1. **NAME OF THE MEDICINAL PRODUCT**

Avodart 0.5 mg capsules, soft.

2. **QUALITATIVE AND QUANTITATIVE COMPOSITION**

Each capsule contains 0.5 mg dutasteride. For excipients, see 6.1.

3. **PHARMACEUTICAL FORM**

Capsule, soft.

The capsules are opaque, yellow, oblong soft gelatin capsules imprinted with GX CE2.

4. **CLINICAL PARTICULARS**

4.1. **Therapeutic Indications**

Avodart is indicated for the treatment and control of benign prostatic hyperplasia (BPH) in men with an enlarged prostate to improve symptoms, reduce prostate size, reduce the risk of acute urinary retention, and reduce the need for BPH-related surgery.

In addition, Avodart in combination with the alpha-blocker tamsulosin is indicated for the treatment of symptomatic BPH in men with an enlarged prostate.

4.2. **Posology and Method of Administration**

*Adult males (including elderly):*

Avodart can be administered alone or in combination with the alpha-blocker tamsulosin (0.4 mg).

The recommended dose of Avodart is one capsule (0.5 mg) taken orally once a day. The capsules should be swallowed whole and not chewed or opened, as contact with the capsule contents may result in irritation of the oropharyngeal mucosa.

Avodart may be taken with or without food.

Although an improvement may be observed at an early stage, it can take up to 6 months before a response to the treatment can be achieved. No dose adjustment is necessary in the elderly.
Renal impairment

The effect of renal impairment on dutasteride pharmacokinetics has not been studied. No adjustment in dosage is anticipated for patients with renal impairment (see 5.2 Pharmacokinetic Properties).

Hepatic impairment

The effect of hepatic impairment on dutasteride pharmacokinetics has not been studied so caution should be used in patients with mild to moderate hepatic impairment (see 4.4 Special Warnings and Special Precautions for Use and 5.2 Pharmacokinetic Properties). In patients with severe hepatic impairment, the use of dutasteride is contraindicated (See section 4.3 Contraindications).

4.3. Contraindications

Avodart is contraindicated for use in women, children and adolescents (see 4.6 Pregnancy and Lactation).

Avodart is contraindicated in patients with hypersensitivity to dutasteride, other 5-alpha-reductase inhibitors, or any of the excipients.

Avodart is contraindicated in patients with severe hepatic impairment.

4.4. Special Warnings and Special Precautions for Use

Dutasteride is absorbed through the skin, therefore, women, children and adolescents must avoid contact with leaking capsules (see 4.6 Pregnancy and Lactation). If contact is made with leaking capsules, the contact area should be washed immediately with soap and water.

Dutasteride was not studied in patients with liver disease. Caution should be used in the administration of dutasteride to patients with mild to moderate hepatic impairment (see 4.2 Posology and Method of Administration, 4.3 Contraindications and 5.2 Pharmacokinetic Properties).

Combination therapy should be prescribed after careful benefit risk assessment due to the potential increased risk of adverse events and after consideration of alternative treatment options including monotherapies (see section 4.2).

In a 4-year clinical study, the incidence of cardiac failure (a composite term of reported events, primarily cardiac failure and congestive cardiac failure) was higher among subjects taking the combination of Avodart and an alpha blocker, primarily tamsulosin, than it was among subjects not taking the combination. No causal relationship between
Avodart (alone or in combination with an alpha blocker) and cardiac failure has been established (see Clinical Studies).

**Effect on prostate specific antigen (PSA) and prostate cancer detection**

Digital rectal examination, as well as other evaluations for prostate cancer, must be performed on patients with BPH prior to initiating therapy with Avodart and periodically thereafter.

Serum prostate-specific antigen (PSA) concentration is an important component of the screening process to detect prostate cancer. Generally, a total serum PSA concentration greater than 4 ng/mL (Hybritech) requires further evaluation and consideration of prostate biopsy.

