

CENTER FOR DRUG EVALUATION AND RESEARCH

APPLICATION NUMBER:

19-309/S016

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Approval Package for:

APPLICATION NUMBER:

19-309/S016

Trade Name: Vasotec I.V. Injection

Generic Name: Enalaprilat

Sponsor: Merck Research Laboratories

Approval Date: October 21, 1993

Indications: The treatment of hypertension when oral therapy is not practical.

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RESEARCH**

APPLICATION NUMBER:

19-309/S016

APPROVAL LETTER

Food and Drug Administration
Rockville MD 20857NDA 18-998/S-040
19-221/S-018
19-309/S-016

OCT 21 1993

Merck Research Laboratories
Attention: Patricia L. Kraft, Ph.D.
Sumneytown Pike
West Point, PA 19486

Dear Dr. Kraft:

We acknowledge the receipt on August 16, 1993 of your August 13, 1993 supplemental new drug applications submitted under section 505(b)(1) of the Federal Food, Drug, and Cosmetic Act for Vasotec (enalapril maleate) Tablets (NDA 18-998), Vaseretic (enalapril maleate/hydrochlorothiazide) Tablets (NDA 19-221), and Vasotec I.V. (enalaprilat) Injection (NDA 19-309).

The supplemental applications provide for draft labeling revised as follows:

NDA 18-998, 19-221, and 19-309

ADVERSE REACTIONS [Enalapril maleate]:

Skin: "pemphigus" has been added;

Miscellaneous: "myositis" has been added;

Clinical Laboratory Test Findings, Hematology: the wording in the last sentence of this subsection has been revised from "A few cases of hemolysis have been reported in patients with G-6-PD deficiency in which a causal relationship cannot be excluded" to "Hemolytic anemia, including cases of hemolysis in patients with G-6-PD deficiency, has been reported; a causal relationship to enalapril has not been established."

NDA 19-221

PRECAUTIONS, Drug Interactions, Cholestyramine and colestipol resins:

The wording of this subsection has been changed to "Absorption of hydrochlorothiazide is impaired in the presence of anionic exchange resins. Single doses of either cholestyramine or colestipol resins bind the hydrochlorothiazide and reduce its absorption from the gastrointestinal tract by up to 85 and 43 percent, respectively."

We have completed the review of these supplemental applications including the submitted draft labeling and have concluded that adequate information has been presented to demonstrate that the drug products are safe and effective for use as recommended in the submitted draft labeling. Accordingly, the supplemental applications are approved effective on the date of this letter. The labeling, however, must be revised as follows:

1. **ADVERSE REACTIONS, Clinical Laboratory Test Findings, Hematology:** Please revise the wording in the final clause of the last sentence of this subsection to read "a causal relationship to enalapril cannot be excluded."

These revisions are terms of the supplemental NDA approval. Marketing the products before making the revisions, exactly as requested, in the products' final printed labeling (FPL) may render the products misbranded and unapproved new drugs.

When available, please submit twelve copies of the FPL to each NDA, seven of which are mounted on heavy weight paper or similar material. For administrative purposes, the submissions of FPL should be designated an "FPL Supplement" to the approved supplemental NDAs. Approval of the supplement by FDA is not required before the labeling is used.

Should additional information relating to the safety and effectiveness of the drugs become available, further revision of that labeling may be required.

We remind you that you must comply with the requirements for an approved NDA set forth under 21 CFR 314.80 and 314.81.

If you have any questions, please contact:

Ms. Kathleen Bongiovanni
Consumer Safety Officer
(301) 443-4730

Sincerely yours,

RJ 10/21/93

Raymond J. Lipicky, M.D.
Director
Division of Cardio-Renal Drug Products
Office of Drug Evaluation I
Center for Drug Evaluation and Research

cc:

Original NDA

HFC-130/JAllen

HFD-110

HFD-110/CSO

HFD-80

HFD-232 (with labeling)

HFD-110/KBongiovanni;9/23/93

sb/9/15/93;9/22/93;9/27/93

R/D: CGanley/9/15/93;10/13/93

SChen/9/20/93;10/13/93

NMorgenstern/9/20/93;10/13/93

Approval Date:18-998 - December 24, 1985

19-221 - October 31, 1986

19-309 - February 9, 1988

APPROVAL

K Bongiovanni
10-15-93

4 Page(s) Withheld

§ 552(b)(4) Trade Secret / Confidential

§ 552(b)(5) Deliberative Process

§ 552(b)(4) Draft Labeling

**CENTER FOR DRUG EVALUATION AND
RESEARCH**

APPLICATION NUMBER:

19-309/S016

LABELING

7494619

MERCK & CO., INC.
West Point, PA 19486, USA

INJECTION

VASOTEC® I.V.

