% (5/7)	67% (6/9)
<b>Statin at the Time of Event Median Daily Dose in mg (range [n])</b>			
Atorvastatin	4 -- (10, 10 [n=2])	3 10 (10-20 [n=3])	4 10 (10-20 [n=3])
Cerivastatin	--	--	--
Fluvastatin	--	--	1 -- (20 [n=1])
Lovastatin	1 -- (20 [n=1])	1 -- (-- [n=0])	--
Pravastatin	3 -- (20, 40 [n=2])	--	1 -- (10 [n=1])
Rosuvastatin	--	--	--
Simvastatin	6 20 (10-40 [n=5])	3 20 (20-40 [n=3])	3 -- (40 [n=1])
<b>Time to Onset in Months**, Median (range)</b>	2.5 (3 wk – 12 mo)	1.5 (2.4 wk - 6 mo)	2 (5 wk – 8 mo)
<b>Peak Serum Total Bilirubin Level in mg/dL, Median (range [n])</b>	23 (2.9-51 [n=12])	27 (22-32 [n=4])	10 (1.2-25 [n=9])
<b>Peak Serum ALT Level in units/L, Median (range[n]) reference range: 6-41 units/L</b>	1,127 (148-4,300 [n=10])	2,912 (2,037-13,531[n=4])	1,319 (538-3,000 [n=9])
<b>Peak Serum AST Level in units/L, Median (range[n]) reference range: 9-34 units/L</b>	1,497 (81-7,200 [n=11])	2,294 (1,755-6,815 [n=4])	1,260 (853-3,000 [n=9])
<b>Peak Serum ALP Level in units/L, Median (range[n]) reference range: 37-116 units/L</b>	206 (155-623 [n=9])	-- (290, 602 [n=2])	307 (131-800 [n=4])

\*Defined as probably associated (supported by the evidence as implicating the drug but not definite or highly likely) or possibly associated (causality is not supported by the preponderance of evidence, but one cannot definitively exclude the possibility)

\*\*Time to onset defined as the interval between exposure time or time after dose increased to reported liver injury event

OSE also looked at cases from the DILIN and Acute Liver Failure Study Group (ALFSG), organizations which have been systematically submitting reports to FDA of drug associated liver injury referred to their respective liver injury outcome studies. For statin associated liver injury, DILIN has submitted 25 reports to FDA as of January 1, 2011, twelve of which resulted in an outcome of hospitalization. In the ALFSG database, there were 9 reports of drug-induced liver injury (DILI) associated with statin therapy. OSE cited a 2010 article from

ALFSG that included 133 prospectively identified cases of idiopathic DILI resulting in acute liver failure. Fifteen patients were taking statins and in 6 of these 15 individuals a statin was identified as the only potential DILI agent. The authors noted that statin hepatotoxicity is “generally benign” and the identification of these 6 cases represents a “provocative observation”.

Using the AERS and drug utilization databases, reporting rates were calculated for U.S. statin cases associated with liver injury and an outcome of death or liver transplant, from the time of initial marketing approval through January 1, 2009. It should be noted that reporting rates are subject to secular reporting trends which normally preclude generation of reporting rates between products with initial marketing dates greater than 2-4 years apart. Despite the limitations of the analysis, it appears that reporting levels for serious liver injury in association with currently marketed statins are generally similar.

**Table 9. Number of U.S. Statin Cases Associated with Liver Injury and an Outcome of Death or Liver Transplant (Severity Score 5). Initial Marketing Approval Through January 1, 2009**

Generic Name (Brand)	Number of cases	Total Number of Prescriptions (TRxs) Dispensed by U.S. Retail Pharmacies, 1991-2008† (in millions)	Observed reporting rate (b) (4)
Lovastatin (Mevacor, Advicor, Altocor)	23	(b) (4)	(b) (4)
Pravastatin (Pravachol)	11		
Simvastatin (Zocor, Vytorin, Simcor)	51		
Fluvastatin (Lescol)	4		
Atorvastatin (Lipitor)	64		
Rosuvastatin (Crestor)	3		
<b>Total</b>	<b>156</b>		

OSE also reviewed current monitoring guidelines including the National Lipid Association’s Liver Expert Panel, which state:

*The Liver Expert Panel does not believe that the available scientific evidence supports the routine monitoring of liver biochemistries in asymptomatic patients receiving statins. The Panel makes this recommendation because (1) irreversible liver damage resulting from statins is exceptionally rare and is likely idiosyncratic in nature, and (2) no data exist to show that routine monitoring of liver biochemistries is effective in identifying the very rare individual who may develop significant liver injury from ongoing statin therapy. In the view of the Panel, routine monitoring will instead identify patients with isolated*

*increased aminotransferase levels, which could motivate physicians to alter or discontinue statin therapy, thereby placing patients at increased risk for cardiovascular events.*

OSE further noted that the NLA's Statin Safety Task Force had a slightly divergent opinion and made the following recommendation:

*Until there is a change in the FDA-approved prescribing information for statins, it is appropriate to continue to measure transaminase levels before starting therapy, 12 weeks after initiating therapy, after a dose increase, and periodically thereafter. However, routine monitoring of liver function tests is not supported by the available evidence and the current recommendation for monitoring needs to be reconsidered by the FDA.*

The OSE review concluded:

*Serious, hepatocellular DILI can be caused by statins. Although the routine monitoring of serum ALT and other markers for liver injury is vital for drug development, it does not appear to be useful in a post-marketing, non-study, ambulatory setting to routinely detect and prevent serious liver injury in association with statins. In place of current recommendations for serum enzyme monitoring, labeling for statins should focus on an alert to identify serious liver injury and clinical symptoms of liver injury, interruption of therapy, physician interactions, and emphasize the importance of appropriate diagnostic work-up.*

OSE further recommended:

*It is justified that the recommendation to perform routine periodic serum ALT monitoring in all treated patients at prespecified intervals currently in place for some marketed statins be removed.*

Based on these recommendations, DMEP requested the following changes to statin labeling:

Under HIGHLIGHTS OF PRESCRIBING INFORMATION, under **WARNINGS AND PRECAUTIONS**:

Liver enzyme abnormalities: Persistent elevations in hepatic transaminases can occur. Check liver enzyme tests before initiating therapy and as clinically indicated thereafter.

Under **5 WARNINGS AND PRECAUTIONS**, [REDACTED] (b) (4) :

It is recommended that liver enzyme tests be performed before the initiation of <<STATIN>> [REDACTED] (b) (4).

There have been rare postmarketing reports of fatal and non-fatal hepatic failure in patients taking statins, including <<STATIN>>. If serious liver injury with clinical symptoms and/or

hyperbilirubinemia or jaundice occurs during treatment with <<STATIN>>, promptly interrupt therapy. If an alternate etiology is not found do not restart <<STATIN>>.

#### Under **6 ADVERSE REACTIONS, Post-Marketing Experience:**

(b) (4)

#### Under **17 PATIENT COUNSELING INFORMATION, Liver Enzymes:**

It is recommended that liver enzyme tests be (b) (4) before the initiation of <<STATIN>> and if signs or symptoms of liver injury occur. All patients treated with <<STATIN>> should be advised to report promptly any symptoms that may indicate liver injury, including fatigue, anorexia, right upper abdominal discomfort, dark urine or jaundice.

(b) (4)

## **2. Cognitive effects – TSI #772**

On September 2, 2009 DMEP opened TSI #772 to evaluate the effect of statins on cognition. This was based on a complaint received from Joe Graedon of the People's Pharmacy, and an unpublished study by Duane Graveline, M.D., M.P.H. and Jay S. Cohen, M.D. entitled "Lipitor-associated memory loss: analysis of 662 cases of cognitive damage", as well as other articles from the published literature.

In attempting to assess this risk, DMEP looked initially at pre-clinical data. Several of the statin drug sponsors had performed pre-clinical cognition studies; however, those studies only address the issue of dementia syndromes, and are less helpful in addressing the issue of acute confusional states or memory impairment. Therefore, it was determined that there was no value added to re-assessing the pre-clinical data.

DMEP sent information request letters to those statin sponsors who had conducted clinical trials in which some form of neurocognitive assessment had been conducted as part of the study protocol. Those trials included: Prospective Study of Pravastatin in the Elderly at Risk (PROSPER), Heart Protection Study (HPS), and Study of the Effectiveness of Additional Reductions in Cholesterol and Homocysteine (SEARCH).

The findings were as follows:

- **PROSPER:** Subjects were screened with a Mini Mental Status Exam (MMSE) and excluded if their score was <24. Cognitive function was assessed in all 5,804 participants at six different time points during the study.

Four neuropsychological tests were performed, two of which tested executive function (attention and speed) and two of which tested memory (immediate and delayed). All tests showed a significant decline over time (3-year follow-up); however, there was no difference between treatment groups, pravastatin 40 mg versus placebo.

- **HPS:** A modified Telephone Interview for Cognitive Status (TICS-m) questionnaire was administered to participants during their final follow-up, either face-to-face in the clinic or over the telephone. Data were available on 8086/10269 (79%) of simvastatin-allocated subjects and 7834/10267 (76%) of placebo-allocated subjects. No significant differences were observed between the treatment groups in the percentages of participants classified as cognitively impaired (defined as a TICS-m score below 22 out of 39), either overall (23.7% simvastatin 40 mg-allocated vs. 24.2% placebo-allocated) or in subgroups defined with respect to their age at study entry (<65 years: 17.1% vs. 17.8%; 65-69 years: 25.8% vs. 25.4%; 70-80 years: 34.6% vs. 36.2%) or their previous history of cerebrovascular disease (no prior stroke: 22.8% vs. 23.3%; prior stroke: 31.9% vs. 33.3%). Nor was there any significant difference between the groups in mean TICS-m score (24.08 vs. 24.06). Similar numbers of participants in each treatment group were reported to have developed dementia during follow-up (31 [0.3%] vs. 31 [0.3%]).

There was a slightly higher frequency of cases of Alzheimer's disease or Alzheimer's type dementia in patients on simvastatin (n=6) compared to placebo (n=3). When looking at all patients with potential diagnoses of dementia including Alzheimer's disease, confusion, disorientation, dementia or cognitive impairment, there was no difference in the frequency of patients in the simvastatin group (n=35; 0.34%) compared to placebo (n=33; 0.32%).

