Alvesco®
Inhalation Aerosol 80 mcg, 160 mcg (ciclesonide)

Treat inflammation effectively, with low potential for adverse events even at high doses[1]

Alvesco® is indicated in treatment to control persistent asthma in adults and adolescents (12 years and older).[1]

Alvesco® provides high pulmonary deposition and small airway distribution[2,3]

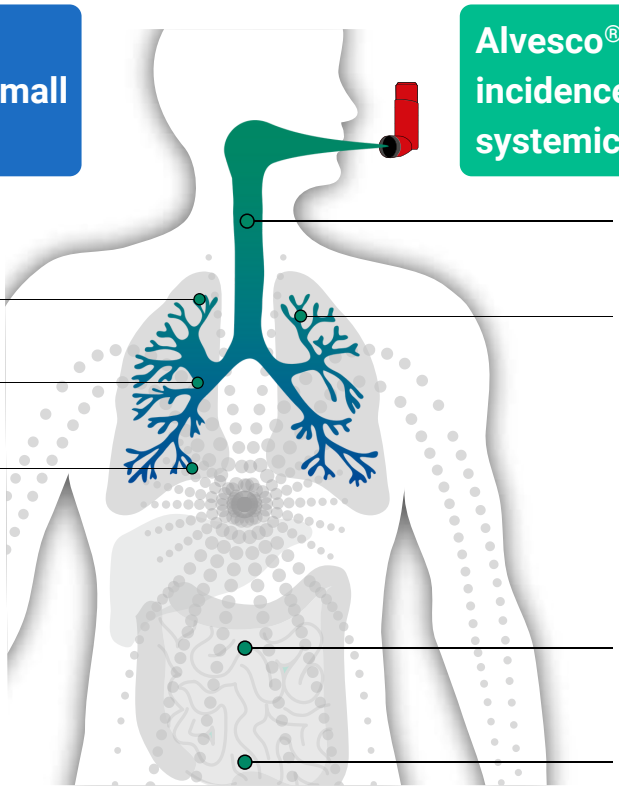
High total lung deposition (52%) of which the majority is distributed to the small airways[3]

High lipophilicity and fast absorption into the lung cells (in vitro)[4]

High affinity to GRs* and high anti-inflammatory activity (des-CIC) (in vitro)[5]

These properties are thought to contribute to:

- Rapid onset of action: improves bronchial hyperreactivity (BHR) 2.5h after the first dose[6†]
- Symptoms start to improve within 24 hours after treatment[1]



Alvesco® provides a low incidence of local and systemic adverse events[1,7]

Low oropharyngeal deposition of 33%[2]

High protein binding resulting in low free concentration ~1%[1]

Low oral bioavailability <1% due to **high first pass metabolism[8]**

High systemic clearance and excretion via the bile is the major route of elimination[1,7]

*glucocorticoid receptors in vitro data

Alvesco® reduces the need for oral steroids in adult patients with persistent and severe asthma compared to placebo[9]

The dose of prednisone was reduced from week 2 of the study in the ciclesonide group, the reduction was maintained for the duration of the study.141 adults and adolescents ≥ 12 with severe, persistent, OCS-dependent asthma were enrolled in a 12 week double-blind, placebo-controlled, parallel-group study[9]

- Alvesco® was well tolerated[9]
- Patients using Alvesco® were able to reduce the OCS dose needed to control their asthma by up to 47.39%[9]
- 30% of patients in the Alvesco® group were able to discontinue OCS completely[9]

Mean change in prednisone dose[9]

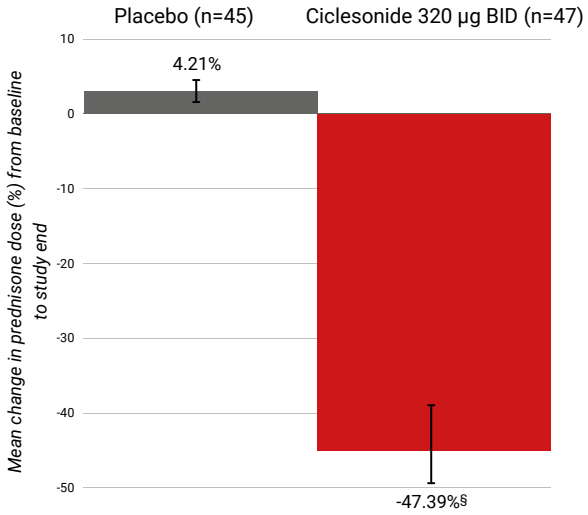


***Figure 6 Mean change in prednisone dose**. Data are presented as means, population ITT. BID = twice daily OCS = oral corticosteroids. §p=0.0003 vs. placebo. Adapted from Bateman E et al, CHEST 2006; 129: 1176–1187*

COVIS PHARMA ZENTIVA

Alvesco®

Inhalation Aerosol 80 mcg, 160 mcg (ciclesonide)

Alvesco® 80 and 160 Inhaler (ciclesonide) Prescribing Information. Prescribers should consult the SmPC before prescribing.

Presentation: Each actuation contains 80mcg or 160mcg ciclesonide respectively.

Indications: To control persistent asthma in adults and adolescents (12 years and older).

