

# Ansaid<sup>®</sup>

(flurbiprofen tablets, USP) 50 mg and 100 mg

## Cardiovascular Risk

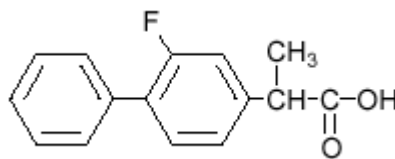
- NSAIDs may cause an increased risk of serious cardiovascular thrombotic events, myocardial infarction, and stroke, which can be fatal. This risk may increase with duration of use. Patients with cardiovascular disease or risk factors for cardiovascular disease may be at greater risk (see **WARNINGS**).
- ANSAID<sup>®</sup> is contraindicated for treatment of peri-operative pain in the setting of coronary artery bypass graft (CABG) surgery (see **WARNINGS**).

## Gastrointestinal Risk

- NSAIDs cause an increased risk of serious gastrointestinal adverse events including bleeding, ulceration, and perforation of the stomach or intestines, which can be fatal. These events can occur at any time during use and without warning symptoms. Elderly patients are at greater risk for serious gastrointestinal events (see **WARNINGS**).

## DESCRIPTION

ANSAID Tablets contain flurbiprofen, which is a member of the phenylalkanoic acid derivative group of nonsteroidal anti-inflammatory drugs. ANSAID Tablets are white, oval, film-coated tablets for oral administration. Flurbiprofen is a racemic mixture of (+)S- and (-)R- enantiomers. Flurbiprofen is a white or slightly yellow crystalline powder. It is slightly soluble in water at pH 7.0 and readily soluble in most polar solvents. The chemical name is [1,1'-biphenyl]-4-acetic acid, 2-fluoro-alpha-methyl-, (±)-. The molecular weight is 244.26. Its molecular formula is C<sub>15</sub>H<sub>13</sub>FO<sub>2</sub> and it has the following structural formula:



The inactive ingredients in ANSAID (both strengths) include carnauba wax, colloidal silicon dioxide, croscarmellose sodium, hypromellose, lactose, magnesium stearate, microcrystalline cellulose, propylene glycol, and titanium dioxide. In addition, the 100 mg tablet contains FD&C Blue No. 2.

## CLINICAL PHARMACOLOGY

### Pharmacodynamics

ANSAID Tablets contain flurbiprofen, a nonsteroidal anti-inflammatory drug that exhibits anti-inflammatory, analgesic, and antipyretic activities in animal models. The mechanism of action of ANSAID, like that of other nonsteroidal anti-inflammatory drugs, is not completely understood but may be related to prostaglandin synthetase inhibition.

### Pharmacokinetics

**Absorption:** The mean oral bioavailability of flurbiprofen from ANSAID Tablets 100 mg is 96% rel-

ative to an oral solution. Flurbiprofen is rapidly and non-stereoselectively absorbed from ANSAID, with peak plasma concentrations occurring at about 2 hours (see Table 1). Administration of ANSAID with either food or antacids may alter the rate but not the extent of flurbiprofen absorption. Ranitidine has been shown to have no effect on either the rate or extent of flurbiprofen absorption from ANSAID.

**Distribution:** The apparent volume of distribution ( $V_z/F$ ) of both R- and S-flurbiprofen is approximately 0.12 L/Kg. Both flurbiprofen enantiomers are more than 99% bound to plasma proteins, primarily albumin. Plasma protein binding is relatively constant for the typical average steady-state concentrations ( $\leq 10 \mu\text{g/mL}$ ) achieved with recommended doses. Flurbiprofen is poorly excreted into human milk. The nursing infant dose is predicted to be approximately 0.1 mg/day in the established milk of a woman taking ANSAID 200 mg/day (see **PRECAUTIONS, Nursing Mothers**).

**Metabolism:** Several flurbiprofen metabolites have been identified in human plasma and urine. These metabolites include 4'-hydroxy-flurbiprofen, 3', 4'-dihydroxy-flurbiprofen, 3'-hydroxy-4'-methoxy-flurbiprofen, their conjugates, and conjugated flurbiprofen. Unlike other arylpropionic acid derivatives (eg, ibuprofen), metabolism of R-flurbiprofen to S-flurbiprofen is minimal. In vitro studies have demonstrated that cytochrome P4502C9 (CYP2C9) plays an important role in the metabolism of flurbiprofen to its major metabolite 4'-hydroxy-flurbiprofen (see **Special Populations**). The 4'-hydroxy-flurbiprofen metabolite showed little anti-inflammatory activity in animal models of inflammation. In vitro studies also demonstrated glucuronidation of both enantiomers of flurbiprofen and 4'-hydroxy-flurbiprofen. UGT2B7 is the predominant UGT isozyme responsible for the glucuronidation. Flurbiprofen does not induce enzymes that alter its metabolism.