Physicians should be aware that a baseline PSA less than 4 ng/mL in patients taking Avodart does not exclude a diagnosis of prostate cancer. Avodart causes a decrease in serum PSA levels by approximately 50%, after 6 months, in patients with BPH, even in the presence of prostate cancer. Although there may be individual variation, the reduction in PSA by approximately 50% is predictable as it was observed over the entire range of baseline PSA values (1.5 to 10 ng/mL).

Patients receiving Avodart should have a new PSA baseline established after 6 months of treatment with Avodart. It is recommended to monitor PSA values regularly thereafter. Any confirmed increase from lowest PSA level while on Avodart may signal the presence of prostate cancer (particularly high grade cancer) or non-compliance to therapy with Avodart and should be carefully evaluated, even if those values are still within the normal range for men not taking a 5α-reductase inhibitor (see Clinical Studies). In the interpretation of a PSA value for a patient taking Avodart, previous PSA values should be sought for comparison.

Total serum PSA levels return to baseline within 6 months of discontinuing treatment.

The ratio of free to total PSA remains constant even under the influence of Avodart. If clinicians elect to use percent-free PSA as an aid in the detection of prostate cancer in men undergoing Avodart therapy, no adjustment to its value appears necessary.

**Prostate cancer and high grade tumours**

In a 4-year study of over 8,000 men aged 50 to 75, with a prior negative biopsy for prostate cancer and baseline PSA between 2.5 ng/mL and 10.0 ng/mL (the REDUCE study), 1,517 men were diagnosed with prostate cancer. There was a higher incidence of Gleason 8-10 prostate cancers in the Avodart group (n=29, 0.9%) compared to the placebo group (n=19, 0.6%). The clinical significance of the numerical imbalance is unknown. Men taking Avodart should be regularly evaluated for prostate cancer risk including PSA testing (see Clinical Studies).
5-alpha-reductase inhibitors may increase the risk of development of high-grade prostate cancer. Whether the effect of 5-alpha-reductase inhibitors to reduce prostate volume, or study-related factors, impacted the results of these studies has not been established.

The relationship between Avodart and high grade prostate cancer is not clear.

**Breast cancer in men**

Breast cancer has been reported in men taking dutasteride in clinical trials (see Clinical Studies) and during the post-marketing period. Prescribers should instruct their patients to promptly report any changes in their breast tissue such as lumps or nipple discharge. It is not clear if there is a causal relationship between the occurrence of male breast cancer and long term use of dutasteride.

**4.5. Interaction with Other Medicinal Products and Other Forms of Interaction**

For information on the decrease of serum PSA levels during treatment with dutasteride and guidance concerning prostate cancer detection, please see section 4.4.

*Effects of other drugs on the pharmacokinetics of dutasteride*

*Use together with CYP3A4 and/or P-glycoprotein-inhibitors:*

Dutasteride is mainly eliminated via metabolism. *In vitro* studies indicate that this metabolism is catalysed by CYP3A4 and CYP3A5. No formal interaction studies have been performed with potent CYP3A4 inhibitors. However, in a population pharmacokinetic study, dutasteride serum concentrations were on average 1.6 to 1.8 times greater, respectively, in a small number of patients treated concurrently with verapamil or diltiazem (moderate inhibitors of CYP3A4 and inhibitors of P-glycoprotein) than in other patients.

Long-term combination of dutasteride with drugs that are potent inhibitors of the enzyme CYP3A4 (e.g. ritonavir, indinavir, nefazodone,itraconazol, ketoconazol administered orally) may increase serum concentrations of dutasteride. Further inhibition of 5-alpha-reductase at increased dutasteride exposure, is not likely. However, a reduction of the dutasteride dosing frequency can be considered if side effects are noted. It should be noted that in the case of enzyme inhibition, the long half-life may be further prolonged and it can take more than 6 months of concurrent therapy before a new steady state is reached.

Administration of 12 g cholestyramine one hour before a 5 mg single dose of dutasteride did not affect the pharmacokinetics of dutasteride.