- **SEARCH:** Assessment of cognitive function, using the TICS-m score, was a tertiary endpoint for the folate arm of the trial. It was performed in 8891 subjects – 4473 on simvastatin 80 mg and 4418 on simvastatin 20 mg – at the final visit. There was no difference in mean TICS-m score between treatment groups ( $24.3 \pm 4.1$  for simvastatin 80 mg vs.  $24.3 \pm 4.3$  for simvastatin 20 mg), and no difference in percentages of patients with scores <20,  $\geq 20$ , <22,  $\geq 22$ , <25,  $\geq 25$ , <30,  $\geq 30$  between treatment groups. The TICS-m score reflects memorizing ability in large part. Verbal fluency scores also did not differ among patients allocated to simvastatin 80 mg and simvastatin 20 mg. Hearing thresholds were assessed at final follow-up and did not differ between the simvastatin groups.

The incidence of memory loss attributed to study treatment was 17 (0.3%) in patients allocated to simvastatin 80 mg, and 8 (0.1%) in patients allocated to simvastatin 20 mg.

It should also be noted that while no formal neurocognitive assessment was performed in the Justification for the Use of Statins in Primary Prevention: an Intervention Trial Evaluating Rosuvastatin (JUPITER), there was noted a

statistically significant increase in the reported adverse event of confusional state in subjects allocated to rosuvastatin 20 mg (n=8 [0.2%]) versus subjects allocated to placebo (n=4 [0.04%]).

DMEP was aware of a Phase III efficacy study of atorvastatin that had been conducted in patients with mild to moderate Alzheimer's Disease. The clinical study report for this study (Study A2581078) was requested from the sponsor and consulted to the Division of Neurology Products (DNP) for review. DNP's findings were as follows:

*The results of Study A2581078, an adequately-designed Phase III efficacy and safety study of atorvastatin (Lipitor) in patients with mild to moderate Probable Alzheimer's Disease, provide no evidence that the administration of Lipitor results in cognitive worsening in this population; neither was there any evidence of a worsening of global function in those treated with atorvastatin in this study.*

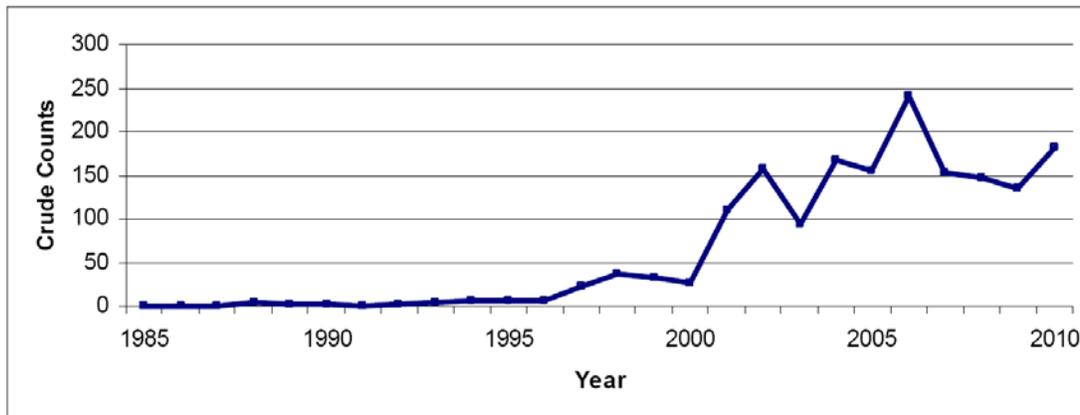
DMEP consulted OSE and requested that a review of AERS and the published literature be conducted to further assess the effect of statins on cognition. In 2002, OSE had performed a review of 279 statin reports associated with transient memory loss. This review had been requested by DMEP in response to a consumer report of transient global amnesia (TGA) with atorvastatin. At that time, OSE determined that the calculated reporting rate for statin-associated TGA (0.12-0.55 per 100,000 patient years) was well below the background incidence rate (3.4-32/100,000 population per year). As memory loss was already included in the statin labels, no labeling change was recommended at that time.

OSE's updated review of AERS focused on reports of serious cases of memory impairment, using the following High Level Terms (HLT):

- Mental Impairment (excluding dementia and memory loss)
- Memory Loss (excluding dementia)
- Amnestic Symptoms
- Confusion and Disorientation

Through January 1, 2011 there were 1,698 U.S. serious reports (crude counts) in AERS.

**Figure 1. Number of U.S. Serious Statin\* Reports (Crude Counts) Associated with Cognitive Change†, by Year Received. Source: AERS, Initial Marketing Approval Through January 1, 2011 (n=1,698)**



\*Includes single ingredient and combination statin products approved by FDA.

†Reports identified in AERS using four HLTs: Mental Impairment (excluding dementia & memory loss), Memory Loss (excluding dementia), Amnesic Symptoms, and Confusion and Disorientation

Further case review was limited to 182 reports received by FDA in 2010. Of those reports, 57 unique cases described transient cognitive change as the primary adverse event. Sixty-nine percent (n=125) of the cases were excluded because they reported multiple events such as rhabdomyolysis, renal failure, and confusion (n=81), were duplicates (n=18), hearsay (n=3), reported by attorneys (n=5), or solicited reports (n=16).

Characteristics of the 57 cases included:

- Age: median of 62 years (30-85)
- Sex: 62% male
- Exposure time: median of 3 years (1 month-12 years)

The literature review included case series of transient cognitive impairment associated with statin use, as well as observational studies on the association between statin use and the incidence of dementia. The observational evidence was summarized based on a meta-analysis by Zhou and colleagues:

*After conducting a systematic review, the authors identified four cohort studies and three case-control studies which examined the association between statin use and dementia. The average observation period ranged from three to nine years. Three case-control studies suggested statin use may lower the incidence of dementia; while the remaining four cohort studies failed to demonstrate an association between statin use and incident dementia. A pooled analysis also failed to demonstrate an association between statin use and incident dementia.*

OSE further noted:

*Results from three prospective cohort studies published within the last year provide similar conflicting results. Analyses of Baltimore Longitudinal Study of Aging and the Ginkgo Evaluation of Memory Study suggested that statin use is associated with a lower risk of dementia. A nested-case control study in the Neurological Disorders in Central Spain cohort failed to detect an association between statin use and cross-sectional performance on a neuropsychological test battery.*

<b>Table 5. Observational Studies Summary: Statin Use and Cognition</b>				
Author (Publication Date)	Study Design	Total Sample Size (% Exposed to Statins)	Outcome	Key Result
Zhou (2007)	Meta-Analysis – Observational Studies	10523 (12%)	Incident Dementia	Adjusted OR=0.77 (95%: 0.45-1.30)
Beydoun (2010)	Cohort Study	1604 (7%)	Incident Dementia	Adjusted HR=0.21 (95%: 0.09-0.48)
Betterman (2011)	Cohort Study	3069 (25%)	Incident Dementia	Adjusted HR=0.79 (95%: 0.65-0.96)
Benito-Leon (2010)	Nested Case-Control	548 (25%)	Neuropsychological Test Performance	No treatment effect observed in any test neuropsychological test administered (global cognition, verbal fluency, psychomotor speed, confrontational naming, verbal memory, logical memory)

OSE concluded:

*The postmarket statin reports associated with transient cognitive change generally describe individuals over the age of 50 years who experience notable (sometimes described as “dramatic”), but ill-defined memory loss or impairment (e.g., “lost my mind”) that is reversible upon discontinuation of statin therapy. The statin exposure time to onset of the event is highly variable (1 day to years). These cases do not appear to be associated with fixed or progressive dementia, such as Alzheimer’s disease.*

*Like the previous (2002) OSE review, the analyzed data in this review did not reveal any discernible dose-event or age (the reported age at the time of event is similar to the age of the population using statins) trends or effects between statins and other drugs; few reports described neurologic follow-up or standardized testing results. Findings from this review (and the 2002 OSE review) are also similar to patient survey results recently published by the University of California San Diego (UCSD) Statin Effects Study investigators. Cognitive issues were reported for all statins, with atorvastatin and simvastatin most frequently reported. The time to onset was variable (1 day to 10 years). Ninety percent reported symptom improvement after the statin was discontinued. Complete recovery time varied from 1 day to several years (median time to first noted improvement was 2.5 weeks). Of 29 participants who underwent rechallenge, 19 reported recurrence of events.*

*An analysis of the epidemiologic evidence and clinical trials did not provide evidence that chronic statin use is associated with cognitive decline at the population level. Two studies demonstrated that exposure to statins for up to six months may prevent the acquisition of a practice effect on select neuropsychological measures. However, the clinical significance of an absent practice effect in the context of normal cognitive performance is questionable. Furthermore, no study systematically assessed patients who experienced statin-associated cognitive impairment during both dechallenge and rechallenge. Such systematic studies would provide additional evidence to support a causal association and better characterize the clinical phenotype.*

OSE recommended that DMEP consider statin class labeling that would characterize the nature of the cognitive changes. In response, DMEP requested that the following be added to the **Adverse Reactions, Postmarketing Experience** sub-section of all statin labels:

There have been rare postmarketing reports of cognitive impairment (e.g., memory loss, forgetfulness, amnesia, memory impairment, confusion) associated with statin use. These cognitive issues have been reported for all statins. The reports are generally nonserious, and reversible upon statin discontinuation, with variable times to symptom onset (1 day to years) and symptom resolution (median of 3 weeks).

(b) (4)

### **3. Drug-drug interaction with protease inhibitors – TSI #756**

On July 23, 2009 TSI #756 was opened to examine the drug-drug interaction between statins and protease inhibitors.

In July 2009, the sponsor for rosuvastatin (CRESTOR) submitted a prior approval supplement (PAS) proposing to include information on increased rosuvastatin exposure when CRESTOR was co-administered with the combinations of protease inhibitors tipranavir/ritonavir, atazanavir/ritonavir or fosamprenavir/ritonavir, based on studies in the published literature. Previous CRESTOR labeling had noted a DDI with lopinavir/ritonavir (KALETRA) resulting in a dose cap of 10 mg of CRESTOR when co-administered with KALETRA.

In a January 2010 review of the PAS, it was noted that there were inconsistencies between the statin labels and the protease inhibitor labels regarding recommendations for co-administration of these products. It was therefore determined that the Office of Clinical Pharmacology (OCP) would review the relevant data on DDIs between statins and HIV and HCV protease inhibitors.