The total plasma clearance of unbound flurbiprofen is not stereoselective, and clearance of flurbiprofen is independent of dose when used within the therapeutic range.

**Excretion:** Following dosing with ANSAID, less than 3% of flurbiprofen is excreted unchanged in the urine, with about 70% of the dose eliminated in the urine as flurbiprofen, 4'-hydroxy-flurbiprofen, and their acyl-glucuronide conjugates. Because renal elimination is a significant pathway of elimination of flurbiprofen metabolites, dosing adjustment in patients with moderate or severe renal dysfunction may be necessary to avoid accumulation of flurbiprofen metabolites. The mean terminal disposition half-lives ( $t_{1/2}$ ) of R- and S-flurbiprofen are similar, about 4.7 and 5.7 hours, respectively. There is little accumulation of flurbiprofen following multiple doses of ANSAID.

**Table 1.**  
**Mean (SD) R,S-Flurbiprofen Pharmacokinetic Parameters Normalized to a 100 mg Dose of ANSAID**

Pharmacokinetic Parameter	Normal Healthy Adults* (18 to 40 years) N=15	Geriatric Arthritis Patients† (65 to 83 years) N=13	End Stage Renal Disease Patients* (23 to 42 years) N=8	Alcoholic Cirrhosis Patients‡ (31 to 61 years) N=8
Peak Concentration (T <sub>g</sub> /mL)	14 (4)	16 (5)	9 <sup>§</sup>	9 <sup>§</sup>
Time of Peak Concentration (h)	1.9 (1.5)	2.2 (3)	2.3 <sup>§</sup>	1.2 <sup>§</sup>
Urinary Recovery of Unchanged Flurbiprofen (% of Dose)	2.9 (1.3)	0.6 (0.6)	0.02 (0.02)	NA <sup>  </sup>
Area Under the Curve (AUC) <sup>¶</sup> (T <sub>g</sub> h/mL)	83 (20)	77 (24)	44 <sup>§</sup>	50 <sup>§</sup>
Apparent Volume of Distribution (V <sub>z</sub> /F, L)	14 (3)	12 (5)	10 <sup>§</sup>	14 <sup>§</sup>
Terminal Disposition Half-life (t <sub>1/2</sub> , h)	7.5 (0.8)	5.8 (1.9)	3.3 <sup>#</sup>	5.4 <sup>#</sup>

\*100 mg single-dose

† Steady-state evaluation of 100 mg every 12 hours

‡ 200 mg single-dose

§ Calculated from mean parameter values of both flurbiprofen enantiomers

|| Not available

¶ AUC from 0 to infinity for single doses and from 0 to the end of the dosing interval for multiple-doses

# Value for S-flurbiprofen

### Special Populations

**Pediatric:** The pharmacokinetics of flurbiprofen have not been investigated in pediatric patients.

**Race:** No pharmacokinetic differences due to race have been identified.

**Geriatric:** Flurbiprofen pharmacokinetics were similar in geriatric arthritis patients, younger arthritis patients, and young healthy volunteers receiving ANSAID Tablets 100 mg as either single or multiple doses.

**Hepatic insufficiency:** Hepatic metabolism may account for >90% of flurbiprofen elimination, so patients with hepatic disease may require reduced doses of ANSAID Tablets compared to patients with normal hepatic function. The pharmacokinetics of R- and S-flurbiprofen were similar, however, in alcoholic cirrhosis patients (N=8) and young healthy volunteers (N=8) following administration of a single 200 mg dose of ANSAID tablets.

Flurbiprofen plasma protein binding may be decreased in patients with liver disease and serum albumin concentrations below 3.1 g/dL (see **PRECAUTIONS, Hepatic Effects**).

**Poor Metabolizers of CYP2C9 Substrates:** Patients who are known or suspected to be poor CYP2C9 metabolizers based on previous history/experience with other CYP2C9 substrates (such as warfarin and phenytoin) should be administered flurbiprofen with caution as they may have abnormally high plasma levels due to reduced metabolic clearance.

**Renal insufficiency:** Renal clearance is an important route of elimination for flurbiprofen metabolites, but a minor route of elimination for unchanged flurbiprofen ( $\leq 3\%$  of total clearance). The unbound clearances of R- and S-flurbiprofen did not differ significantly between normal healthy volunteers (N=6, 50 mg single dose) and patients with renal impairment (N=8, inulin clearances ranging from 11 to 43 mL/min, 50 mg multiple doses). Flurbiprofen plasma protein binding may be decreased in patients with renal impairment and serum albumin concentrations below 3.9 g/dL. Elimination of flurbiprofen metabolites may be reduced in patients with renal impairment (see WARNINGS, Renal Effects).