*Effects of dutasteride on the pharmacokinetics of other drugs*
Dutasteride has no effect on the pharmacokinetics of warfarin or digoxin. This indicates that dutasteride does not inhibit/induce CYP2C9 or the transporter P-glycoprotein. In vitro interaction studies indicate that dutasteride does not inhibit the enzymes CYP1A2, CYP2D6, CYP2C9, CYP2C19 or CYP3A4.

In a small study (N=24) of two weeks duration in healthy men, no pharmacokinetic or pharmacodynamic interaction was observed between dutasteride and tamsulosin or terazosin.

There was no evidence of an interaction when dutasteride was co-administered with tamsulosin in a clinical trial of 327 patients for up to 9 months.

### 4.6. Pregnancy and Lactation

Avodart is contraindicated for use by women.

**Fertility**

The effects of dutasteride 0.5 mg/day on semen characteristics were evaluated in normal volunteers aged 18 to 52 (n=27 dutasteride, n=23 placebo) throughout 52 weeks of treatment and 24 weeks of post treatment follow-up. At 52 weeks, the mean percent reduction from baseline in total sperm count, semen volume, and sperm motility were 23%, 26%, and 18%, respectively, in the dutasteride group when adjusted for changes from baseline in the placebo group. Sperm concentration and sperm morphology were unaffected. After 24 weeks of follow-up, the mean percent change in total sperm count in the dutasteride group remained 23% lower than baseline. While mean values for all semen parameters at all time points remained within the normal ranges and did not meet predefined criteria for a clinically significant change (30%), two subjects in the dutasteride group had decreases in sperm count of greater than 90% from baseline at 52 weeks, with partial recovery at the 24-week follow-up. The possibility of reduced male fertility cannot be excluded.

**Pregnancy**

As with other 5-alpha-reductase inhibitors, dutasteride inhibits the conversion of testosterone to dihydrotestosterone and may, if administered to a woman carrying a male foetus, inhibit the development of the external genitalia of the foetus (see 4.4 Special Warnings and Special Precautions for Use). Small amounts of dutasteride have been recovered from the semen in subjects receiving Avodart 0.5 mg day. Based on studies in animals, it is unlikely that a male foetus will be adversely affected if his mother is exposed to the semen of a patient being treated with Avodart (the risk of which is greatest during the first 16 weeks of pregnancy). However, as with all 5-alpha-reductase inhibitors, when the patient's partner is or may potentially be pregnant it is recommended that the patient avoids exposure of his partner to semen by use of a condom.
Lactation

It is not known whether dutasteride is excreted in human milk.

4.7. Effects on Ability to Drive and Use Machines

Based on the pharmacodynamic properties of dutasteride, treatment with dutasteride would not be expected to interfere with the ability to drive or operate machinery.

4.8. UNDESIRABLE EFFECTS

Clinical Trial Data

Avodart Monotherapy

Approximately 19% of the 2167 patients who received dutasteride in the Phase III placebo-controlled trials developed adverse reactions. The majority of events were mild to moderate and occurred in the reproductive system.

The following adverse reactions have been reported with a higher incidence than in the placebo groups during the first year of treatment in controlled clinical trials:

<table>
<thead>
<tr>
<th>Organ system</th>
<th>Adverse reaction</th>
<th>Incidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reproductive system and breast disorders</td>
<td>Impotence*</td>
<td>6.0%</td>
</tr>
<tr>
<td></td>
<td>Altered (decreased) libido*</td>
<td>3.7%</td>
</tr>
<tr>
<td></td>
<td>Ejaculation disorders*</td>
<td>1.8%</td>
</tr>
<tr>
<td></td>
<td>Breast disorders+</td>
<td>1.3%</td>
</tr>
</tbody>
</table>

* These sexual adverse events are associated with dutasteride treatment (including monotherapy and combination with tamsulosin). These adverse events may persist after treatment discontinuation. The role of dutasteride in this persistence is unknown.
+ Includes breast enlargement and/or breast tenderness

The incidence of adverse events is decreasing with time.
The incidence of more rare adverse reactions or adverse reactions that may occur after long term treatment is currently unknown.