On August 3, 2011 OCP completed its review of the cross labeling initiative for drug interaction updates between protease inhibitors and statins. DMEP was requested to make changes to the atorvastatin and pravastatin labels to provide the results of DDI studies conducted with certain protease inhibitors, and in the case of atorvastatin, to provide dose caps where appropriate, based on the results of the following DDI studies:

- Tipranavir/ritonavir increases atorvastatin AUC and  $C_{max}$  9.4-fold and 8.6-fold, respectively. Because clinical data demonstrating an increased risk of myopathy or rhabdomyolysis with co-administration are lacking, a contraindication was not supported and “Avoid atorvastatin” was recommended for labeling.
- Telaprevir increases atorvastatin AUC and  $C_{max}$  7.88-fold and 10.6-fold, respectively. Because clinical data demonstrating an increased risk of myopathy or rhabdomyolysis with co-administration are lacking, a contraindication was not supported and “Avoid atorvastatin” was recommended for labeling.
- Darunavir/ritonavir increases atorvastatin AUC and  $C_{max}$  3.4-fold and 2.25-fold, respectively. A dose cap of atorvastatin 20 mg was recommended for labeling.
- Fosamprenavir increases atorvastatin AUC and  $C_{max}$  2.3-fold and 4.04-fold, respectively. A dose cap of atorvastatin 20 mg was recommended for labeling.

(b) (4)

Based on OCP's recommendation, DMEP requested the following changes to the atorvastatin and pravastatin labels:

### Atorvastatin:

Under HIGHLIGHTS OF PRESCRIBING INFORMATION, **DRUG INTERACTIONS**, Drug Interactions Associated with Increased Risk of Myopathy/Rhabdomyolysis

Drug Interactions Associated with Increased Risk of Myopathy/Rhabdomyolysis (2.6, 5.1, 7, 12.3)	
Interacting Agents	Prescribing Recommendations
Cyclosporine, HIV protease inhibitors (tipranavir plus ritonavir), hepatitis C protease inhibitor (telaprevir)	<del>Do not exceed 10 mg atorvastatin daily</del> Avoid atorvastatin
HIV protease inhibitor (lopinavir plus ritonavir)	Use with caution and lowest dose necessary
Clarithromycin, itraconazole, HIV protease inhibitors ( <del>ritonavir plus saquinavir plus ritonavir, lopinavir plus ritonavir, darunavir plus ritonavir, fosamprenavir, fosamprenavir plus ritonavir</del> )	<del>Caution when exceeding doses &gt;20mg atorvastatin daily. The lowest dose necessary should be used.</del> Do not exceed 20 mg atorvastatin daily
HIV protease inhibitor (nelfinavir)	Do not exceed 40 mg atorvastatin daily

Under **DOSAGE AND ADMINISTRATION**:

#### **2.6 Dosage in Patients Taking Cyclosporine, Clarithromycin, Itraconazole, or Certain Protease Inhibitors a Combination of Ritonavir plus Saquinavir or Lopinavir plus Ritonavir**

In patients taking cyclosporine or the HIV protease inhibitors (tipranavir plus ritonavir) or the Hepatitis C protease inhibitor (telaprevir), therapy ~~should be limited to with LIPITOR 40 mg once daily~~ should be avoided. In patients with HIV taking lopinavir plus ritonavir, caution should be used when prescribing LIPITOR and the lowest dose necessary employed. In patients taking clarithromycin, itraconazole, or in patients with HIV taking a combination of ~~ritonavir plus saquinavir plus ritonavir, or lopinavir plus ritonavir~~ darunavir plus ritonavir, fosamprenavir, or fosamprenavir plus ritonavir ~~for doses of therapy with LIPITOR should be limited to exceeding 20 mg, and appropriate clinical assessment is recommended to ensure that the lowest dose necessary of LIPITOR is employed.~~ In patients with HIV taking nelfinavir, therapy with LIPITOR should be limited to 40 mg, and appropriate clinical assessment is recommended to ensure that the lowest dose necessary of LIPITOR is employed.

Under **5 WARNINGS AND PRECAUTIONS, 5.1 Skeletal Muscle**:

The risk of myopathy during treatment with drugs in this class is increased with concurrent administration of cyclosporine, fibric acid derivatives, erythromycin, clarithromycin, the hepatitis C protease inhibitor telaprevir, combinations of HIV protease inhibitors, including ritonavir plus saquinavir plus ritonavir, or lopinavir plus ritonavir, tipranavir plus ritonavir, darunavir plus ritonavir, fosamprenavir, or fosamprenavir plus ritonavir, niacin, or azole antifungals. Physicians considering combined therapy with LIPITOR and fibric acid derivatives, erythromycin, clarithromycin, a combination of ritonavir plus saquinavir plus ritonavir, or lopinavir plus ritonavir, darunavir plus ritonavir, fosamprenavir, or fosamprenavir plus ritonavir, immunosuppressive drugs, azole antifungals, or lipid-modifying doses of niacin should carefully weigh the potential benefits and risks and should carefully monitor patients for any signs or symptoms of muscle pain, tenderness, or weakness, particularly during the initial months of therapy and during any periods of upward dosage titration of either drug.

Under **Table 1. Drug Interactions Associated with Increased Risk of Myopathy/Rhabdomyolysis:**

**Table 1. Drug Interactions Associated with Increased Risk of Myopathy/Rhabdomyolysis**

Interacting Agents	Prescribing Recommendations
Cyclosporine, <u>HIV protease inhibitors (tipranavir plus ritonavir)</u> , hepatitis C protease inhibitor ( <u>telaprevir</u> )	<u>Do not exceed 10 mg atorvastatin daily</u> <u>Avoid atorvastatin</u>
<u>HIV protease inhibitor (lopinavir plus ritonavir)</u>	<u>Use with caution and lowest dose necessary</u>
Clarithromycin, itraconazole, HIV protease inhibitors ( <u>ritonavir plus saquinavir plus ritonavir*</u> , or <u>lopinavir plus ritonavir darunavir plus ritonavir, fosamprenavir, fosamprenavir plus ritonavir</u> )	<u>Caution when exceeding doses &gt;20mg atorvastatin daily. The lowest dose necessary should be used.</u> <u>Do not exceed 20 mg atorvastatin daily</u>
<u>HIV protease inhibitor (nelfinavir)</u>	<u>Do not exceed 40 mg atorvastatin daily</u>

\*Use with caution and with the lowest dose necessary

Under **DRUG INTERACTIONS, Combination of Protease Inhibitors, 7.1 Strong Inhibitors of CYP 3A4:**

**Combination of Protease Inhibitors:** Atorvastatin AUC was significantly increased with concomitant administration of LIPITOR 40 mg with several combinations of HIV protease inhibitors, as well as with the Hepatitis C protease inhibitor telaprevir, ritonavir plus saquinavir (400 mg twice daily) or LIPITOR 20 mg with lopinavir plus ritonavir (400 mg + 100 mg twice daily) compared to that of LIPITOR alone [see *Clinical Pharmacology* (12.3)]. Therefore, in patients taking the HIV protease inhibitors tipranavir plus ritonavir, or the hepatitis C protease inhibitor telaprevir, concomitant use of LIPITOR should be avoided. In patients taking the HIV protease inhibitor lopinavir plus ritonavir, caution should be used when prescribing LIPITOR and the lowest dose necessary should be used. In patients taking the HIV protease inhibitors saquinavir plus ritonavir, darunavir plus ritonavir, fosamprenavir, or fosamprenavir plus ritonavir, the

dose of LIPITOR should not exceed 20 mg and should be used with caution. ~~caution should be used when the LIPITOR dose exceeds 20 mg.~~

Under 12 CLINICAL PHARMACOLOGY, 12.3 Pharmacokinetics, TABLE 3. Effect of Coadministered Drugs on the Pharmacokinetics of Atorvastatin:

Co-administered drug and dosing regimen	Atorvastatin		
	Dose (mg)	Change in AUC	Change in Cmax
Tipranavir 500 mg BID/ritonavir 200 mg BID, 7 days	10 mg, SD	↑9.4 fold	↑8.6 fold
Nelfinavir 1250 mg BID, 14 days	10 mg QD for 28 days	↑74%	↑2.2-fold
Fosamprenavir 1400 mg BID, 14 days	10 mg QD for 4 days	↑2.3-fold	↑4.04-fold
Fosamprenavir 700 mg BID/ritonavir 100 mg BID, 14 days	10 mg QD for 4 days	↑2.53-fold	↑2.84-fold
Darunavir 300 mg BID/ritonavir 100 mg BID, 9 days	10 mg QD for 4 days	↑3.4-fold	↑2.25-fold
Telaprevir 750 mg q8h, 10 days	20 mg, SD	↑7.88-fold	↑10.6-fold

Co-administered drug and dosing regimen	Atorvastatin		
	Dose (mg)	Change in AUC	Change in Cmax
<sup>#, ‡</sup> Ritonavir Saquinavir 400 mg BID/saquinavir ritonavir 400 mg BID, 15 days	40 mg QD for 4 days	↑3.9-fold	↑4.3-fold

<sup>‡</sup>The dose of saquinavir plus ritonavir in this study is not the clinically used dose. The increase in atorvastatin exposure when used clinically is likely to be higher than what was observed in this study. Therefore caution should be applied and the lowest dose necessary should be used.