Flurbiprofen is not significantly removed from the blood into dialysate in patients undergoing continuous ambulatory peritoneal dialysis.

### **Drug-Drug Interactions (see also PRECAUTIONS, Drug Interactions)**

**Antacids:** Administration of ANSAID to volunteers under fasting conditions or with antacid suspension yielded similar serum flurbiprofen-time profiles in young adult subjects (n=12). In geriatric subjects (n=7), there was a reduction in the rate but not the extent of flurbiprofen absorption.

**Aspirin:** Concurrent administration of ANSAID and aspirin resulted in 50% lower serum flurbiprofen concentrations. This effect of aspirin (which is also seen with other nonsteroidal anti-inflammatory drugs) has been demonstrated in patients with rheumatoid arthritis (n=15) and in healthy volunteers (n=16) (see PRECAUTIONS, Drug Interactions).

**Beta-adrenergic blocking agents:** The effect of flurbiprofen on blood pressure response to propranolol and atenolol was evaluated in men with mild uncomplicated hypertension (n=10). Flurbiprofen pretreatment attenuated the hypotensive effect of a single dose of propranolol but not atenolol. Flurbiprofen did not appear to affect the beta-blocker-mediated reduction in heart rate. Flurbiprofen did not affect the pharmacokinetic profile of either drug (see PRECAUTIONS, Drug Interactions).

**Cimetidine, Ranitidine:** In normal volunteers (n=9), pretreatment with cimetidine or ranitidine did not affect flurbiprofen pharmacokinetics, except for a small (13%) but statistically significant increase in the area under the serum concentration curve of flurbiprofen in subjects who received cimetidine.

**Digoxin:** In studies of healthy males (n=14), concomitant administration of flurbiprofen and digoxin did not change the steady state serum levels of either drug.

**Diuretics:** Studies in healthy volunteers have shown that, like other nonsteroidal anti-inflammatory drugs, flurbiprofen can interfere with the effects of furosemide. Although results have varied from study to study, effects have been shown on furosemide-stimulated diuresis, natriuresis, and kaliuresis. Other nonsteroidal anti-inflammatory drugs that inhibit prostaglandin synthesis have been shown to interfere with thiazide and potassium-sparing diuretics (see PRECAUTIONS, Drug Interactions).

**Lithium:** In a study of 11 women with bipolar disorder receiving lithium carbonate at a dosage of 600 to 1200 mg/day, administration of 100 mg ANSAID every 12 hours increased plasma lithium concentrations by 19%. Four of 11 patients experienced a clinically important increase ( $>25\%$  or  $>0.2$  mmol/L). Nonsteroidal anti-inflammatory drugs have also been reported to decrease the renal clearance of lithium by about 20% (see PRECAUTIONS, Drug Interactions).

**Methotrexate:** In a study of six adult arthritis patients, coadministration of methotrexate (10 to 25 mg/dose) and ANSAID (300 mg/day) resulted in no observable interaction between these two drugs.

**Oral Hypoglycemic Agents:** In a clinical study, flurbiprofen was administered to adult diabetics who were already receiving glyburide (n=4), metformin (n=2), chlorpropamide with phenformin (n=3), or

glyburide with phenformin (n=6). Although there was a slight reduction in blood sugar concentrations during concomitant administration of flurbiprofen and hypoglycemic agents, there were no signs or symptoms of hypoglycemia.

## INDICATIONS AND USAGE

Carefully consider the potential benefits and risks of ANSAID and other treatment options before deciding to use ANSAID. Use the lowest effective dose for the shortest duration consistent with individual patient treatment goals (see **WARNINGS**).

ANSAID is indicated:

- For relief of the signs and symptoms of rheumatoid arthritis.
- For relief of the signs and symptoms of osteoarthritis.

## CONTRAINDICATIONS

ANSAID Tablets are contraindicated in patients with known hypersensitivity to flurbiprofen. ANSAID should not be given to patients who have experienced asthma, urticaria, or allergic-type reactions after taking aspirin or other nonsteroidal anti-inflammatory drugs. Severe, rarely fatal, anaphylactic-like reactions to nonsteroidal anti-inflammatory drugs have been reported in such patients (see **WARNINGS, Anaphylactoid Reactions, and PRECAUTIONS, Preexisting Asthma**).