No change to the adverse event profile was apparent over a further 2 years in open-label extension studies.

Avodart in combination with the alpha-blocker tamsulosin

The following investigator-judged drug-related adverse events (with a cumulative incidence of greater than or equal to 1%) have been reported in the CombAT
(Combination of Avodart and Tamsulosin) Study, a comparison of Avodart 0.5 mg and tamsulosin 0.4 mg once daily for four years in combination or as monotherapy.

<table>
<thead>
<tr>
<th>Adverse Reaction</th>
<th>Incidence during treatment period</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Year 1</td>
</tr>
<tr>
<td>Combination(^a) (n)</td>
<td>(n=1610)</td>
</tr>
<tr>
<td>Dutasteride</td>
<td>(n=1623)</td>
</tr>
<tr>
<td>Tamsulosin</td>
<td>(n=1611)</td>
</tr>
<tr>
<td>Impotence(^b)</td>
<td></td>
</tr>
<tr>
<td>Combination(^a)</td>
<td>6%</td>
</tr>
<tr>
<td>Dutasteride</td>
<td>5%</td>
</tr>
<tr>
<td>Tamsulosin</td>
<td>3%</td>
</tr>
<tr>
<td>Altered (decreased) libido(^b)</td>
<td></td>
</tr>
<tr>
<td>Combination(^a)</td>
<td>5%</td>
</tr>
<tr>
<td>Dutasteride</td>
<td>4%</td>
</tr>
<tr>
<td>Tamsulosin</td>
<td>2%</td>
</tr>
<tr>
<td>Ejaculation disorders(^b)</td>
<td></td>
</tr>
<tr>
<td>Combination(^a)</td>
<td>9%</td>
</tr>
<tr>
<td>Dutasteride</td>
<td>1%</td>
</tr>
<tr>
<td>Tamsulosin</td>
<td>3%</td>
</tr>
<tr>
<td>Breast disorders(^c)</td>
<td></td>
</tr>
<tr>
<td>Combination(^a)</td>
<td>2%</td>
</tr>
<tr>
<td>Dutasteride</td>
<td>2%</td>
</tr>
<tr>
<td>Tamsulosin</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Dizziness</td>
<td></td>
</tr>
<tr>
<td>Combination(^a)</td>
<td>1%</td>
</tr>
<tr>
<td>Dutasteride</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Tamsulosin</td>
<td>1%</td>
</tr>
</tbody>
</table>

\(^a\) Combination = dutasteride 0.5 mg once daily plus tamsulosin 0.4 mg once daily.

\(^b\) These sexual adverse events are associated with dutasteride treatment (including monotherapy and combination with tamsulosin). These adverse events may persist after treatment discontinuation. The role of dutasteride in this persistence is unknown.

\(^c\) Includes breast tenderness and breast enlargement.

**Post-marketing Data**
Adverse drug reactions are listed below by system organ class and frequency. Frequencies are defined as: very common (≥1/10), common (≥1/100 to <1/10), uncommon (≥1/1000 to <1/100), rare (≥1/10,000 to <1/1000) and very rare (<1/10,000) including isolated reports. Frequency categories determined from post-marketing data refer to reporting rate rather than true frequency.

**Immune system disorders**

Very rare: Allergic reaction, including rash, pruritus, urticaria, localised oedema, and angioedema

**Psychiatric disorders**

Very rare: Depressed mood

**Skin and subcutaneous tissue disorders**

Rare: Alopecia (primarily body hair loss), hypertrichosis

**Reproductive system and breast disorders**

Very rare: Testicular pain and testicular swelling

**4.9. Overdose**

In volunteer studies of Avodart, single daily doses of dutasteride up to 40 mg/day (80 times the therapeutic dose) have been administered for 7 days without significant safety concerns. In clinical studies, doses of 5 mg daily have been administered to subjects for 6 months with no additional adverse effects to those seen at therapeutic doses of 0.5 mg. There is no specific antidote for Avodart, therefore, in suspected overdosage symptomatic and supportive treatment should be given as appropriate.