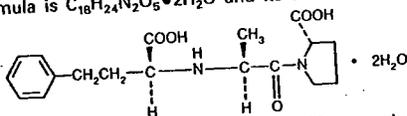
(ENALAPRILAT)

USE IN PREGNANCY

When used in pregnancy during the second and third trimesters, ACE inhibitors can cause injury and even death to the developing fetus. When pregnancy is detected, VASOTEC I.V. should be discontinued as soon as possible. See WARNINGS, *Fetal/Neonatal Morbidity and Mortality*.

DESCRIPTION

VASOTEC® I.V. (Enalaprilat) is a sterile aqueous solution for intravenous administration. Enalaprilat is an angiotensin converting enzyme inhibitor. It is chemically described as (S)-1-[N-(1-carboxy-3-phenylpropyl)-L-alanyl]-L-proline dihydrate. Its empirical formula is $C_{18}H_{24}N_2O_5 \cdot 2H_2O$ and its structural formula is:



Enalaprilat is a white to off-white, crystalline powder with a molecular weight of 384.43. It is sparingly soluble in methanol and slightly soluble in water.

Each milliliter of VASOTEC I.V. contains 1.25 mg enalaprilat (anhydrous equivalent); sodium chloride to adjust tonicity; sodium hydroxide to adjust pH; water for injection, q.s.; with benzyl alcohol, 9 mg, added as a preservative.

CLINICAL PHARMACOLOGY

Enalaprilat, an angiotensin-converting enzyme (ACE) inhibitor when administered intravenously, is the active metabolite of the orally administered pro-drug, enalapril maleate. Enalaprilat is poorly absorbed orally.

Mechanism of Action

Intravenous enalaprilat, or oral enalapril, after hydrolysis to enalaprilat, inhibits ACE in human subjects and animals. ACE is a peptidyl dipeptidase that catalyzes the conversion of angiotensin I to the vasoconstrictor substance, angiotensin II. Angiotensin II also stimulates aldosterone secretion by the adrenal cortex. Inhibition of ACE results in decreased plasma angiotensin II, which leads to decreased vasopressor activity and to decreased aldosterone secretion. Although the latter decrease is small, it results in small increases of serum potassium. In hypertensive patients treated with enalapril alone for up to 48 weeks, mean increases in serum potassium of approximately 0.2 mEq/L were observed. In patients treated with enalapril plus a thiazide diuretic, there was essentially no change in serum potassium. (See PRECAUTIONS.) Removal of angiotensin II negative feedback on renin secretion leads to increased plasma renin activity.

ACE is identical to kininase, an enzyme that degrades bradykinin. Whether increased levels of bradykinin, a potent vasodilator peptide, play a role in the therapeutic effects of enalaprilat remains to be elucidated.

While the mechanism through which enalaprilat lowers blood pressure is believed to be primarily suppression of the renin-angiotensin-aldosterone system, enalaprilat has antihypertensive activity even in patients with low-renin hypertension. In clinical studies, black hypertensive patients (usually a low-renin hypertensive population) had a smaller average response to enalaprilat monotherapy than non-black patients.

Pharmacokinetics and Metabolism

Following intravenous administration of a single dose, the serum concentration profile of enalaprilat is polyexponential with a prolonged terminal phase, apparently representing a small frac-

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tion of the administered dose that has been bound to ACE. The amount bound does not increase with dose, indicating a saturable site of binding. The effective half-life for accumulation of enalaprilat, as determined from oral administration of multiple doses of enalapril maleate, is approximately 11 hours. Excretion of enalaprilat is primarily renal with more than 90 percent of an administered dose recovered in the urine as unchanged drug within 24 hours. Enalaprilat is poorly absorbed following oral administration.

The disposition of enalaprilat in patients with renal insufficiency is similar to that in patients with normal renal function until the glomerular filtration rate is 30 mL/min or less. With glomerular filtration rate ≤ 30 mL/min, peak and trough enalaprilat levels increase, time to peak concentration increases and time to steady state may be delayed. The effective half-life of enalaprilat is prolonged at this level of renal insufficiency. (See DOSAGE AND ADMINISTRATION.) Enalaprilat is dialyzable at the rate of 62 mL/min.