Co-administered drug and dosing regimen	Atorvastatin		
	Dose (mg)	Change in AUC <sup>&amp;</sup>	Change in Cmax <sup>&amp;</sup>
<sup>#</sup> Lopinavir 400 mg BID/ ritonavir 100 mg BID, 14 days	20 mg QD for 4 days	⊖5.9 fold	⊖4.7 fold

Under 12 CLINICAL PHARMACOLOGY, 12.3 Pharmacokinetics, TABLE 4. Effect of Atorvastatin on the Pharmacokinetics of Co-administered Drugs:

Atorvastatin	Co-administered drug and dosing regimen		
	Drug/Dose (mg)	Change in AUC	Change in C <sub>max</sub>
<u>10 mg, SD</u>	<u>Tipranavir 500 mg BID/ritonavir 200 mg BID, 7 days</u>	<u>No change</u>	<u>No change</u>
<u>10 mg QD for 4 days</u>	<u>Fosamprenavir 1400 mg BID, 14 days</u>	<u>↓27%</u>	<u>↓18%</u>
<u>10 mg QD for 4 days</u>	<u>Fosamprenavir 700 mg BID/ritonavir 100 mg BID, 14 days</u>	<u>No change</u>	<u>No change</u>

**Pravastatin:**

**Under 12 CLINICAL PHARMACOLOGY, 12.2 Pharmacokinetics, Table 3:  
Effect of Coadministered Drugs on the Pharmacokinetics of Pravastatin:**

Coadministered Drug and Dosing Regimen	Pravastatin		
	Dose (mg)	Change in AUC	Change in C <sub>max</sub>
<u>Darunavir 600 mg BID/Ritonavir 100 mg BID for 7 days</u>	<u>40 mg single dose</u>	<u>↑81%</u>	<u>↑63%</u>
<u>Kaletra 400 mg/100 mg BID for 14 days</u>	<u>20 mg OD for 4 days</u>	<u>↑33%</u>	<u>↑26%</u>

**Under 12 CLINICAL PHARMACOLOGY, 12.2 Pharmacokinetics, Table 4:  
Effect of Pravastatin on the Pharmacokinetics of Coadministered Drugs**

Pravastatin Dosing Regimen	Name and Dose	Change in AUC	Change in C <sub>max</sub>
<u>20 mg OD for 4 days</u>	<u>Kaletra 400 mg/100 mg BID for 14 days</u>	<u>No change</u>	<u>No change</u>

A December 6, 2011 OCP review of DDI's with lovastatin noted that available data support a contraindication with strong CYP3A4 inhibitors, such as the HIV protease inhibitors. The data were summarized as follows:

- *According to the Guidance for Industry Drug Interaction Studies, lovastatin is listed as one of the sensitive in vivo CYP3A4 substrates. Therefore, strong CYP3A4 inhibitors are predicted to significantly increase lovastatin exposure because lovastatin is extensively metabolized by CYP3A4 isozyme.*
- *Literature survey indicates that itraconazole increases lovastatin exposure up to 15- to 20-fold and the drug interaction seems to result in rhabdomyolysis. Itraconazole is the representative strong CYP3A4 inhibitor and therefore, the effect of itraconazole on lovastatin exposure can be extrapolated to other strong CYP3A4 inhibitors listed in the Guidance as well as the FDA website.*

- *Strong CYP3A4 inhibitors are contraindicated for simvastatin because of the significant drug interaction and its potential for the increased risk on the rhabdomyolysis. Physicochemical and pharmacokinetic properties of lovastatin are comparable with those of simvastatin. Meanwhile, itraconazole increased the exposure of lovastatin (up to 20-fold) more than that of simvastatin (up to 13-fold), and it indicates that strong CYP3A4 inhibitor can cause greater lovastatin exposure increase compared to that of simvastatin. Therefore, it seems reasonable to extrapolate the effect of strong CYP3A4 inhibitors on simvastatin to that on lovastatin.*

Therefore, concomitant use of lovastatin with HIV protease inhibitors, as well as the HCV protease inhibitors boceprevir and telaprevir, will be contraindicated.

**Lovastatin:**

Under **CONTRAINDICATIONS:**

Concomitant administration with strong CYP3A4 inhibitors, e.g., itraconazole, ketoconazole, posaconazole, HIV protease inhibitors, boceprevir, telaprevir, erythromycin, clarithromycin, telithromycin and nefazodone)

Under **WARNINGS, Myopathy/Rhabdomyolysis, Strong inhibitors of CYP3A4:**

Lovastatin, like several other inhibitors of HMG-CoA reductase, is a substrate of cytochrome P450 3A4 (CYP3A4). When lovastatin is used with a strong inhibitor of CYP3A4, elevated plasma levels of HMG-CoA reductase inhibitory activity can increase the risk of myopathy and rhabdomyolysis, particularly with higher doses of lovastatin. Certain drugs which inhibit this metabolic pathway can raise the plasma levels of lovastatin and may increase the risk of myopathy. These include itraconazole, ketoconazole, and posaconazole, the macrolide antibiotics erythromycin and clarithromycin, and the ketolide antibiotic telithromycin, HIV protease inhibitors, boceprevir, telaprevir, or the antidepressant nefazodone. Combination of these drugs with lovastatin is contraindicated.

Under **WARNINGS, Myopathy/Rhabdomyolysis, Table VII: Drug Interactions Associated with Increased Risk of Myopathy/Rhabdomyolysis:**

<b>Interacting Agents</b>	<b>Prescribing Recommendations</b>
Itraconazole Ketoconazole Posaconazole Erythromycin Clarithromycin Telithromycin HIV protease inhibitors <u>Boceprevir</u> <u>Telaprevir</u> Nefazodone	<u>Avoid-Contraindicated</u> with lovastatin

Under **PRECAUTIONS, Drug Interactions, CYP3A4 Interactions:**

Lovastatin is metabolized by CYP3A4 but has no CYP3A4 inhibitory activity; therefore it is not expected to affect the plasma concentrations of other drugs metabolized by CYP3A4. Strong inhibitors of CYP3A4 (e.g., below itraconazole, ketoconazole, posaconazole, clarithromycin, telithromycin, HIV protease inhibitors, bocprevir, telaprevir, nefazodone), and large quantities of grapefruit juice increase the risk of myopathy by reducing the elimination of lovastatin.

**Itraconazole**

**Ketoconazole**

**Erythromycin**

**Clarithromycin**

**Telithromycin**

**HIV protease inhibitors**

**Nefazodone**

**Large quantities of grapefruit juice (>1 quart daily)**

#### **4. Increases in HbA1c and fasting plasma glucose – TSI #891**

On April 8, 2010 TSI #891 was opened to evaluate the effect of statins on increases in HbA1c and fasting plasma glucose. This was based on findings from the JUPITER trial, which reported a 27% increase in investigator-reported diabetes mellitus in rosuvastatin-exposed subjects compared to placebo-exposed subjects. High-dose atorvastatin had previously been associated with worsening glycemic control in the PROVE-IT TIMI 22 substudy.

Several articles from the published literature were also considered, including:

- Sattar N et al. Statins and risk of incident diabetes: a collaborative meta-analysis of randomized statin trials. *Lancet*.2010;375:735-742
- Sukhija R et al. Effect of Statins on Fasting Plasma Glucose in Diabetic and Nondiabetic Patients. *Journal of Investigative Medicine*.2009;57(3): 495-499
- Rajpathak SN et al. Statin Therapy and Risk of Developing Type 2 Diabetes: A Meta-Analysis. *Diabetes Care*.2009;32:1924-1929
- Koh KK et al. Atorvastatin Causes Insulin Resistance and Increases Ambient Glycemia in Hypercholesterolemic Patients. *JACC*.2010;55(12):1209-1216
- Thongtang N et al. Effects of Maximal Atorvastatin and Rosuvastatin Treatment on Markers of Glucose Homeostasis and Inflammation. *Am J Cardiol*.2011;107:387-392
- Kostapanos MS et al. Do Statins Beneficially or Adversely Affect Glucose Homeostasis? *Current Vascular Pharmacology*.2010;8:612-631
- Mills EJ et al. Efficacy and safety of statin treatment for cardiovascular disease: a network meta-analysis of 170255 patients from 76 randomized trials. *Q J Med*.2011;104:109-124

- Culver AL et al. Statin Use and Risk of Diabetes Mellitus in Postmenopausal Women in the Women’s Health Initiative. *Arch Intern Med*. Published online January 9, 2012.

The Sattar meta-analysis, which looked at 13 statin trials with 91,140 participants, reported that “statin therapy was associated with a 9% increased risk for incident diabetes (odds ratio [OR] 1.09; 95% CI 1.02-1.17), with little heterogeneity ( $I^2=11%$ ) between trials.”

The Rajpathak meta-analysis, which looked at 6 statin trials with 57,593 participants, reported a “small increase in diabetes risk” (relative risk [RR] 1.13; 95% CI 1.03-1.23), with “no evidence of heterogeneity across trials”.

The Mills meta-analysis, which looked at 76 randomized clinical trials (RCTs) with 170,255 participants, reported that 17 RCTs reported on increased risk of development of incident diabetes (Odds ratio [OR] 1.09; 95% CI 1.02-1.17,  $p=0.001$ ,  $I^2=11%$ ).

Culver et al looked at postmenopausal women participating in the Women’s Health Initiative (WHI) to investigate whether the incidence of new-onset diabetes mellitus is associated with statin use. The study involved 153,840 women. Statin use at baseline was associated with an increased risk of DM (hazard ratio [HR], 1.71; 95% CI, 1.61-1.83); the multivariate-adjusted HR was 1.48; 95% CI, 1.38-1.59. The association was observed for all types of statin medications.

At the time of approval of the JUPITER supplement, the following labeling was required for CRESTOR:

**5.5 Endocrine Effects**

Increases in HbA1c and fasting serum glucose levels have been reported with HMG-CoA reductase inhibitors, including CRESTOR.

The data for an effect of statins on incident diabetes, and increases in HbA1c and/or fasting plasma glucose seem to indicate a class effect; however, given the limitations of epidemiological data, and the findings from the West of Scotland Coronary Prevention Study (WOSCOPS) clinical trial, which suggested that pravastatin may decrease the incidence of diabetes by 30%, the division did not seek a labeling change for pravastatin.

Therefore, based on clinical trial data, epidemiological data, and the published literature, the following labeling change was requested for all statins except pravastatin:

**5.X Endocrine Function:**

Increases in HbA1c and fasting serum glucose levels have been reported with HMG-CoA reductase inhibitors, including <<STATIN>>.

## 5. Drug-drug interaction with ranolazine – TSI #988

TSI #988 was opened by the Division of Cardiovascular and Renal Products (DCRP) in July 2010 when during routine data monitoring of the AERS database for cases of ranolazine and torsades de pointes, a signal was identified for rhabdomyolysis in patients receiving ranolazine and statins.

Nine cases of drug interaction were related to concomitant use of ranolazine and a statin. Of those nine cases, seven (all male) involved the statin associated adverse events of rhabdomyolysis (6) and myalgia (1). Four of those six patients were stable on long-term statin therapy prior to the initiation of ranolazine. Most cases involved the use of simvastatin.