**5. PHARMACOLOGICAL PROPERTIES**

**5.1. Pharmacodynamic Properties**

Pharmacotherapeutic group: testosterone-5-alpha-reductase inhibitors. ATC code: G04C B02.

Dutasteride reduces circulating levels of dihydrotestosterone (DHT) by inhibiting both type 1 and type 2, 5α-reductase isoenzymes which are responsible for the conversion of testosterone to 5α-DHT.

*Effects on DHT/Testosterone:*
Effect of daily doses of Avodart on the reduction on DHT is dose dependant and is observed within 1-2 weeks (85% and 90% reduction, respectively). In patients with BPH treated with dutasteride 0.5 mg/day, the median decrease in serum DHT was 94% at 1 year and 93% at 2 years and the median increase in serum testosterone was 19% at both 1 and 2 years.

Effect on Prostate Volume:

Significant reductions in prostate volume have been detected as early as one month after initiation of treatment and reductions continued through Month 24 (p<0.001). Avodart led to a mean reduction of total prostate volume of 23.6% (from 54.9 cc at baseline to 42.1 cc) at Month 12 compared with a mean reduction of 0.5% (from 54.0 cc to 53.7 cc) in the placebo group. Significant (p<0.001) reductions also occurred in prostate transitional zone volume as early as one month continuing through Month 24, with a mean reduction in prostate transitional zone volume of 17.8% (from 26.8 cc at baseline to 21.4 cc) in the Avodart group compared to a mean increase of 7.9% (from 26.8 cc to 27.5 cc) in the placebo group at Month 12. Reduction of the size of prostate leads to improvement of symptoms and a decreased risk for AUR and BPH-related surgery.

CLINICAL STUDIES:

Avodart monotherapy

Avodart 0.5 mg/day or placebo was evaluated in 4325 male subjects with moderate to severe symptoms of BPH who had prostates ≥30 cc and a PSA value within the range 1.5 - 10 ng/mL in three primary efficacy 2-year multicenter, multinational, placebo-controlled, double-blind studies. Results from pooled analyses of these study data are presented.

The most important clinical efficacy parameters were American Urological Association Symptom Index (AUA-SI), maximum urinary flow (Q_max) and the incidence of acute urinary retention and BPH-related surgery.

AUA-SI is a seven-item questionnaire about BPH-related symptoms with a maximum score of 35. At baseline the average score was approx. 17. After six months, one and two years treatment the placebo group had an average improvement of 2.5, 2.5 and 2.3 points respectively while the Avodart group improved 3.2, 3.8 and 4.5 points respectively. The differences between the groups were statistically significant.

Q_max (maximum urine flow):

Mean baseline Q_max for the studies was approx 10 mL/sec (normal Q_max ≥15 mL/sec). After one and two years treatment the flow in the placebo group had improved by 0.8 and 0.9 mL/sec respectively and 1.7 and 2.0 mL/sec respectively in the Avodart group. The difference between the groups was statistically significant from Month 1 to Month 24. The increase in Q_max seen during the first 2 years of double-blind treatment was maintained throughout an additional 2 years of open-label extension studies. Also, the
reduction in prostate volume seen during the first 2 years of double-blind treatment was maintained throughout an additional 2 years of open-label extension studies.

**Acute Urinary Retention and Surgical Intervention:**

After two years of treatment, the incidence of AUR was 4.2% in the placebo group against 1.8% in the Avodart group (57% risk reduction). This difference is statistically significant and means that 42 patients (95% CI: 30-73) needs to be treated for two years to avoid one case of AUR.

The incidence of BPH-related surgery after two years was 4.1% in the placebo group and 2.2% in the Avodart group (48% risk reduction). This difference is statistically significant and means that 51 patients (95% CI: 33-109) needs to be treated for two years to avoid one surgical intervention.

**Hair distribution:**

The effect of dutasteride on hair distribution was not formally studied during the phase III programme, however, 5-alpha-reductase inhibitors could reduce hair loss and may induce hair growth in subjects with male pattern hair loss (male androgenetic alopecia).