Studies in dogs indicate that enalaprilat does not enter the brain, and that enalapril crosses the blood-brain barrier poorly, if at all. Multiple doses of enalapril maleate in rats do not result in accumulation in any tissues. Milk in lactating rats contains radioactivity following administration of ^{14}C enalapril maleate. Radioactivity was found to cross the placenta following administration of labeled drug to pregnant hamsters.

Pharmacodynamics

VASOTEC I.V. results in the reduction of both supine and standing systolic and diastolic blood pressure, usually with no orthostatic component. Symptomatic postural hypotension is therefore infrequent, although it might be anticipated in volume-depleted patients (see WARNINGS). The onset of action usually occurs within fifteen minutes of administration with the maximum effect occurring within one to four hours. The abrupt withdrawal of enalaprilat has not been associated with a rapid increase in blood pressure.

The duration of hemodynamic effects appears to be dose-related. However, for the recommended dose, the duration of action in most patients is approximately six hours.

Following administration of enalapril, there is an increase in renal blood flow; glomerular filtration rate is usually unchanged. The effects appear to be similar in patients with renovascular hypertension.

INDICATIONS AND USAGE

VASOTEC I.V. is indicated for the treatment of hypertension when oral therapy is not practical.

VASOTEC I.V. has been studied with only one other antihypertensive agent, furosemide, which showed approximately additive effects on blood pressure. Enalapril, the pro-drug of enalaprilat, has been used extensively with a variety of other antihypertensive agents, without apparent difficulty except for occasional hypotension.

In using VASOTEC I.V., consideration should be given to the fact that another angiotensin converting enzyme inhibitor, captopril, has caused agranulocytosis, particularly in patients with renal impairment or collagen vascular disease, and that available data are insufficient to show that VASOTEC I.V. does not have a similar risk. (See WARNINGS.)

CONTRAINDICATIONS

VASOTEC I.V. is contraindicated in patients who are hypersensitive to any component of this product and in patients with a history of angioedema related to previous treatment with an angiotensin converting enzyme inhibitor.

WARNINGS**Hypotension**

Excessive hypotension is rare in uncomplicated hypertensive patients but is a possible consequence of the use of enalaprilat especially in severely salt/volume depleted persons such as those treated vigorously with diuretics or patients on dialysis. Patients at risk for excessive hypotension, sometimes associated with oliguria and/or progressive azotemia, and rarely with acute renal failure and/or death, include those with the following condi-

VASOTEC® I.V. (Enalaprilat)

tions or characteristics: heart failure, hyponatremia, high dose diuretic therapy, recent intensive diuresis or increase in diuretic dose, renal dialysis, or severe volume and/or salt depletion of any etiology. It may be advisable to eliminate the diuretic, reduce the diuretic dose or increase salt intake cautiously before initiating therapy with VASOTEC I.V. in patients at risk for excessive hypotension who are able to tolerate such adjustments. (See PRECAUTIONS, *Drug Interactions*, ADVERSE REACTIONS, and DOSAGE AND ADMINISTRATION.) In patients with heart failure, with or without associated renal insufficiency, excessive hypotension has been observed and may be associated with oliguria and/or progressive azotemia, and rarely with acute renal failure and/or death. Because of the potential for an excessive fall in blood pressure especially in these patients, therapy should be followed closely whenever the dose of enalaprilat is adjusted and/or diuretic is increased. Similar considerations may apply to patients with ischemic heart or cerebrovascular disease, in whom an excessive fall in blood pressure could result in a myocardial infarction or cerebrovascular accident.

If hypotension occurs, the patient should be placed in the supine position and, if necessary, receive an intravenous infusion of normal saline. A transient hypotensive response is not a contraindication to further doses, which usually can be given without difficulty once the blood pressure has increased after volume expansion.

Angioedema

Angioedema of the face, extremities, lips, tongue, glottis and/or larynx has been reported in patients treated with angiotensin converting enzyme inhibitors, including enalaprilat. In such cases VASOTEC I.V. should be promptly discontinued and appropriate therapy and monitoring should be provided until complete and sustained resolution of signs and symptoms has occurred. In instances where swelling has been confined to the face and lips the condition has generally resolved without treatment, although antihistamines have been useful in relieving symptoms. Angioedema associated with laryngeal edema may be fatal. Where there is involvement of the tongue, glottis or larynx, likely to cause airway obstruction, appropriate therapy, e.g., subcutaneous epinephrine solution 1:1000 (0.3 mL to 0.5 mL) and/or measures necessary to ensure a patent airway, should be promptly provided. (See ADVERSE REACTIONS.)