ANSAID is contraindicated for the treatment of peri-operative pain in the setting of coronary artery bypass graft (CABG) surgery (see **WARNINGS**).

## WARNINGS

### CARDIOVASCULAR EFFECTS

#### Cardiovascular Thrombotic Events

Clinical trials of several COX-2 selective and nonselective NSAIDs of up to three years duration have shown an increased risk of serious cardiovascular (CV) thrombotic events, myocardial infarction, and stroke, which can be fatal. All NSAIDs, both COX-2 selective and nonselective, may have a similar risk. Patients with known CV disease or risk factors for CV disease may be at greater risk. To minimize the potential risk for an adverse CV event in patients treated with an NSAID, the lowest effective dose should be used for the shortest duration possible. Physicians and patients should remain alert for the development of such events, even in the absence of previous CV symptoms. Patients should be informed about the signs and/or symptoms of serious CV events and the steps to take if they occur.

There is no consistent evidence that concurrent use of aspirin mitigates the increased risk of serious CV thrombotic events associated with NSAID use. The concurrent use of aspirin and an NSAID does increase the risk of serious GI events (see **WARNINGS, Gastrointestinal Effects - Risk of Ulceration, Bleeding, and Perforation**).

Two large, controlled clinical trials of a COX-2 selective NSAID for the treatment of pain in the first 10-14 days following CABG surgery found an increased incidence of myocardial infarction and stroke (see **CONTRAINDICATIONS**).

#### Hypertension

NSAIDs including ANSAID, can lead to onset of new hypertension or worsening of pre-existing hypertension, either of which may contribute to the increased incidence of CV events. Patients taking thiazides or loop diuretics may have impaired response to these therapies when taking NSAIDs. NSAIDs, including ANSAID, should be used with caution in patients with hypertension. Blood pressure (BP) should be monitored closely during the initiation of NSAID treatment and throughout

the course of therapy.

### **Congestive Heart Failure and Edema**

Fluid retention and edema have been observed in some patients taking NSAIDs. ANSAID should be used with caution in patients with fluid retention or heart failure.

### **Gastrointestinal Effects - Risk of Ulceration, Bleeding, and Perforation**

NSAIDs, including ANSAID, can cause serious gastrointestinal (GI) adverse events including inflammation, bleeding, ulceration, and perforation of the stomach, small intestine, or large intestine, which can be fatal. These serious adverse events can occur at any time, with or without warning symptoms, in patients treated with NSAIDs. Only one in five patients, who develop a serious upper GI adverse event on NSAID therapy, is symptomatic. Upper GI ulcers, gross bleeding, or perforation caused by NSAIDs occur in approximately 1% of patients treated for 3-6 months, and in about 2-4% of patients treated for one year. These trends continue with longer duration of use, increasing the likelihood of developing a serious GI event at some time during the course of therapy. However, even short-term therapy is not without risk. NSAIDs should be prescribed with extreme caution in those with a prior history of ulcer disease or gastrointestinal bleeding. Patients with a *prior history of peptic ulcer disease and/or gastrointestinal bleeding* who use NSAIDs have a greater than 10-fold increased risk for developing a GI bleed compared to patients treated with neither of these risk factors. Other factors that increase the risk of GI bleeding in patients treated with NSAIDs include concomitant use of oral corticosteroids or anticoagulants, longer duration of NSAID therapy, smoking, use of alcohol, older age, and poor general health status. Most spontaneous reports of fatal GI events are in elderly or debilitated patients and therefore, special care should be taken in treating this population.

To minimize the potential risk for an adverse GI event in patients treated with an NSAID, the lowest effective dose should be used for the shortest possible duration. Patients and physicians should remain alert for signs and symptoms of GI ulcerations and bleeding during NSAID therapy and promptly initiate additional evaluation and treatment if a serious GI event is suspected. This should include discontinuation of the NSAID until a serious GI adverse event is ruled out. For high-risk patients, alternate therapies that do not involve NSAIDs should be considered.

### **Renal Effects**

Long-term administration of NSAIDs has resulted in renal papillary necrosis and other renal injury. Renal toxicity has also been seen in patients in whom renal prostaglandins have a compensatory role in the maintenance of renal perfusion. In these patients, administration of a nonsteroidal anti-inflammatory drug may cause a dose-dependent reduction in prostaglandin formation and, secondarily, in renal blood flow, which may precipitate overt renal decompensation. Patients at greatest risk of this reaction are those with impaired renal function, heart failure, liver dysfunction, those taking diuretics and ACE inhibitors, and the elderly. Discontinuation of NSAID therapy is usually followed by recovery to the pretreatment state.