Dosage and administration: Recommended dose is 160 mcg once daily. Can be increased to 640mcg/day (as. 320mcg twice daily) in patients with severe asthma while reducing or discontinuing oral corticosteroids. Symptoms start to improve within 24 hours of treatment. Once control is achieved, dose should be individualised and titrated to the minimum dose needed to maintain good asthma control. Dose reduction to 80mcg/day may be effective maintenance for some patients. Should preferably be administered in the evening although morning dosing has also been effective. Patients with severe asthma should have regular assessments. Increasing use of short-acting bronchodilators indicates deterioration of asthma control. In this situation, patients should be reassessed. Can be used with AeroChamber Plus spacer device to address specific patient needs.

Method of Administration: Inhalation use only. Patient needs to be instructed how to use the inhaler correctly (refer to SmPC and Package Leaflet). If the inhaler is new or not used for one week or more, three puffs should be released into the air. No shaking is necessary as this is a solution aerosol. Patient should stand or sit during inhalation and inhaler should be held upright with the thumb on the base, below mouthpiece.

Special Populations: *Paediatric Population:* not for use in patients aged under 12 years. *Elderly:* no need to adjust the dose. *Renal impairment:* no need to adjust the dose. *Hepatic impairment:* no need to adjust the dose.

Fertility, pregnancy and lactation: *Pregnancy:* Should only be used during pregnancy if potential benefit to the mother justifies the potential risk to the fetus. *Breastfeeding:* it is unknown whether inhaled ciclesonide is excreted in human milk. Should only be considered if the expected benefit to the mother is greater than any risk to the child. *Fertility:* animal studies shown glucocorticoids to induce malformations but not likely to be relevant for humans given recommended inhalation doses.

Contraindications: Hypersensitivity to ciclesonide or any of the excipients.

Special warnings and precautions: Administer with caution in patients with active or quiescent pulmonary tuberculosis, fungal, viral or bacterial infections. Not indicated for the treatment of status asthmaticus or acute episodes of asthma. Patients should be advised to have rescue medication to relieve acute asthma symptoms. Using high doses for prolonged periods may cause systemic effects, including adrenal suppression, growth retardation in children and adolescents, decrease in bone mineral density, cataract and glaucoma, and more rarely, a range of psychological or behavioural effects including psychomotor hyperactivity, sleep disorders, anxiety, depression or aggression (particularly in children). It is important that the dose of inhaled corticosteroid is titrated to the lowest dose. It is recommended to regularly monitor the height of children and adolescents receiving prolonged treatment. *Adrenal impairment:* Patients transferred from oral steroids remain at risk for a considerable time after transferring to inhaled ciclesonide. May require advice to determine the extent before elective procedures. *Transfer of patients being treated with oral corticosteroids:* Need special care to recover from impaired adrenocortical function. Patients treated with systemic steroids for prolonged time or at high dose should be monitored regularly and dose should be reduced cautiously. Replacement of systemic steroid treatment with inhaled therapy may unmask allergies. Paradoxical bronchospasm or other symptoms of bronchoconstriction should be treated with inhaled short- acting bronchodilator. Therapy should be continued after careful consideration. Inhaler technique should be checked regularly. Concomitant treatment with ketoconazole or other potent CYP3A4 inhibitors should be avoided. This medicine contains 4.7 mg alcohol (ethanol) in each dose, equivalent to less than 1 ml beer or wine. The small amount of alcohol in this medicine will not have any noticeable effects.

Drug Interactions: Potent inhibitors of CYP3A4 (e.g., ketoconazole, itraconazole and ritonavir or nelfinavir). Concomitant use should be avoided unless benefit outweighs the risks.

Effects on ability to drive/use machines: No or negligible influence.

Undesirable effects: Nausea, vomiting, bad taste, palpitations, application site reactions, application site dryness, angioedema, hypersensitivity, oral fungal infections, headache, psychomotor hyperactivity, depression, sleep disorders, aggression, behavioural changes, dysphonia, cough after inhalation, paradoxical bronchospasm, eczema, rash, hypertension. See SmPC for full list of adverse events.

Pack size and UK list price:
Alvesco 80 inhaler (PL 52811/0007), pack size: 120, £ 32.83
Alvesco 160 inhaler (PL 52811/0008), pack size: 60, £ 19.31
Alvesco 160 inhaler (PL 52811/0008), pack size: 120, £ 38.62

Legal category: POM

Marketing Authorisation Holder: Covis Pharma Europe B.V. Gustav Mahlerplein 2 1082MA Amsterdam The Netherlands

Distributor: Zentiva Pharma UK Limited, 12 New Fetter Lane, London, EC4A 1JP, United Kingdom

Date of Preparation: 01 July 2023 **Ref:** 000595662

Adverse events should be reported.
Reporting forms and information can be found at www.mhra.gov.uk/yellowcard.

Adverse events should also be reported to Covis via email to medinfoEMEA@covispharma.com or via phone on 08004334029.

1. Alvesco SmPC
2. Newman S et al, Respir Med 2006; 100: 375-383
3. Leach C et al, J Allergyu Clin immunol 2009; 129: 88-93
4. Nonaka T et al, BMC Pharmacol 2007; 7: 12
5. Stoeck M et al, J Pharmacol Exp Ther 2004; 309: 249-258
6. Erin E, Chest 2008; 134: 740-745
7. Derendorf H et al, Eur Respir J 2006; 28: 1042-1050
8. Nave R et al, Clin Pharmacokinet 2004; 43: 479-486
9. Bateman E et al, CHEST 2006; 129: 1176–1187

†Results from a double-blind, randomised, placebo-controlled, 3-period, crossover study in 21 adults with persistent asthma

Date of Prep: July 2023
Reference: 000598023

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