Patients with a history of angioedema unrelated to ACE inhibitor therapy may be at increased risk of angioedema while receiving an ACE inhibitor (see also CONTRAINDICATIONS).

Neutropenia/Agranulocytosis

Another angiotensin converting enzyme inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression, rarely in uncomplicated patients but more frequently in patients with renal impairment especially if they also have a collagen vascular disease. Available data from clinical trials of enalapril are insufficient to show that enalapril does not cause agranulocytosis in similar rates. Marketing experience has revealed several cases of neutropenia, or agranulocytosis in which a causal relationship to enalapril cannot be excluded. Periodic monitoring of white blood cell counts in patients with collagen vascular disease and renal disease should be considered.

Fetal/Neonatal Morbidity and Mortality

ACE inhibitors can cause fetal and neonatal morbidity and death when administered to pregnant women. Several dozen cases have been reported in the world literature. When pregnancy is detected, ACE inhibitors should be discontinued as soon as possible.

The use of ACE inhibitors during the second and third trimesters of pregnancy has been associated with fetal and neonatal injury, including hypotension, neonatal skull hypoplasia, anuria, reversible or irreversible renal failure, and death. Oligohydramnios has also been reported, presumably resulting from decreased fetal renal function; oligohydramnios in this setting has been associated with fetal limb contractures, craniofacial deformation, and hypoplastic lung development. Prematurity, intrauterine growth retardation, and patent ductus arteriosus have also been reported, although it is not clear whether these occurrences were due to the ACE-inhibitor exposure.

These adverse effects do not appear to have resulted from intrauterine ACE-inhibitor exposure that has been limited to the first trimester. Mothers whose embryos and fetuses are exposed to ACE inhibitors only during the first trimester should be so informed. Nonetheless, when patients become pregnant, physi-

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cians should make every effort to discontinue the use of VASOTEC I.V. as soon as possible.

Rarely (probably less often than once in every thousand pregnancies), no alternative to ACE inhibitors will be found. In these rare cases, the mothers should be apprised of the potential hazards to their fetuses, and serial ultrasound examinations should be performed to assess the intraamniotic environment.

If oligohydramnios is observed, VASOTEC I.V. should be discontinued unless it is considered lifesaving for the mother. Contraction stress testing (CST), a non-stress test (NST), or biophysical profiling (BPP) may be appropriate, depending upon the week of pregnancy. Patients and physicians should be aware, however, that oligohydramnios may not appear until after the fetus has sustained irreversible injury.

Infants with histories of *in utero* exposure to ACE inhibitors should be closely observed for hypotension, oliguria, and hyperkalemia. If oliguria occurs, attention should be directed toward support of blood pressure and renal perfusion. Exchange transfusion or dialysis may be required as means of reversing hypotension and/or substituting for disordered renal function. Enalapril, which crosses the placenta, has been removed from neonatal circulation by peritoneal dialysis with some clinical benefit, and theoretically may be removed by exchange transfusion, although there is no experience with the latter procedure.

No teratogenic effects of oral enalapril were seen in studies of pregnant rats, and rabbits. On a mg/kg basis, the doses used were up to 333 times (in rats), and 50 times (in rabbits) the maximum recommended human dose.

PRECAUTIONS**General**

Impaired Renal Function: As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible individuals. In patients with severe heart failure whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with angiotensin converting enzyme inhibitors, including enalapril or enalaprilat, may be associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death.

In clinical studies in hypertensive patients with unilateral or bilateral renal artery stenosis, increases in blood urea nitrogen and serum creatinine were observed in 20 percent of patients receiving enalapril. These increases were almost always reversible upon discontinuation of enalapril or enalaprilat and/or diuretic therapy. In such patients renal function should be monitored during the first few weeks of therapy.

Some hypertensive patients with no apparent pre-existing renal vascular disease have developed increases in blood urea and serum creatinine, usually minor and transient, especially when enalaprilat has been given concomitantly with a diuretic. This is more likely to occur in patients with pre-existing renal impairment. Dosage reduction of enalaprilat and/or discontinuation of the diuretic may be required.

Evaluation of the hypertensive patient should always include assessment of renal function. (See DOSAGE AND ADMINISTRATION.)

Hemodialysis Patients: Anaphylactoid reactions have been reported in patients dialyzed with high-flux membranes (e.g., AN 69®) and treated concomitantly with an ACE inhibitor. In these patients consideration should be given to using a different type of dialysis membrane or a different class of antihypertensive agent.