### **Advanced Renal Disease**

In clinical studies, the elimination half-life of flurbiprofen was unchanged in patients with renal impairment. Flurbiprofen metabolites are eliminated primarily by the kidneys. Elimination of 4'-hydroxy-flurbiprofen was reduced in patients with moderate to severe renal impairment. Therefore, treatment with ANSAID is not recommended in these patients with advanced renal disease. If ANSAID therapy must be initiated, close monitoring of the patients renal function is advisable (see **CLINICAL PHARMACOLOGY**).

### **Anaphylactoid Reactions**

As with other NSAIDs, anaphylactoid reactions may occur in patients without known prior exposure to ANSAID. ANSAID should not be given to patients with the aspirin triad. This symptom complex

typically occurs in asthmatic patients who experience rhinitis with or without nasal polyps, or who exhibit severe, potentially fatal bronchospasm after taking aspirin or other NSAIDs (see **CONTRAINDICATIONS** and **PRECAUTIONS: Preexisting Asthma**). Emergency help should be sought in cases where an anaphylactoid reaction occurs.

### **Skin Reactions**

NSAIDs, including ANSAID, can cause serious skin adverse events such as exfoliative dermatitis, Steven-Johnson Syndrom (SJS), and toxic epidermal necrolysis (TEN), which can be fatal. These serious events may occur without warning. Patients should be informed about the signs and symptoms of serious skin manifestations and use of the drug should be discontinued at the first appearance of skin rash or any other sign of hypersensitivity.

### **Pregnancy**

In late pregnancy, as with other NSAIDs, ANSAID should be avoided because it may cause premature closure of the ductus arteriosus.

## **PRECAUTIONS**

### **General**

ANSAID cannot be expected to substitute for corticosteroids or to treat corticosteroid insufficiency. Abrupt discontinuation of corticosteroids may lead to disease exacerbation. Patients on prolonged corticosteroid therapy should have their therapy tapered slowly if a decision is made to discontinue corticosteroids.

The pharmacological activity of ANSAID in reducing fever and inflammation may diminish the utility of these diagnostic signs in detecting complications of presumed noninfectious, painful conditions.

### **Hepatic effects:**

Borderline elevations of one or more liver tests may occur in up to 15% of patients taking nonsteroidal anti-inflammatory drugs, including ANSAID. These laboratory abnormalities may progress, may remain unchanged, or may be transient with continuing therapy. Notable elevations of ALT or AST (approximately three or more times the upper limit of normal) have been reported in approximately 1% of patients in clinical trials with nonsteroidal anti-inflammatory drugs. In addition, rare cases of severe hepatic reactions, including jaundice, fulminant hepatitis, liver necrosis, and hepatic failure, some of them with fatal outcomes have been reported.

A patient with symptoms and/or signs suggesting liver dysfunction, or with abnormal liver test values, should be evaluated for evidence of the development of a more severe hepatic reaction while on therapy with ANSAID. If clinical signs and symptoms consistent with liver disease develop, or if systemic manifestations occur (eg, eosinophilia, rash, etc.), ANSAID should be discontinued.

### **Hematological effects:**

Anemia is sometimes seen in patients receiving nonsteroidal anti-inflammatory drugs, including ANSAID. This may be due to fluid retention, GI blood loss, or an incompletely described effect upon erythropoiesis. Patients on long-term treatment with nonsteroidal anti-inflammatory drugs, including ANSAID, should have their hemoglobin or hematocrit checked periodically even if they do not exhibit any signs or symptoms of anemia.

Nonsteroidal anti-inflammatory drugs inhibit platelet aggregation and have been shown to prolong bleeding time in some patients. Unlike aspirin, their effect on platelet function is quantitatively less, of shorter duration, and reversible. ANSAID does not generally affect platelet counts, prothrombin time (PT), or partial thromboplastin time (PTT). Patients receiving ANSAID who may be adversely affected by alterations in platelet function, such as those with coagulation disorders or patients receiving anticoagulants, should be carefully monitored.

**Preexisting asthma:**

Patients with asthma may have aspirin-sensitive asthma. The use of aspirin in patients with aspirin-sensitive asthma has been associated with severe bronchospasm, which can be fatal. Since cross reactivity, including bronchospasm, between aspirin and other nonsteroidal anti-inflammatory drugs has been reported in such aspirin-sensitive patients, ANSAID should not be administered to patients with this form of aspirin sensitivity and should be used with caution in patients with preexisting asthma.

**Vision changes:**

Blurred and/or diminished vision has been reported with the use of ANSAID and other nonsteroidal anti-inflammatory drugs. Patients experiencing eye complaints should have ophthalmologic examinations.