According to the OCP review:

*Ranolazine and SV are both cleared via CYP3A metabolism. Hence, concomitant administration of the two may lead to pharmacokinetic DDI. Administration of ranolazine (1000 mg twice daily) with SV (80 mg once daily) resulted in a ~2-fold increase in  $C_{max}$  and ~1.5-fold increase in AUC of SV and SVA, at steady state. Increased systemic exposure to SV and SVA has been associated with increased risk of myopathy and rhabdomyolysis. The 80 mg dose of SV has been shown to be associated with increased incidence of myopathy and rhabdomyolysis. In addition, there is little gain in effectiveness of the 80 mg over 40 mg dose. The DMEP regulatory briefing held on 6/4/2010 suggested progressive removal of 80 mg dose of simvastatin from the market, leaving 40 mg as the highest available dose. Therefore, given the 2-fold increase in systemic exposure expected on concomitant administration of ranolazine and SV, limiting the dose of SV to 20 mg will avoid exposures similar or greater to that observed with 80 mg.*

*In addition, for other statins which are primarily metabolized by CYP3A (e.g., lovastatin and atorvastatin), concomitant medications which are CYP3A inhibitors are expected to elevate statin exposure, and risk of myopathy. However, at present, definitive data (such as available with simvastatin) is not available for other statins, in order to recommend dose-adjustments.*

On June 8, 2011, in conjunction with the approval of new dosing restrictions with the 80 mg dose of simvastatin, DMEP approved a dose cap of simvastatin 20 mg when simvastatin is coadministered with ranolazine.

In addition, the current ranolazine label recommends a dose adjustment of sensitive CYP3A4 substrates such as lovastatin based on the 2-fold simvastatin exposure increase by ranolazine.

Based on the information above, the following recommendations for labeling changes were made:

**Mevacor:**

Under **WARNINGS, *Myopathy/Rhabdomyolysis***:

**Ranolazine:** The risk of myopathy, including rhabdomyolysis, may be increased by concomitant administration of ranolazine. Dose adjustment of lovastatin may be considered during co-administration.

Under **PRECAUTIONS, *Other Drug Interactions***:

*Ranolazine:* The risk of myopathy, including rhabdomyolysis, may be increased by concomitant administration of ranolazine.

**Altprev:**



**Advicor:**



**6. Myopathy with concomitant administration with colchicine**

In June 2010, a Regulatory Briefing was conducted to discuss the increased risk of myopathy, including rhabdomyolysis, associated with the use of simvastatin 80

mg, based on DMEP's review of the Study of the Effectiveness of Additional Reductions in Cholesterol and Homocysteine (SEARCH) clinical trial. In preparation for the briefing, OSE noted an interaction between statins and colchicine resulting in an increased risk of myopathy. Colchicine, a substrate of P-glycoprotein and CYP3A4, carried the following information in its label:

**5.4 Neuromuscular Toxicity**

Colchicine-induced neuromuscular toxicity and rhabdomyolysis have been reported with chronic treatment in therapeutic doses. Patients with renal dysfunction and elderly patients, even those with normal renal and hepatic function, are at increased risk. Concomitant use of atorvastatin, simvastatin, pravastatin, fluvastatin, gemfibrozil, fenofibrate, fenofibric acid, or bezafibrate (themselves associated with myotoxicity) or cyclosporine may potentiate the development of myopathy. Once colchicine is stopped, the symptoms generally resolve within 1 week to several months.

This was based on reports from the literature as summarized in the table below, and adapted from a 2008 OCP review of NDA 22-352 (Colstat [colchicine tablets]).

Lipid Lowering Agents			
HMG-CoA Reductase Inhibitors	Simvastatin: <u>Baker et al. (2004); Hsu et al. (2002)</u>	Both are CYP3A4 and P-gp substrates; P-gp inhibition by simvastatin	Acute myopathy or rhabdomyolysis (could be attributed to either drug)
	Fluvastatin: <u>Atasoyu et al. (2005)</u>	Synergistic myotoxicity via PK & PD mechanism; fluvastatin is not a P-gp inhibitor	
	Pravastatin: <u>Alayli et al. (2005)</u>	Synergistic myotoxicity via PK & PD mechanism; pravastatin is not a P-gp inhibitor	
	Atorvastatin: <u>Tufan et al. (2006)</u>	Both are CYP3A4 substrates; P-gp inhibition by atorvastatin	
Fibrates	Gemfibrozil: <u>Atmaca et al., 2002</u>	Synergistic toxic effect of both drugs	
	Fenofibrate & Diltiazem: <u>Sinsawaiwong et al., 1997</u>	Mechanism-based inhibition of CYP3A4 by diltiazem.	

On June 8, 2011, the following changes were approved for the simvastatin-containing drugs:

**5 WARNINGS AND PRECAUTIONS**

**5.1 Myopathy/Rhabdomyolysis**

Cases of myopathy, including rhabdomyolysis, have been reported with simvastatin coadministered with colchicine, and caution should be exercised when prescribing simvastatin with colchicine.

**7 DRUG INTERACTIONS**

**7.7 Colchicine**

Cases of myopathy, including rhabdomyolysis, have been reported with simvastatin coadministered with colchicine, and caution should be exercised when prescribing simvastatin with colchicine.

In order to harmonize and update the appropriate statin labels, similar labeling changes were requested for atorvastatin, pravastatin, and fluvastatin. Furthermore, because of physicochemical and pharmacokinetic similarities between lovastatin and simvastatin, similar labeling changes were requested for lovastatin.

## 7. Myopathy with concomitant administration with fibrates

A National Institutes of Health (NIH) funded trial, the Action to Control Cardiovascular Risk in Diabetes (ACCORD) Lipid Trial, was reviewed by DMEP and discussed at an Advisory Committee meeting on May 19, 2011. ACCORD-Lipid evaluated the occurrence of major adverse cardiovascular events (MACE), a composite of nonfatal heart attack, nonfatal stroke, and cardiovascular death in patients receiving simvastatin plus fenofibrate, compared to simvastatin alone. The trial found that there was no difference in cardiovascular outcomes between the two groups (Hazard Ratio = 0.92; 95% Confidence Interval: 0.79-1.08; p=0.32).

This was the second failed cardiovascular outcome trial for fenofibrate. In the Fenofibrate Intervention and Event Lowering in Diabetes (FIELD) study, fenofibrate demonstrated a non-significant 11% relative reduction in the primary outcome of coronary heart disease events (Hazard Ratio = 0.89; 95% Confidence Interval: 0.75-1.05; p=0.04) versus placebo.

The absence to date of proven cardiovascular benefit with fenofibrates must be viewed in the context of observational data showing an increase in the risk of myopathy with fenofibrates, especially when co-administered with a statin. In 2011, OSE conducted a review of observational data on rhabdomyolysis with fenofibrates and gemfibrozil in combination with statins. Their review looked at 3 studies:

- Graham DJ, Staffa JA, Shatin D et al. Incidence of hospitalized rhabdomyolysis in patients treated with lipid-lowering drugs. *JAMA* 2004;292:2585-2590.
- Amend KL, Landon J, Thyagarajan V, Niemcryk S, McAfee A. Incidence of hospitalized rhabdomyolysis with statin and fibrate use in an insured US population. *Ann Pharmacother* 2011;45:1230-1239.
- Enger C, Gately R, Ming EE, Niemcryk SJ, Williams L, McAfee AT. Pharmacoepidemiology safety study of fibrate and statin concomitant therapy. *Am J Cardiol* 2010;106:1594-1601.

According to the OSE review, the best available evidence suggests that fenofibrate-statin combination is associated with an increased hazard rate for rhabdomyolysis (HR, 3.26, 95% CI, 1.21-8.80) relative to statin monotherapy. There also appears to be a differential risk associated with the gemfibrozil-statin combination therapy versus the fenofibrate-statin combination therapy, with a

numerically higher rate of rhabdomyolysis observed with gemfibrozil-statin combination therapy (HR, 11.93, 95% CI, 3.96-35.93) compared to statin monotherapy.

Most statin labels contain language in the FPI (Warnings and Precautions and Drug Interactions sections) regarding the increased risk of myopathy, including rhabdomyolysis, when statins and fibrates are co-administered. In order to highlight this increased risk, as well as to note the differential risk between gemfibrozil-statin combination therapy and fenofibrate-statin combination therapy, all sponsors of statin drugs with labels in the PLR format (i.e., all except the lovastatin products) were requested to add the following information to the Highlights page. The following language was also provided in the Drug Interactions section of the PI's, depending on the level of risk determined for each statin product:

-----**DRUG INTERACTIONS**-----

Other Lipid-lowering Medications: Use with other fibrate products or lipid-modifying doses ( $\geq 1$  g/day) of niacin increases the risk of adverse skeletal muscle effects. Caution should be used when prescribing with <<STATIN>>.

**7.X Lipid-Lowering Drugs That Can Cause Myopathy When Given Alone**

Gemfibrozil: <<Contraindicated or Avoid>> with <<STATIN>>

Other fibrates: Caution should be used when prescribing with <<STATIN>>

**7.X Gemfibrozil**

Due to an increased risk of myopathy/rhabdomyolysis when HMG-CoA reductase inhibitors are coadministered with gemfibrozil, concomitant administration of <<STATIN>> with gemfibrozil should be avoided.

**7.X Other Fibrates**

Because it is known that the risk of myopathy during treatment with HMG-CoA reductase inhibitors is increased with concurrent administration of other fibrates, <<STATIN>> should be administered with caution when used concomitantly with other fibrates.

**8. Myopathy with concomitant administration with lipid-modifying doses of niacin**

In March 2010, DMEP approved a labeling revision for simvastatin based on interim results from an ongoing clinical trial - the Heart Protection Study 2 (HPS2) – Treatment of HDL to Reduce the Incidence of Vascular Events (THRIVE), a cardiovascular outcome trial being conducted in 20,000 patients with vascular disease from the UK, China and Scandinavia to investigate whether combining niacin with a new drug (laropiprant) that minimizes niacin's flushing effect can reduce the risk of serious heart attacks and strokes among people already taking treatment to lower their LDL-cholesterol. The interim HPS2 – THRIVE results showed that the incidence of myopathy was higher in patients of

Chinese descent (0.43%) compared with patients not of Chinese descent (0.03%) taking 40 mg simvastatin plus cholesterol-modifying doses ( $\geq 1$  g/day) of a niacin-containing product. The exact mechanism of this drug interaction is not fully understood.