Hyperkalemia: Elevated serum potassium (greater than 5.7 mEq/L) was observed in approximately one percent of hypertensive patients in clinical trials receiving enalapril. In most cases these were isolated values which resolved despite continued therapy. Hyperkalemia was a cause of discontinuation of therapy in 0.28 percent of hypertensive patients. Risk factors for the development of hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium-sparing agents or potassium supplements, which should be used cautiously, if at all, with VASOTEC I.V. (See *Drug Interactions*.)

Cough: Cough has been reported with the use of ACE inhibitors. Characteristically, the cough is nonproductive, persistent and resolves after discontinuation of therapy. ACE inhibitor-induced cough should be considered as part of the differential diagnosis of cough.

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Surgery/Anesthesia: In patients undergoing major surgery or during anesthesia with agents that produce hypotension, enalapril may block angiotensin II formation secondary to compensatory renin release. If hypotension occurs and is considered to be due to this mechanism, it can be corrected by volume expansion.

Drug Interactions

Hypotension—Patients on Diuretic Therapy: Patients on diuretics and especially those in whom diuretic therapy was recently instituted, may occasionally experience an excessive reduction of blood pressure after initiation of therapy with enalaprilat. The possibility of hypotensive effects with enalaprilat can be minimized by administration of an intravenous infusion of normal saline, discontinuing the diuretic or increasing the salt intake prior to initiation of treatment with enalaprilat. If it is necessary to continue the diuretic, provide close medical supervision for at least one hour after the initial dose of enalaprilat. (See WARNINGS.)

Agents Causing Renin Release: The antihypertensive effect of VASOTEC I.V. appears to be augmented by antihypertensive agents that cause renin release (e.g., diuretics).

Other Cardiovascular Agents: VASOTEC I.V. has been used concomitantly with digitalis, beta adrenergic-blocking agents, methyldopa, nitrates, calcium-blocking agents, hydralazine and prazosin without evidence of clinically significant adverse interactions.

Agents Increasing Serum Potassium: VASOTEC I.V. attenuates potassium loss caused by thiazide-type diuretics. Potassium-sparing diuretics (e.g., spironolactone, triamterene, or amiloride), potassium supplements, or potassium-containing salt substitutes may lead to significant increases in serum potassium. Therefore, if concomitant use of these agents is indicated because of demonstrated hypokalemia, they should be used with caution and with frequent monitoring of serum potassium.

Lithium: Lithium toxicity has been reported in patients receiving lithium concomitantly with drugs which cause elimination of sodium, including ACE inhibitors. A few cases of lithium toxicity have been reported in patients receiving concomitant enalapril and lithium and were reversible upon discontinuation of both drugs. It is recommended that serum lithium levels be monitored frequently if enalapril is administered concomitantly with lithium.

Carcinogenesis, Mutagenesis, Impairment of Fertility
Carcinogenicity studies have not been done with VASOTEC I.V.

VASOTEC I.V. is the bioactive form of its ethyl ester, enalapril maleate. There was no evidence of a tumorigenic effect when enalapril was administered orally for 106 weeks to rats at doses up to 90 mg/kg/day (150 times* the maximum daily human oral dose). Enalapril has also been administered for 94 weeks to male and female mice at oral doses up to 90 and 180 mg/kg/day, respectively (150 and 300 times* the maximum oral daily dose for humans), and showed no evidence of carcinogenicity.

VASOTEC I.V. was not mutagenic in the Ames microbial mutagen test with or without metabolic activation. Enalapril showed no drug-related changes in the following genotoxicity studies: rec-assay, reverse mutation assay with *E. coli*, sister chromatid exchange with cultured mammalian cells, the micronucleus test with mice, and in an *in vivo* cytogenetic study using mouse bone marrow. There were no adverse effects on reproductive performance in male and female rats treated with 10 to 90 mg enalapril/kg/day.

Pregnancy

Pregnancy Categories C (first trimester) and D (second and third trimesters). See WARNINGS, *Fetal/Neonatal Morbidity and Mortality*.

Nursing Mothers

Enalapril and enalaprilat are detected in human milk in trace amounts. Caution should be exercised when VASOTEC I.V. is given to a nursing mother.