**Information For Patients**

Patients should be informed of the following information before initiating therapy with an NSAID and periodically during the course of ongoing therapy. Patients should also be encouraged to read the NSAID Medication Guide that accompanies each prescription dispensed.

- ANSAID, like other NSAIDs, may cause CV side effects, such as MI or stroke, which may result in hospitalization and even death. Although serious CV events can occur without warning symptoms, patients should be alert for the signs and symptoms of chest pain, shortness of breath, weakness, slurring of speech, and should ask for medical advice when observing any indicative sign or symptoms. Patients should be apprised of the importance of this follow-up (see **WARNINGS, CARDIOVASCULAR EFFECTS**).
- ANSAID, like other NSAIDs, can cause GI discomfort and, rarely, serious GI side effects, such as ulcers and bleeding, which may result in hospitalization and even death. Although serious GI tract ulcerations and bleeding can occur without warning symptoms, patients should be alert for the signs and symptoms of ulcerations and bleeding, and should ask for medical advice when observing any indicative sign or symptoms including epigastric pain, dyspepsia, melena, and hematemesis. Patients should be apprised of the importance of this follow-up (see **WARNINGS: Gastrointestinal Effects: Risk of Ulceration, Bleeding and Perforation**).
- ANSAID, like other NSAIDs, can cause serious skin side effects such as exfoliative dermatitis, SJS and TEN, which may result in hospitalization and even death. Although serious skin reactions may occur without warning, patients should be alert for the signs and symptoms of skin rash and blisters, fever, or other signs hypersensitivity such as itching, and should ask for medical advice when observing any indicative sign or symptoms. Patients should be advised to stop the drug immediately if they develop any type of rash and contact their physicians as soon as possible.
- Patients should promptly report, signs or symptoms of unexplained weight gain, or edema to their physicians.
- Patients should be informed of the warning signs and symptoms of hepatotoxicity (e.g., nausea, fatigue, lethargy, pruritus, jaundice, right upper quadrant tenderness and “flu-like” symptoms). If these occur, patients should be instructed to stop therapy and seek immediate medical therapy.
- Patients should be informed of the signs of an anaphylactoid reaction (e.g. difficulty breathing,



swelling of the face or throat). If these occur, patients should be instructed to seek immediate emergency help (see **WARNINGS, Anaphylactoid Reactions**).

- In late pregnancy, as with other NSAIDs, ANSAID should be avoided because it may cause premature closure of the ductus arteriosus.

### **Laboratory Tests**

Because serious GI tract ulcerations and bleeding can occur without warning symptoms, physicians should monitor for signs of symptoms of GI bleeding. Patients on long-term treatment with nonsteroidal anti-inflammatory drugs should have their CBC and chemistry profile checked periodically. If clinical signs and symptoms consistent with liver or renal disease develop, systemic manifestations occur (eg, eosinophilia, rash etc.), or abnormal liver tests persist or worsen, ANSAID should be discontinued.

### **Drug Interactions**

#### ***ACE-inhibitors:***

Reports suggest that nonsteroidal anti-inflammatory drugs may diminish the antihypertensive effect of ACE-inhibitors. This interaction should be given consideration in patients taking nonsteroidal anti-inflammatory drugs concomitantly with ACE-inhibitors.

#### ***Anticoagulants:***

The effects of warfarin and NSAIDs on GI bleeding are synergistic, such that users of both drugs together have a risk of serious GI bleeding higher than users of either drug alone. The physician should be cautious when administering ANSAID to patients taking warfarin or other anticoagulants.

#### ***Aspirin:***

Concurrent administration of aspirin lowers serum flurbiprofen concentrations (see **CLINICAL PHARMACOLOGY, Drug-Drug Interactions**). The clinical significance of this interaction is not known; however, as with other NSAIDs, concomitant administration of flurbiprofen and aspirin is not generally recommended because of the potential for increased adverse effects.

#### ***Beta-adrenergic blocking agents:***

Flurbiprofen attenuated the hypotensive effect of propranolol but not atenolol (see **CLINICAL PHARMACOLOGY, Drug-Drug Interactions**). The mechanism underlying this interference is unknown. Patients taking both flurbiprofen and a beta-blocker should be monitored to ensure that a satisfactory hypotensive effect is achieved.

#### ***Diuretics:***

Clinical studies, as well as post marketing observations, have shown that ANSAID can reduce the natriuretic effect of furosemide and thiazides in some patients. This response has been attributed to inhibition of renal prostaglandin synthesis. During concomitant therapy with NSAIDs, the patient should be observed closely for signs of renal failure (see **WARNINGS, Renal Effects**), as well as diuretic efficacy.