Drug-drug interaction studies report an increase in simvastatin exposure of 41-64% with co-administration of simvastatin and ER niacin. According to OCP, the cause of the observed changes in exposure of simvastatin due to ER niacin is not well established as this is not due to changes in the known pathways (e.g., via CYP3A4 or OATP1B1). Furthermore, a PK study of simvastatin in Chinese subjects showed no significant differences in Chinese and non-Asian subjects in simvastatin  $C_{max}$  and  $AUC_{0-last}$ , and simvastatin acid  $AUC_{0-last}$  or  $C_{max}$ .

The OCP Genomics Group further noted that the SLCO1B1 genotype that has been associated with statin-induced myopathy, is less prevalent in Asian populations than European populations and, therefore, does not seem to explain the higher myopathy risk rates among Chinese subjects in HPS2-THRIVE.

So, it remains unclear if this increased risk of myopathy with statin and niacin co-administration is unique to Chinese subjects, or applies to other Asians and non-Asians as well.

Furthermore, in the AIM-HIGH study, which compared ER-niacin with simvastatin to simvastatin alone in reducing the residual cardiovascular risk in patients with established cardiovascular disease, “there was no incremental clinical benefit from the addition of niacin to statin therapy during a 36-month follow-up period, despite significant improvements in HDL cholesterol and triglyceride levels”.

The lack of clear benefit in conjunction with uncertainty as to the nature of the increased risk of myopathy in patients treated with niacin plus a statin led FDA to believe that this risk needed to be highlighted in statin labeling.

The labeling approved for simvastatin in March 2010 noted that patients of Chinese descent should not receive simvastatin 80 mg with cholesterol-modifying doses of niacin-containing products.

In June 2011, in conjunction with labeling revisions required based on the Agency’s review of the SEARCH trial, this language was modified to note that “caution should be used when treating Chinese patients with simvastatin doses exceeding 20 mg/day coadministered with lipid-modifying doses of niacin-containing products.”

Most statin labels contain information in the FPI (Warnings and Precautions and Drug Interactions sections) noting that “The risk of skeletal muscle effects may be enhanced when <<STATIN>> is used in combination with niacin; a reduction in

<<STATIN>> dosage should be considered in this setting.” All sponsors of statin drugs with labels in the PLR format were requested to modify the HIGHLIGHTS page, with corresponding changes to the FPI if indicated, as follows:

-----DRUG INTERACTIONS-----

Other Lipid-lowering Medications: Use with other fibrate products or lipid-modifying doses ( $\geq 1$  g/day) of niacin increases the risk of adverse skeletal muscle effects. Caution should be used when prescribing with <<STATIN>>.

**7.X Niacin**

The risk of skeletal muscle effects may be enhanced when <<STATIN>> is used in combination with lipid-modifying doses ( $\geq 1$  g/day) of niacin; a reduction in <<STATIN>> dosage should be considered in this setting.

**9. Update to lovastatin drug-drug interactions and dose caps**

Subsequent to the June 2011 labeling revisions to the simvastatin-containing products which were largely based on the SEARCH clinical trial data and the increased risk of myopathy associated with the 80 mg dose of simvastatin, a review of drug-drug interactions with lovastatin was conducted. The physicochemical and pharmacokinetic properties of lovastatin are comparable with those of simvastatin. Lovastatin is a sensitive *in vivo* CYP3A4 substrate; therefore, strong CYP3A4 inhibitors are predicted to significantly increase lovastatin exposure. According to OCP:

*Itraconazole increased the exposure of lovastatin (up to 20-fold) more than that of simvastatin (up to 13-fold), and it indicates that strong CYP3A4 inhibitor can cause greater lovastatin exposure increase compared to that of simvastatin. Therefore, it seems reasonable to extrapolate the effect of strong CYP3A4 inhibitors on simvastatin to that on lovastatin.*

Based on available studies from the literature, as well as extrapolation from simvastatin data, the following changes to the lovastatin label were recommended:

Under **CONTRAINDICATIONS:**

Concomitant administration with strong CYP3A4 inhibitors (e.g., itraconazole, ketoconazole, posaconazole, HIV protease inhibitors, boceprevir, telaprevir, erythromycin, clarithromycin, telithromycin and nefazodone).

Under **WARNINGS, Myopathy/Rhabdomyolysis, Strong Potent inhibitors of CYP3A4:**

Lovastatin, like several other inhibitors of HMG-CoA reductase, is a substrate of cytochrome P450 3A4 (CYP3A4). ~~When lovastatin is used with a potent inhibitor of~~

CYP3A4, elevated plasma levels of HMG-CoA reductase inhibitory activity can increase the risk of myopathy and rhabdomyolysis, particularly with higher doses of lovastatin. Certain drugs which inhibit this metabolic pathway can raise the plasma levels of lovastatin and may increase the risk of myopathy. These include itraconazole, ketoconazole, and posaconazole, the macrolide antibiotics erythromycin and clarithromycin, and the ketolide antibiotic telithromycin, HIV protease inhibitors, boceprevir, telaprevir, or the antidepressant nefazodone. Combination of these drugs with lovastatin is contraindicated.

**~~The use of lovastatin concomitantly with the potent CYP3A4 inhibitors itraconazole, ketoconazole, erythromycin, clarithromycin, telithromycin, HIV protease inhibitors, nefazodone, or large quantities of grapefruit juice (>1 quart daily) should be avoided.~~** Concomitant use of other medicines labeled as having a potent strong inhibitory effect on CYP3A4 should be avoided unless the benefits of combined therapy outweigh the increased risk. If treatment with itraconazole, ketoconazole, posaconazole, erythromycin, clarithromycin or telithromycin is unavoidable, therapy with lovastatin should be suspended during the course of treatment.

Although not studied clinically, voriconazole has been shown to inhibit lovastatin metabolism *in vitro* (human liver microsomes). Therefore, voriconazole is likely to increase the plasma concentration of lovastatin. It is recommended that dose adjustment of lovastatin be considered during coadministration. Increased lovastatin concentration in plasma has been associated with an increased risk of myopathy/rhabdomyolysis.

#### Under **WARNINGS, Myopathy/Rhabdomyolysis:**

**~~Gemfibrozil, particularly with higher doses of lovastatin: The dose of lovastatin should not exceed 20 mg daily in patients receiving concomitant medication with gemfibrozil. The combined use of lovastatin with gemfibrozil should be avoided, unless the benefits are likely to outweigh the increased risks of this drug combination.~~**

**~~Other lipid-lowering drugs (other fibrates or  $\geq 1$  g/day of niacin): The dose of lovastatin should not exceed 20 mg daily in patients receiving concomitant medication with other fibrates or  $\geq 1$  g/day of niacin.~~** Caution should be used when prescribing other fibrates or lipid-lowering doses ( $\geq 1$  g/day) of niacin with lovastatin, as these agents can cause myopathy when given alone. **The benefit of further alterations in lipid levels by the combined use of lovastatin with other fibrates or niacin should be carefully weighed against the potential risks of these combinations.**

**Cyclosporine: The use of lovastatin with cyclosporine should be avoided.**

**~~Cyclosporine or dDanazol, diltiazem or verapamil with higher doses of lovastatin: The dose of lovastatin should not exceed 20 mg daily in patients receiving concomitant medication with cyclosporine or danazol, diltiazem, or verapamil.~~** The benefits of the use of lovastatin in patients receiving cyclosporine or danazol, diltiazem, or verapamil should be carefully weighed against the risks of these combinations.

**~~Amiodarone or verapamil: The dose of lovastatin should not exceed 40 mg daily in patients receiving concomitant medication with amiodarone or verapamil.~~** The combined use of lovastatin at doses higher than 40 mg daily with amiodarone or verapamil should be avoided unless the clinical benefit is likely to outweigh the increased risk of myopathy. The risk of myopathy/rhabdomyolysis is

increased when either amiodarone or verapamil is used concomitantly with higher doses of a closely related member of the HMG-CoA reductase inhibitor class.

Under **WARNINGS, Myopathy/Rhabdomyolysis:**

**Cyclosporine:** The use of lovastatin with cyclosporine should be avoided.

**~~Amiodarone or verapamil:~~** The dose of lovastatin should not exceed 40 mg daily in patients receiving concomitant medication with amiodarone or verapamil. The combined use of lovastatin at doses higher than 40 mg daily with amiodarone or verapamil should be avoided unless the clinical benefit is likely to outweigh the increased risk of myopathy. The risk of myopathy/rhabdomyolysis is increased when either amiodarone or verapamil is used concomitantly with higher doses of a closely related member of the HMG-CoA reductase inhibitor class.

**~~Cyclosporine, or Danazol, diltiazem or verapamil~~ with higher doses of lovastatin:** The dose of lovastatin should not exceed 20 mg daily in patients receiving concomitant medication with cyclosporine, or danazol, diltiazem, or verapamil. The benefits of the use of lovastatin in patient receiving cyclosporine, or danazol, diltiazem, or verapamil should be carefully weighed against the risks of these combinations.

Under **WARNINGS, Myopathy/Rhabdomyolysis, Table VII: Drug Interactions Associated with Increased Risk of Myopathy/Rhabdomyolysis:**

<b>Interacting Agents</b>	<b>Prescribing Recommendations</b>
Ketoconazole Itraconazole Posaconazole Erythromycin Clarithromycin Telithromycin HIV protease inhibitors Boceprevir Telaprevir Nefazodone	<del>Avoid</del> <u>Contraindicated</u> with lovastatin
<u>Gemfibrozil</u> Cyclosporine	<u>Avoid with lovastatin</u>
<del>Gemfibrozil</del> <del>Other fibrates</del> <del>Lipid lowering doses (≥1 g/day) of niacin</del> Cyclosporine Danazol <u>Diltiazem</u> <u>Verapamil</u>	Do not exceed 20 mg lovastatin daily
Amiodarone <del>Verapamil</del>	Do not exceed 40 mg lovastatin daily
Grapefruit juice	Avoid large quantities of grapefruit juice (>1 quart daily)

Under **PRECAUTIONS, Drug Interactions, CYP3A4 Interactions:**

Lovastatin is metabolized by CYP3A4 but has no CYP3A4 inhibitory activity; therefore it is not expected to affect the plasma concentrations of other drugs metabolized by CYP3A4. ~~Potent~~ Strong inhibitors of CYP3A4 (e.g., ~~below~~ itraconazole, ketoconazole, posaconazole, clarithromycin, telithromycin, HIV protease inhibitors, boceprevir, telaprevir, nefazodone and erythromycin), and large quantities of grapefruit juice increase the risk of myopathy by reducing the elimination of lovastatin

**Itraconazole**

**Ketoconazole**

**Erythromycin**

**Clarithromycin**

**Telithromycin**

**HIV protease inhibitors**

**Nefazodone**

**Large quantities of grapefruit juice (>1 quart daily)**

*In vitro* studies have demonstrated that voriconazole inhibits the metabolism of lovastatin. Adjustment of the lovastatin dose may be needed to reduce the risk of myopathy, including rhabdomyolysis, if voriconazole must be used concomitantly with lovastatin.