**Thyroid function:**

Thyroid function was evaluated in a one year study in healthy men. Free thyroxine levels were stable on dutasteride treatment but TSH levels were mildly increased (by 0.4 MCIU/mL) compared to placebo at the end of one year's treatment. However, as TSH levels were variable, median TSH ranges (1.4 - 1.9 MCIU/mL) remained within normal limits (0.5 - 5/6 MCIU/mL), free thyroxine levels were stable within the normal range and similar for both placebo and dutasteride treatment, the changes in TSH were not considered clinically significant. In all the clinical studies, there has been no evidence that dutasteride adversely affects thyroid function.

**Breast neoplasia:**

In BPH monotherapy clinical trials, providing 3374 patient years of exposure to dutasteride, there were 2 cases of breast cancer reported in dutasteride-treated patients, one after 10 weeks and one after 11 months of treatment, and 1 case in a patient who received placebo. In subsequent clinical trials in a 4 year BPH study (CombAT) and in a 4 year comparison of placebo and Avodart (REDUCE study), 8231 men aged 50 to 75, with a prior negative biopsy for prostate cancer and baseline PSA between 2.5 ng/mL and 10.0 ng/mL, providing 17489 patient years exposure to Avodart and 5027 patient years exposure to Avodart and tamsulosin combination there were no additional cases in any of the treatment groups. The relationship between long term use of dutasteride and male breast cancer is unknown.

**Avodart in combination with the alpha-blocker tamsulosin:**
Avodart 0.5 mg/day, tamsulosin 0.4 mg/day or the combination of Avodart 0.5 mg plus tamsulosin 0.4 mg was evaluated in 4844 male subjects with enlarged prostates (greater than or equal to 30 cc) in a multicenter, double blind, parallel group study over 4 years. The primary efficacy endpoint at 2 years of treatment was the level of improvement from baseline in the international prostate symptom score (IPSS).

After 2 years of treatment, combination therapy showed a statistically significant adjusted mean improvement in symptom scores from baseline of -6.2 units. The adjusted mean improvements in symptom scores observed with the individual therapies were -4.9 units for Avodart and -4.3 units for tamsulosin. The adjusted mean improvement in flow rate from baseline was 2.4 mL/sec for the combination, 1.9 mL/sec for Avodart and 0.9 mL/sec for tamsulosin. The adjusted mean improvement in BPH Impact Index (BII) from baseline was -2.1 units for the combination, -1.7 for Avodart and -1.5 for tamsulosin.

The reduction in total prostate volume and transition zone volume after 2 years of treatment was statistically significant for combination therapy compared to tamsulosin monotherapy alone.

The primary efficacy endpoint at 4 years of treatment was time to first event of AUR or BPH-related surgery. After 4 years of treatment, combination therapy statistically significantly reduced the risk of AUR or BPH-related surgery (65.8% reduction in risk p<0.001 [95% CI: 54.7% to 74.1%]) compared to tamsulosin monotherapy. The incidence of AUR or BPH-related surgery by Year 4 was 4.2% for combination therapy and 11.9% for tamsulosin (p<0.001). Compared to Avodart monotherapy, combination therapy reduced the risk of AUR or BPH-related surgery by 19.6%; the difference between treatment groups was not significant (p=0.18 [95% CI: -10.9% to 41.7%]). The incidence of AUR or BPH-related surgery by Year 4 was 4.2% for combination therapy and 5.2% for Avodart.

Clinical progression was defined as a composite of worsening symptoms, (IPSS), and BPH-related events of AUR, incontinence, UTI, and renal insufficiency. Combination therapy was associated with a statistically significantly lower rate of clinical progression compared with tamsulosin (p<0.001, 44.1% risk reduction [95% CI: 33.6% to 53.0%]) after 4 years. The rates of clinical progression for combination therapy, tamsulosin, and Avodart were: 12.6%, 21.5%, and 17.8%, respectively.