#### ***Lithium:***

NSAIDs have produced an elevation of plasma lithium levels and a reduction in renal lithium clearance. The mean minimum lithium concentration increased 15% and the renal clearance was decreased by approximately 20%.

These effects have been attributed to inhibition of renal prostaglandin synthesis by the nonsteroidal anti-inflammatory drug. Thus, when nonsteroidal anti-inflammatory drugs and lithium are administered concurrently, subjects should be observed carefully for signs of lithium toxicity.

**Methotrexate:**

Nonsteroidal anti-inflammatory drugs have been reported to competitively inhibit methotrexate accumulation in rabbit kidney slices. This may indicate that they could enhance the toxicity of methotrexate. Caution should be used when nonsteroidal anti-inflammatory drugs are administered concomitantly with methotrexate.

**Pregnancy:****Teratogenic effects: Pregnancy Category C**

Reproductive studies conducted in rats and rabbits have not demonstrated evidence of developmental abnormalities. However, animal reproduction studies are not always predictive of human response. There are no adequate and well-controlled studies in pregnant women. ANSAID should be used in pregnancy only if the potential benefit justifies the potential risk to the fetus.

**Nonteratogenic effects:**

Because of the known effects of nonsteroidal anti-inflammatory drugs on the fetal cardiovascular system (closure of ductus arteriosus), use during late pregnancy should be avoided.

**Labor and Delivery**

In rat studies with nonsteroidal anti-inflammatory drugs, as with other drugs known to inhibit prostaglandin synthesis, an increased incidence of dystocia, delayed parturition, and decreased pup survival occurred. The effects of ANSAID on labor and delivery in pregnant women are unknown.

**Nursing Mothers**

Concentrations of flurbiprofen in breast milk and plasma of nursing mothers suggest that a nursing infant could receive approximately 0.10 mg flurbiprofen per day in the established milk of a woman taking ANSAID 200 mg/day. Because of possible adverse effects of prostaglandin-inhibiting drugs on neonates, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

**Pediatric Use**

Safety and effectiveness in pediatric patients have not been established.

**Geriatric Use**

As with any NSAID, caution should be exercised in treating the elderly (65 years and older). Clinical experience with ANSAID suggests that elderly patients may have a higher incidence of gastrointestinal complaints than younger patients, including ulceration, bleeding, flatulence, bloating, and abdominal pain. **To minimize the potential risk for gastrointestinal events, the lowest effective dose should be used for the shortest possible duration** (see **WARNINGS, Gastrointestinal Effects - Risk of Ulceration, Bleeding, and Perforation**). Likewise, elderly patients are at greater risk of developing renal decompensation (see **WARNINGS, Renal Effects**).

The pharmacokinetics of flurbiprofen do not seem to differ in elderly patients from those in younger individuals (see **CLINICAL PHARMACOLOGY, Special Populations**). The rate of absorption of ANSAID was reduced in elderly patients who also received antacids, although the extent of absorption was not affected (see **CLINICAL PHARMACOLOGY, Drug-Drug Interactions**).

## ADVERSE REACTIONS

**TABLE 2.**

Reported adverse events in patients receiving ANSAID or other nonsteroidal anti-inflammatory drugs

Reported in patients treated with ANSAID			Reported in patients treated with other products but not ANSAID
Incidence of 1% or greater †	Incidence < 1% - Causal Relationship Probable ‡	Incidence < 1% - Causal Relationship Unknown ‡	
<b>BODY AS A WHOLE</b> edema	anaphylactic reaction chills fever		< 1%: death infection sepsis
<b>CARDIOVASCULAR SYSTEM</b>	congestive heart failure hypertension vascular diseases vasodilation	angina pectoris arrhythmias myocardial infarction	< 1%: hypotension palpitations syncope tachycardia vasculitis
<b>DIGESTIVE SYSTEM</b> abdominal pain constipation diarrhea dyspepsia/heartburn elevated liver enzymes flatulence GI bleeding nausea vomiting	bloody diarrhea esophageal disease gastric/peptic ulcer disease gastritis jaundice (cholestatic and noncholestatic) hematemesis hepatitis stomatitis/glossitis	appetite changes cholecystitis colitis dry mouth exacerbation of inflammatory bowel disease periodontal abscess small intestine inflammation with loss of blood and protein	> 1%: GI perforation GI ulcers (gastric/duodenal)  < 1%: eructation liver failure pancreatitis
<b>HEMIC AND LYMPHATIC SYSTEM</b>	aplastic anemia (including agranulocytosis or pancytopenia) decrease in hemoglobin and hematocrit ecchymosis/purpura eosinophilia hemolytic anemia iron deficiency anemia leukopenia thrombocytopenia	lymphadenopathy	> 1%: anemia increased bleeding time  < 1%: melena rectal bleeding
<b>METABOLIC AND NUTRITIONAL SYSTEM</b> body weight changes	hyperuricemia	hyperkalemia	< 1%: hyperglycemia