Pediatric Use

*Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

VASOTEC I.V. has been found to be generally well tolerated in controlled clinical trials involving 349 patients (168 with hyperten-

*Based on patient weight of 50 kg

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sion, 153 with congestive heart failure and 28 with coronary artery disease). The most frequent clinically significant adverse experience was hypotension (3.4 percent), occurring in eight patients (5.2 percent) with congestive heart failure, three (1.8 percent) with hypertension and one with coronary artery disease. Other adverse experiences occurring in greater than one percent of patients were: headache (2.9 percent) and nausea (1.1 percent).

Adverse experiences occurring in 0.5 to 1.0 percent of patients in controlled clinical trials included: myocardial infarction, fatigue, dizziness, fever, rash and constipation.

Angioedema: Angioedema has been reported in patients receiving enalaprilat. Angioedema associated with laryngeal edema may be fatal. If angioedema of the face, extremities, lips, tongue, glottis and/or larynx occurs, treatment with enalaprilat should be discontinued and appropriate therapy instituted immediately. (See WARNINGS.)

Cough: See PRECAUTIONS, *Cough*.

Enalapril Maleate

Since enalapril is converted to enalaprilat, those adverse experiences associated with enalapril might also be expected to occur with VASOTEC I.V.

The following adverse experiences have been reported with enalapril and, within each category, are listed in order of decreasing severity.

Body As A Whole: Syncope, orthostatic effects, anaphylactoid reactions (see PRECAUTIONS, *Hemodialysis Patients*), chest pain, abdominal pain, asthenia.

Cardiovascular: Cardiac arrest; myocardial infarction or cerebrovascular accident, possibly secondary to excessive hypotension in high risk patients (see WARNINGS, *Hypotension*); pulmonary embolism and infarction; pulmonary edema; rhythm disturbances including atrial tachycardia and bradycardia; atrial fibrillation; orthostatic hypotension; angina pectoris; palpitation.

Digestive: Ileus, pancreatitis, hepatic failure, hepatitis (hepatocellular [proven on rechallenge] or cholestatic jaundice), melena, diarrhea, vomiting, dyspepsia, anorexia, glossitis, stomatitis, dry mouth.

Hematologic: Rare cases of neutropenia, thrombocytopenia and bone marrow depression.

Musculoskeletal: Muscle cramps.

Nervous/Psychiatric: Depression, vertigo, confusion, ataxia, somnolence, insomnia, nervousness, peripheral neuropathy (e.g., paresthesia, dysesthesia).

Respiratory: Bronchospasm, dyspnea, pneumonia, bronchitis, cough, rhinorrhea, sore throat and hoarseness, asthma, upper respiratory infection, pulmonary infiltrates.

Skin: Exfoliative dermatitis, toxic epidermal necrolysis, Stevens-Johnson syndrome, pemphigus, herpes zoster, erythema multiforme, urticaria, pruritus, alopecia, flushing, diaphoresis, photosensitivity.

Special Senses: Blurred vision, taste alteration, anosmia, tinnitus, conjunctivitis, dry eyes, tearing.

Urogenital: Renal failure, oliguria, renal dysfunction (see PRECAUTIONS and DOSAGE AND ADMINISTRATION), urinary tract infection, flank pain, gynecomastia, impotence.

Miscellaneous: A symptom complex has been reported which may include a positive ANA, an elevated erythrocyte sedimentation rate, arthralgia/arthritis, myalgia/myositis, fever, serositis, vasculitis, leukocytosis, eosinophilia, photosensitivity, rash and other dermatologic manifestations.

Hypotension: Combining the results of clinical trials in patients with hypertension or congestive heart failure, hypotension (including postural hypotension, and other orthostatic effects) was reported in 2.3 percent of patients following the initial dose of enalapril or during extended therapy. In the hypertensive patients, hypotension occurred in 0.9 percent and syncope occurred in 0.5 percent of patients. Hypotension or syncope was a cause for discontinuation of therapy in 0.1 percent of hypertensive patients. (See WARNINGS.)

Fetal/Neonatal Morbidity and Mortality: See WARNINGS, *Fetal/Neonatal Morbidity and Mortality*.

Clinical Laboratory Test Findings

Serum Electrolytes: Hyperkalemia (see PRECAUTIONS), hyponatremia.

Creatinine, Blood Urea Nitrogen: In controlled clinical trials minor increases in blood urea nitrogen and serum creatinine,

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reversible upon discontinuation of therapy, were observed in about 0.2 percent of patients with essential hypertension treated with enalapril alone. Increases are more likely to occur in patients receiving concomitant diuretics or in patients with renal artery stenosis. (See PRECAUTIONS.)