#### Under **PRECAUTIONS**, *Other Drug Interactions*:

~~Cyclosporine or Danazol~~: The risk of myopathy/rhabdomyolysis is increased by concomitant administration of cyclosporine ~~or danazol~~ particularly with higher doses of lovastatin.

Danzol, Diltiazem, or Verapamil: The risk of myopathy/rhabdomyolysis is increased by concomitant administration of danazol, diltiazem, or verapamil particularly with higher doses of lovastatin.

~~Amiodarone or Verapamil~~: The risk of myopathy/rhabdomyolysis is increased when either amiodarone ~~or verapamil~~ is used concomitantly with a closely related member of the HMG-CoA reductase inhibitor class.

#### Under **PRECAUTIONS**, *Endocrine Function*:

Caution should also be exercised if an HMG-CoA reductase inhibitor or other agent used to lower cholesterol levels is administered to patients also receiving other drugs (e.g., ~~ketoconazole~~, spironolactone, cimetidine) that may decrease the levels or activity of endogenous steroid hormones.

#### Under **DOSAGE AND ADMINISTRATION**:

*Dosage in Patients taking ~~Cyclosporine or Danazol, Diltiazem, or Verapamil~~*

In patients taking ~~cyclosporine or danazol, diltiazem, or verapamil~~ concomitantly with lovastatin, therapy should begin with 10 mg of lovastatin and should not exceed 20 mg/day.

*Dosage in Patients taking ~~Amiodarone or Verapamil~~*

In patients taking ~~amiodarone or verapamil~~ concomitantly with MEVACOR, the dose should not exceed 40 mg/day.

*Concomitant Lipid-Lowering Therapy*

MEVACOR is effective alone or when used concomitantly with bile-acid sequestrants. ~~If MEVACOR is used in combination with gemfibrozil, other fibrates or lipid lowering doses ( $\geq 1$ g/day) of niacin, the dose of MEVACOR should not exceed 20 mg/day.~~

Under **CLINICAL PHARMACOLOGY**:

	Number of Subjects	Dosing of Coadministered Drug or Grapefruit Juice	Dosing of Lovastatin	AUC Ratio* (with / without coadministered drug) No Effect = 1.00	
				Lovastatin	Lovastatin acid <sup>†</sup>
Gemfibrozil	11	600 mg BID for 3 days	40 mg	0.96	2.80
Itraconazole <sup>‡</sup>	12	200 mg QD for 4 days	40 mg on Day 4	> 36 <sup>§</sup>	22
	10	100 mg QD for 4 days	40 mg on Day 4	> 14.8 <sup>§</sup>	15.4
Grapefruit Juice <sup>¶</sup> (high dose)	10	200 mL of double-strength TID <sup>#</sup>	80 mg single dose	15.3	5.0
Grapefruit Juice <sup>¶</sup> (low dose)	16	8 oz (about 250 mL) of single-strength <sup>‡</sup> for 4 days	40 mg single dose	1.94	1.57
Cyclosporine	16	Not described <sup>β</sup>	10 mg QD for 10 days	5- to 8-fold	ND <sup>α</sup>
	Number of Subjects	Dosing of Coadministered Drug or Grapefruit Juice	Dosing of Lovastatin	AUC Ratio* (with / without coadministered drug) No Effect = 1.00	
				Total Lovastatin acid <sup>‡</sup>	
Diltiazem	10	120 mg BID for 14 days	20 mg	3.57 <sup>‡</sup>	

\* Results based on a chemical assay

<sup>†</sup> Lovastatin acid refers to the β-hydroxyacid of lovastatin

<sup>‡</sup> The mean total AUC of lovastatin without itraconazole phase could not be determined accurately. Results could be representative of strong CYP3A4 inhibitors such as ketoconazole, posaconazole, clarithromycin, telithromycin, HIV protease inhibitors, and nefazodone

<sup>§</sup> Estimated minimum change

<sup>¶</sup> The effect of amounts of grapefruit juice between those used in these two studies on lovastatin pharmacokinetics has not been studied

<sup>#</sup> Double-strength: one can of frozen concentrate diluted with one can of water. Grapefruit juice was administered TID for 2 days, and 200 mL together with single dose lovastatin and 30 and 90 minutes following single dose lovastatin on Day 3

<sup>‡</sup> Single-strength: one can of frozen concentrate diluted with 3 cans of water. Grapefruit juice was administered with breakfast for 3 days, and lovastatin was administered in the evening on Day 3

<sup>β</sup> Cyclosporine-treated patients with psoriasis or post kidney or heart transplant patients with stable graft function, transplanted at least 9 months prior to study

**10. Update to simvastatin and lovastatin drug-drug interaction:**

In May 2011, the hepatitis C protease inhibitors boceprevir and telaprevir were approved. These protease inhibitors have been characterized as being strong CYP3A4 inhibitors. Because simvastatin is contraindicated with strong CYP3A4 inhibitors, and because the simvastatin label individually lists strong CYP3A4 inhibitors with which simvastatin is contraindicated, these two recently approved protease inhibitors will be added to the list in all simvastatin-containing products (Zocor, Vytorin, and Simcor).

Because of the physicochemical and pharmacokinetic similarities between simvastatin and lovastatin, and consistent with changes being made to the lovastatin labeling which include a new contraindication with strong CYP3A4 inhibitors, the labeling for lovastatin will be modified to add boceprevir and telaprevir to the list of strong CYP3A4 inhibitors with which lovastatin is contraindicated.

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/s/  
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AMY G EGAN  
06/04/2012

**CENTER FOR DRUG EVALUATION AND  
RESEARCH**

*APPLICATION NUMBER:*

**019766Orig1s083**

**OTHER REVIEW(S)**

## Division of Metabolic & Endocrine Drug Products

### Labeling Review

**Application Number:** 19766/S-083

**Name of Drug:** Zocor (simvastatin)Tablets

**Sponsor:** Merck

**Submission Date:** September 20, 2011 and October 3, 2011

#### **Background and Summary:**

ZOCOR<sup>®</sup> is an HMG-CoA reductase inhibitor (statin) indicated as an adjunctive therapy to diet to:

- Reduce the risk of total mortality by reducing CHD deaths and reduce the risk of non-fatal myocardial infarction, stroke, and the need for revascularization procedures in patients at high risk of coronary events. (1.1)
- Reduce elevated total-C, LDL-C, Apo B, TG and increase HDL-C in patients with primary hyperlipidemia (heterozygous familial and nonfamilial) and mixed dyslipidemia. (1.2)
- Reduce elevated TG in patients with hypertriglyceridemia and reduce TG and VLDL-C in patients with primary dysbeta-lipoproteinemia. (1.2)
- Reduce total-C and LDL-C in adult patients with homozygous familial hypercholesterolemia. (1.2)
- Reduce elevated total-C, LDL-C, and Apo B in boys and postmenarchal girls, 10 to 17 years of age with heterozygous familial hypercholesterolemia after failing an adequate trial of diet therapy. (1.2, 1.3)

It is supplied in the tablet dose strengths of 5, 10, 20, 40 and 80 mg.

The last approved labeling supplement was S-077 and S-082. This supplemental new drug application provided for changes to the **DOSAGE AND ADMINISTRATION, CONTRAINDICATIONS, WARNINGS AND PRECAUTIONS, ADVERSE REACTIONS, DRUG INTERACTIONS, USE IN SPECIFIC POPULATIONS,** and **CLINICAL PHARMACOLOGY** sections of the Zocor (simvastatin) package insert informing patients and prescribers about the increased risk of myopathy, including rhabdomyolysis, in patients treated with 80 mg of simvastatin versus those treated with 20 mg.

Supplement, S-083, is a supplemental new drug application that provides for a number of revisions and additions to the **WARNINGS AND PRECAUTIONS** and **DRUG INTERACTIONS** sections of the Highlights of Prescribing Information section and changes to the **DOSAGE AND ADMINISTRATION, WARNINGS AND**

**PRECAUTIONS, ADVERSE REACTIONS, CLINICAL PHARMACOLOGY, and PATIENT COUNSELING INFORMATION** sections of the Full Prescribing Information sections of the Zocor package insert. The modifications were based on a comprehensive review of clinical trial data, Adverse Event Reporting System (AERS) reports, published literature, and the labels of other approved drugs containing information on statin coadministration. Below please find a labeling review with all newly included text highlighted. For all revisions (i.e. insertions and deletions), please refer to the attached, approved labeling.