Reported in patients treated with ANSAID			Reported in patients treated with other products but not ANSAID
Incidence of 1% or greater †	Incidence < 1% - Causal Relationship Probable ‡	Incidence < 1% - Causal Relationship Unknown ‡	
<b>NERVOUS SYSTEM</b> headache nervousness and other manifestations of central nervous system (CNS) stimulation (eg, anxiety, insomnia, increased reflexes, tremor) symptoms associated with CNS inhibition (eg, amnesia, asthenia, depression, malaise, somnolence)	ataxia cerebrovascular ischemia confusion paresthesia twitching	convulsion cerebrovascular accident emotional lability hypertonia meningitis myasthenia subarachnoid hemorrhage	< 1%: coma dream abnormalities drowsiness hallucinations
<b>RESPIRATORY SYSTEM</b> rhinitis	asthma epistaxis	bronchitis dyspnea hyperventilation laryngitis pulmonary embolism pulmonary infarct	< 1%: pneumonia respiratory depression
<b>SKIN AND APPENDAGES</b> rash	angioedema eczema exfoliative dermatitis photosensitivity pruritus toxic epidermal necrolysis urticaria	alopecia dry skin herpes simplex/zoster nail disorder sweating	< 1%: erythema multiforme Stevens Johnson syndrome
<b>SPECIAL SENSES</b> changes in vision dizziness/vertigo tinnitus	conjunctivitis parosmia	changes in taste corneal opacity ear disease glaucoma retinal hemorrhage retrobulbar neuritis transient hearing loss	> 1%: pruritus  < 1%: hearing impairment
<b>UROGENITAL SYSTEM</b> signs and symptoms suggesting urinary tract infection	hematuria interstitial nephritis renal failure	menstrual disturbances prostate disease vaginal and uterine hemorrhage vulvovaginitis	> 1%: abnormal renal function  < 1%: dysuria oliguria polyuria proteinuria

† from clinical trials

‡ from clinical trials, post-marketing surveillance, or literature

## OVERDOSAGE

Symptoms following acute overdoses with nonsteroidal anti-inflammatory drugs are usually limited to lethargy, drowsiness, nausea, vomiting, and epigastric pain, which are generally reversible with supportive care. Gastrointestinal bleeding can occur. Hypertension, acute renal failure, respiratory depression and coma may occur, but are rare. Anaphylactoid reactions have been reported with therapeutic ingestion of nonsteroidal anti-inflammatory drugs, and may occur following an overdose. Patients should be managed by symptomatic and supportive care following overdose with a nonsteroidal anti-inflammatory drug. There are no specific antidotes. Emesis and/or activated charcoal (60 to 100 g in adults, 1 to 2 g/kg in children) and/or osmotic cathartic may be indicated in patients seen within 4 hours of ingestion with symptoms, or following a large overdose (5 to 10 times the usual dose). Forced diuresis, alkalization of urine, hemodialysis, or hemoperfusion may not be useful due to high protein binding.

## DOSAGE AND ADMINISTRATION

Carefully consider the potential benefits and risks of ANSAID and other treatment options before deciding to use ANSAID. Use the lowest effective dose for the shortest duration consistent with individual patient treatment goals (see **WARNINGS**).

After observing the response to initial therapy with ANSAID, the dose and frequency should be adjusted to suit an individual patient's needs.

For relief of the signs and symptoms of rheumatoid arthritis or osteoarthritis, the recommended starting dose of ANSAID is 200 to 300 mg per day, divided for administration two, three, or four times a day. The largest recommended single dose in a multiple-dose daily regimen is 100 mg.

## HOW SUPPLIED

ANSAID Tablets are available as follows:

**50 mg:** white, oval, film-coated, imprinted ANSAID 50 mg  
Bottles of 2000 NDC 0009-0170-24

**100 mg:** blue, oval, film-coated, imprinted ANSAID 100 mg  
Bottles of 100 NDC 0009-0305-03  
Bottles of 2000 NDC 0009-0305-30

Store at controlled room temperature 20° to 25°C (68° to 77°F) [see USP].

Rx only



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