Hematology: Small decreases in hemoglobin and hematocrit (mean decreases of approximately 0.3 g percent and 1.0 vol percent, respectively) occur frequently in hypertensive patients another cause of anemia coexists. In clinical trials, less than 0.1 percent of patients discontinued therapy due to anemia. Hemolytic anemia, including cases of hemolysis in patients with G-6-PD deficiency, has been reported; a causal relationship to enalapril has not been established.

Liver Function Tests: Elevations of liver enzymes and/or serum bilirubin have occurred.

OVERDOSAGE

In clinical studies, some hypertensive patients received a maximum dose of 80 mg of enalaprilat intravenously over a fifteen minute period. At this high dose, no adverse effects beyond those as associated with the recommended dosages were observed. The intravenous LD₅₀ of enalaprilat is 3740-5890 mg/kg in female mice.

The most likely manifestation of overdosage would be hypotension, for which the usual treatment would be intravenous infusion of normal saline solution.

Enalaprilat may be removed from general circulation by hemodialysis and has been removed from neonatal circulation by peritoneal dialysis.

DOSAGE AND ADMINISTRATION

FOR INTRAVENOUS ADMINISTRATION ONLY

The dose in hypertension is 1.25 mg every six hours administered intravenously over a five minute period. A clinical response is usually seen within 15 minutes. Peak effects after the first dose may not occur for up to four hours after dosing. The peak effects of the second and subsequent doses may exceed those of the first.

No dosage regimen for VASOTEC I.V. has been clearly demonstrated to be more effective in treating hypertension than 1.25 mg every six hours. However, in controlled clinical studies in hypertensive patients, doses as high as 5 mg every six hours were well tolerated with doses greater than 20 mg per day. There has been inadequate experience with doses greater than 20 mg per day.

In studies of patients with hypertension, VASOTEC I.V. has not been administered for periods longer than 48 hours. In other studies, patients have received VASOTEC I.V. for as long as seven days.

The dose for patients being converted to VASOTEC I.V. from oral therapy for hypertension with enalapril maleate is 1.25 mg every six hours. For conversion from intravenous to oral therapy, the recommended initial dose of Tablets VASOTEC (Enalapril Maleate) is 5 mg once a day with subsequent dosage adjustments as necessary.

Patients on Diuretic Therapy

For patients on diuretic therapy the recommended starting dose for hypertension is 0.625 mg administered intravenously over a five minute period; also see below, *Patients at Risk of Excessive Hypotension*. A clinical response is usually seen within 15 minutes. Peak effects after the first dose may not occur for up to four hours after dosing, although most of the effect is usually apparent within the first hour. If after one hour there is an inadequate clinical response, the 0.625 mg dose may be repeated. Additional doses of 1.25 mg may be administered at six hour intervals.

VASOTEC® I.V. (Enalaprilat)

For conversion from intravenous to oral therapy, the recommended initial dose of Tablets VASOTEC (Enalapril Maleate) for patients who have responded to 0.625 mg of enalaprilat every six hours is 2.5 mg once a day with subsequent dosage adjustment as necessary.

Dosage Adjustment in Renal Impairment

The usual dose of 1.25 mg of enalaprilat every six hours is recommended for patients with a creatinine clearance >30 mL/min (serum creatinine of up to approximately 3 mg/dL). For patients with creatinine clearance ≤30 mL/min (serum creatinine ≥3 mg/dL), the initial dose is 0.625 mg. (See WARNINGS.)

If after one hour there is an inadequate clinical response, the 0.625 mg dose may be repeated. Additional doses of 1.25 mg may be administered at six hour intervals.

For dialysis patients, see below, *Patients at Risk of Excessive Hypotension*.

For conversion from intravenous to oral therapy, the recommended initial dose of Tablets VASOTEC (Enalapril Maleate) is 5 mg once a day for patients with creatinine clearance >30 mL/min and 2.5 mg once daily for patients with creatinine clearance ≤30 mL/min. Dosage should then be adjusted according to blood pressure response.

Patients at Risk of Excessive Hypotension

Hypertensive patients at risk of excessive hypotension include those with the following concurrent conditions or characteristics: heart failure, hyponatremia, high dose diuretic therapy, recent severe volume and/or salt depletion of any etiology (see WARNINGS), intensive diuresis or increase in diuretic dose, renal dialysis, or INGS). Single doses of enalaprilat as low as 0.2 mg have produced excessive hypotension in normotensive patients with these diagnoses. Because of the potential for an extreme hypotensive response in these patients, therapy should be started under very close medical supervision. The starting dose should be no greater than 0.625 mg administered intravenously over a period of no less than five minutes and preferably longer (up to one hour).