### Review:

Addition of the following highlighted information:

----- RECENT MAJOR CHANGES-----	
Dosage and Administration	
Recommended Dosing (2.1)	06/2011
Restricted Dosing for 10/80 mg (2.2)	06/2011
Coadministration with Other Drugs (2.3)	10/2011
Patients with Homozygous Familial Hypercholesterolemia (2.4)	06/2011
Chinese Patients Taking Lipid-Modifying Doses (≥1 g/day Niacin) of Niacin-Containing Products (2.8)	
Contraindications (4)	06/2011
Warnings and Precautions	
Myopathy/Rhabdomyolysis (5.1)	10/2011
Liver Enzymes (5.2)	10/2011
Endocrine Function (5. (b) (4))	10/2011

- WARNINGS AND PRECAUTIONS-----
- **Patients should be advised of the increased risk of myopathy including rhabdomyolysis with the 80-mg dose. (5.1)**
  - Skeletal muscle effects (e.g., myopathy and rhabdomyolysis): Risks increase with higher doses and concomitant use of certain medicines. Predisposing factors include advanced age (≥65), female gender, uncontrolled hypothyroidism, and renal impairment. (4, 5.1, 8.5, 8.6)
  - Patients should be advised to report promptly any symptoms of myopathy. Simvastatin therapy should be discontinued immediately if myopathy is diagnosed or suspected. See Drug Interaction table. (5.1)
  - Liver enzyme abnormalities and monitoring: Persistent elevations in hepatic transaminases can occur. **Check liver enzymes tests before initiating therapy and during treatment as clinically indicated thereafter.** (5.2)

-----DRUG INTERACTIONS-----  
**Drug Interactions Associated with Increased Risk of  
 Myopathy/Rhabdomyolysis (2.3, 4, 5.1, 7.1, 7.2, 7.3, 12.3)**

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Interacting Agents	Prescribing Recommendations
Itraconazole, ketoconazole, posaconazole, erythromycin, clarithromycin, telithromycin, HIV protease inhibitors, nefazodone, gemfibrozil, cyclosporine, danazol	Contraindicated with simvastatin
Verapamil, diltiazem	Do not exceed 10 mg simvastatin daily
Amiodarone, amlodipine, ranolazine	Do not exceed 20 mg simvastatin daily
Grapefruit juice	Avoid large quantities of grapefruit juice (>1 quart daily)

- Other Lipid-lowering Medications: Use with other fibrate products or lipid-modifying doses ( $\geq 1$  g/day) of niacin increases the risk of adverse skeletal muscle effects. Caution should be used when prescribing with simvastatin. (5.1, 7.2, 7.4)
- Coumarin anticoagulants: Concomitant use with ZOCOR prolongs INR. Achieve stable INR prior to starting ZOCOR. Monitor INR frequently until stable upon initiation or alteration of ZOCOR therapy. (7.6)

## 2 DOSAGE AND ADMINISTRATION

### 2.3 Coadministration with Other Drugs

*Patients taking Amiodarone, Amlodipine or Ranolazine*

- The dose of ZOCOR should not exceed 20 mg/day [see *Warnings and Precautions* (5.1), *Drug Interactions* (7.3), and *Clinical Pharmacology* (12.3)].

## 5 WARNINGS AND PRECAUTIONS

### 5.1 Myopathy/Rhabdomyolysis

Many of the patients who have developed rhabdomyolysis on therapy with simvastatin have had complicated medical histories, including renal insufficiency usually as a consequence of long-standing diabetes mellitus. Such patients merit closer monitoring. ZOCOR therapy should be discontinued if markedly elevated CPK levels occur or myopathy is diagnosed or suspected. ZOCOR therapy should also be temporarily withheld in any patient experiencing an acute or serious condition predisposing to the development of renal failure secondary to rhabdomyolysis, e.g., sepsis; hypotension; major surgery; trauma; severe metabolic, endocrine, or electrolyte disorders; or uncontrolled epilepsy.

TABLE 1  
Drug Interactions Associated with Increased  
Risk of Myopathy/Rhabdomyolysis

Interacting Agents	Prescribing Recommendations
Itraconazole Ketoconazole Posaconazole Erythromycin Clarithromycin Telithromycin HIV protease inhibitors Nefazodone Gemfibrozil Cyclosporine Danazol	Contraindicated with simvastatin
Verapamil Diltiazem	Do not exceed 10 mg simvastatin daily
Amiodarone Amlodipine Ranolazine	Do not exceed 20 mg simvastatin daily
Grapefruit juice	Avoid large quantities of grapefruit juice (>1 quart daily)

## 5.2 Liver Dysfunction

Persistent increases (to more than 3X the ULN) in serum transaminases have occurred in approximately 1% of patients who received simvastatin in clinical studies. When drug treatment was interrupted or discontinued in these patients, the transaminase levels usually fell slowly to pretreatment levels. The increases were not associated with jaundice or other clinical signs or symptoms. There was no evidence of hypersensitivity.

In the Scandinavian Simvastatin Survival Study (4S) [see Clinical Studies (14.1)], the number of patients with more than one transaminase elevation to >3X ULN, over the course of the study, was not significantly different between the simvastatin and placebo groups (14 [0.7%] vs. 12 [0.6%]). Elevated transaminases resulted in the discontinuation of 8 patients from therapy in the simvastatin group (n=2,221) and 5 in the placebo group (n=2,223). Of the 1,986 simvastatin treated patients in 4S with normal liver function tests (LFTs) at baseline, 8 (0.4%) developed consecutive LFT elevations to >3X ULN and/or were discontinued due to transaminase elevations during the 5.4 years (median follow-up) of the study. Among these 8 patients, 5 initially developed these abnormalities within the first year. All of the patients in this study received a starting dose of 20 mg of simvastatin; 37% were titrated to 40 mg.

In 2 controlled clinical studies in 1,105 patients, the 12 month incidence of persistent hepatic transaminase elevation without regard to drug relationship was 0.9% and 2.1% at the 40- and 80 mg dose, respectively. No patients developed persistent liver function abnormalities following the initial 6 months of treatment at a given dose.

It is recommended that liver function tests be performed before the initiation of treatment, and thereafter when clinically indicated. There have been rare postmarketing reports of

fatal and non-fatal hepatic failure in patients taking statins, including simvastatin. If serious liver injury with clinical symptoms and/or hyperbilirubinemia or jaundice occurs during treatment with ZOCOR, promptly interrupt therapy. If an alternate etiology is not found do not restart ZOCOR. Note that ALT may emanate from muscle, therefore ALT rising with CK may indicate myopathy [see Warnings and Precautions (5.1)].

### 5.3 Endocrine Function

Increases in HbA1c and fasting serum glucose levels have been reported with HMG-CoA reductase inhibitors, including ZOCOR.

## ADVERSE REACTIONS, Post-Marketing Experience

### 6.2 Post-Marketing Experience

Because the below reactions are reported voluntarily from a population of uncertain size, it is generally not possible to reliably estimate their frequency or establish a causal relationship to drug exposure. The following additional adverse reactions have been identified during postapproval use of simvastatin: pruritus, alopecia, a variety of skin changes (e.g., nodules, discoloration, dryness of skin/mucous membranes, changes to hair/nails), dizziness, muscle cramps, myalgia, pancreatitis, paresthesia, peripheral neuropathy, vomiting, anemia, erectile dysfunction, interstitial lung disease, rhabdomyolysis, hepatitis/jaundice, fatal and non-fatal hepatic failure, and depression.

An apparent hypersensitivity syndrome has been reported rarely which has included some of the following features: anaphylaxis, angioedema, lupus erythematosus-like syndrome, polymyalgia rheumatica, dermatomyositis, vasculitis, purpura, thrombocytopenia, leukopenia, hemolytic anemia, positive ANA, ESR increase, eosinophilia, arthritis, arthralgia, urticaria, asthenia, photosensitivity, fever, chills, flushing, malaise, dyspnea, toxic epidermal necrolysis, erythema multiforme, including Stevens-Johnson syndrome.

There have been rare postmarketing reports of cognitive impairment (e.g., memory loss, forgetfulness, amnesia, memory impairment, confusion) associated with statin use. These cognitive issues have been reported for all statins. The reports are generally nonserious, and reversible upon statin discontinuation, with variable times to symptom onset (1 day to years) and symptom resolution (median of 3 weeks).

## 17 PATIENT COUNSELING INFORMATION

### 17.2 Liver Enzymes

It is recommended that liver function tests be performed before the initiation of ZOCOR, and thereafter when clinically indicated. All patients treated with ZOCOR should be advised to report promptly any symptoms that may indicate liver injury, including fatigue, anorexia, right upper abdominal discomfort, dark urine or jaundice.

### Conclusion:

The PI submitted on October 3, 2011, (Package Identification # 9992857) was accepted by the reviewing team (Drs. Amy Egan, Eric Colman, and Eileen Craig). A manual

labeling review was completed from the last approved labeling for S-082, which was approved on June 8, 2011 (PI Identifier # 9876256). Zocor does **NOT** have an FDA approved PPI. Agency will issue an approval letter on this prior approval labeling supplement.

Reviewed by: M.A. Simoneau, R.Ph., Regulatory Project Manager/10.5.11  
(See appended electronic signature page)

23 Page(s) of Draft Labeling have been Withheld in Full as b4 (CCI/TS) immediately following this page

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/s/  
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MARGARET A SIMONEAU  
10/18/2011

**CENTER FOR DRUG EVALUATION AND  
RESEARCH**

*APPLICATION NUMBER:*

**019766Orig1s083**

**ADMINISTRATIVE and CORRESPONDENCE  
DOCUMENTS**

**From:** [Chiang, Raymond](#)  
**To:** ["Swanson, Richard John";](#)  
**cc:** ["carl\\_sparrow@merck.com"; Simoneau, Margaret A;](#)  
**Subject:** RE: NDA 19766/S-083 (Zocor), NDA 21687/S-041 (Vytorin), and NDA 202343 (Juvисync) labeling comments  
**Date:** Thursday, September 29, 2011 2:19:55 PM

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Hello Dr. Swanson and Dr. Sparrow,

As per our phone conversation, see the Division's comments below (in black font) regarding proposed labeling for NDA 19766/S-083 (Zocor), NDA 21687/S-041 (Vytorin), and NDA 202343 (Juvисync).

We disagree with your modification under **5 Warnings and Precautions, 5.1 Myopathy/Rhabdomyolysis**. The first sentence of the proposed new paragraph should state: "ZOCOR/JUVISYNC/VYTORIN therapy should be discontinued if markedly elevated CPK levels occur or myopathy is diagnosed or suspected." The use of the word "and" implies that one must await the results of blood tests documenting an elevation in CPK levels before stopping simvastatin therapy, even if myopathy is suspected based on clinical presentation. Also, as was noted in SEARCH, myopathy was diagnosed in patients who had markedly elevated CPK levels detected in routine lab monitoring, but had not complained of muscle symptoms until queried after the lab abnormality was noted.

We agree with your deletion of [REDACTED] <sup>(b) (4)</sup>  
[REDACTED] from the HIGHLIGHTS OF PRESCRIBING INFORMATION, **WARNINGS AND PRECAUTIONS** section.

We disagree with your modification to the language under HIGHLIGHTS OF PRESCRIBING INFORMATION, **DRUG INTERACTIONS** section. We will consider modification of this section upon review of the final study report for HPS2-THRIVE.

If you have any questions, please do not hesitate to call or email.

thanks,

ray and margaret

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/s/  
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RAYMOND S CHIANG  
09/29/2011