Patients should be followed closely whenever the dose of enalaprilat is adjusted and/or diuretic is increased.

Administration

VASOTEC I.V. should be administered as a slow intravenous infusion, as indicated above. It may be administered as provided or diluted with up to 50 mL of a compatible diluent.

Parenteral drug products should be inspected visually for particulate matter and discoloration prior to use whenever solution and container permit.

Compatibility and Stability

VASOTEC I.V. as supplied and mixed with the following intravenous diluents has been found to maintain full activity for 24 hours at room temperature:

- 5 percent Dextrose Injection
 - 0.9 percent Sodium Chloride Injection
 - 0.9 percent Sodium Chloride Injection in 5 percent Dextrose
 - 5 percent Dextrose in Lactated Ringer's Injection
- McGaw ISOLYTE® E.

HOW SUPPLIED

No. 3508 — VASOTEC I.V., 1.25 mg per mL, is a clear, colorless solution and is supplied in vials containing 1 mL and 2 mL.
NDC 0006-3508-01, 1 mL vials.
NDC 0006-3508-04, 2 mL vials.

Storage

Store below 30°C (86°F).

*Registered trademark of American Hospital Supply Corporation.

Dist. by:



MERCK & CO., INC., West Point, PA 19486, USA

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**CENTER FOR DRUG EVALUATION AND
RESEARCH**

APPLICATION NUMBER:

19-309/S016

**ADMINISTRATIVE and CORRESPONDENCE
DOCUMENTS**

7

CSO Review of Labeling

NDA: 18-998/S-040 Vasotec (enalapril maleate) Tablets
19-221/S-018 Vaseretic (enalapril maleate/HCTZ) Tablets
~~19-309/S-016~~ Vasotec (enalaprilat) I.V.

Date of submissions: August 13, 1993

OCT 21 1993

Date of receipt: August 16, 1993

Applicant: Merck Research Laboratories

Background: Merck has submitted final printed labeling for Special Supplements - Changes Being Effected, to update the PRECAUTIONS and/or ADVERSE REACTIONS sections. In the cover letters for the supplements, Merck states that the changes will become effective on or about October 1, 1993.

Review:

NDA 18-998, 19-221, and 19-309

ADVERSE REACTIONS [Enalapril maleate]:

Skin: "pemphigus" has been added;

Miscellaneous: "myositis" has been added;

Clinical Laboratory Test Findings, Hematology: the wording in the last sentence of this subsection has been revised from "A few cases of hemolysis have been reported in patients with G-6-PD deficiency in which a causal relationship cannot be excluded." to "Hemolytic anemia, including cases of hemolysis in patients with G-6-PD deficiency, has been reported; a causal relationship to enalapril has not been established."

The revision in the wording of the last sentence of the Clinical Laboratory Test Findings, Hematology subsections includes changes other than those described in the "Summary of Revisions" submitted with these supplements, which lists the change as "revision of wording to include 'hemolytic anemia.'" The change to the last phrase, from "a causal relationship cannot be excluded" to "a causal relationship to enalapril has not been established" was neither mentioned in the text nor supported. In a discussion with Dr. Lipicky on September 23, 1993, he said that we should approve the supplements on draft, asking them to change the phrase back in their final printed labeling.

NDA 19-221

PRECAUTIONS, Drug Interactions, Cholestyramine and colestipol resins: For consistency with the FDA letter to NDA 11-835 dated September 17, 1993, the wording of this subsection has been changed to "Absorption of hydrochlorothiazide is impaired in the presence of anionic exchange resins. Single doses of either cholestyramine or colestipol resins bind the hydrochlorothiazide and reduce its absorption from the gastrointestinal tract by up to 85 and 43 percent, respectively."

Recommendation: I will prepare an acknowledge and approval-on-draft letter for these supplements, asking them to change the last phrase in the last sentence in ADVERSE REACTIONS, Clinical Laboratory Test Findings, Hematology subsection to "a causal relationship to enalapril cannot be excluded."

Kathleen F. Bongiovanni
Kathleen F. Bongiovanni

9-23-93

cc: 18-998/S-040
19-221/S-018
19-309/S-016
HFD-110 (all)
HFD-111/KBongiovanni
HFD-111/SBenton
kb/9/14/93; 9/23/93.