The statistically significant adjusted mean improvement in symptom scores (IPSS) from baseline was maintained from year 2 to year 4. At 4 years, the adjusted mean improvements in symptom scores observed were -6.3 units for combination therapy, -5.3 units for Avodart monotherapy and -3.8 units for tamsulosin monotherapy.

After 4 years of treatment, the adjusted mean improvement in flow rate ($Q_{max}$) from baseline was 2.4 mL/sec for combination therapy, 2.0 mL/sec for Avodart monotherapy and 0.7 mL/sec for tamsulosin monotherapy. Compared with tamsulosin, the adjusted
mean improvement from baseline in $Q_{\text{max}}$ was statistically significantly greater with combination therapy at each 6-month assessment from Month 6 to Month 48 (p<0.001). Compared with Avodart, the adjusted mean improvement from baseline in $Q_{\text{max}}$ was not statistically significantly different than with combination therapy (p=0.050 at Month 48).

Combination therapy was significantly superior (p<0.001) to tamsulosin monotherapy and to Avodart monotherapy for the improvement in health outcome parameters BII and BPH-related Health Status (BHS) at 4 years. The adjusted mean improvement in BII from baseline was -2.2 units for the combination, -1.8 for Avodart and -1.2 for tamsulosin. The adjusted mean improvement in BHS from baseline was -1.5 units for the combination, -1.3 for Avodart and -1.1 for tamsulosin.

The reduction in total prostate volume and transition zone volume after 4 years of treatment was statistically significant for combination therapy compared to tamsulosin monotherapy alone.

**Cardiac failure:**

In this 4 year BPH study the incidence of the composite term cardiac failure in the combination group (14/1610, 0.9%) was higher than in either monotherapy group: Avodart, (4/1623, 0.2%) and tamsulosin, (10/1611, 0.6%) (see section 4.4).

In a 4-year comparison of placebo and Avodart in 8231 men aged 50 to 75, with a prior negative biopsy for prostate cancer and baseline PSA between 2.5 ng/mL and 10.0 ng/mL (the REDUCE study) there was a higher incidence of the composite term cardiac failure in subjects taking Avodart (30/4105, 0.7%) versus placebo (16/4126, 0.4%) for a relative risk estimate for time to first cardiac failure event of 1.91 [95% CI: 1.04, 3.50]. In a post-hoc analysis of concomitant alpha blocker use, there was a higher incidence of the composite term cardiac failure in subjects taking Avodart and an alpha blocker concomitantly (12/1152, 1.0%), compared to subjects not taking Avodart and an alpha blocker concomitantly: Avodart and no alpha blocker (18/2953, 0.6%), placebo and an alpha blocker (1/1399, <0.1%), placebo and no alpha blocker (15/2727, 0.6%). No causal relationship between Avodart (alone or in combination with an alpha blocker) and cardiac failure has been established (see section 4.4 Special Warnings and Special Precautions for Use).

**Prostate cancer and high grade tumours**

In a 4-year comparison of placebo and Avodart in 8231 men aged 50 to 75, with a prior negative biopsy for prostate cancer and baseline PSA between 2.5 ng/mL and 10.0 ng/mL (the REDUCE study), 6,706 subjects had prostate needle biopsy data available for analysis to determine Gleason Scores. There were 1517 subjects diagnosed with prostate cancer in the study. The majority of biopsy-detectable prostate cancers in both treatment groups were diagnosed as low grade (Gleason 5-6). There was no difference in the incidence of Gleason 7-10 cancers (p=0.81).
There was a higher incidence of Gleason 8-10 prostate cancers in the Avodart group (n=29, 0.9%) compared to the placebo group (n=19, 0.6%) (p=0.15). In Years 1-2, the number of subjects with Gleason 8-10 cancers was similar in the Avodart group (n=17, 0.5%) and the placebo group (n=18, 0.5%). In Years 3-4, more Gleason 8-10 cancers were diagnosed in the Avodart group (n=12, 0.5%) compared with the placebo group (n=1, <0.1%) (p=0.0035). There are no data available on the effect of Avodart beyond 4 years in men at risk of prostate cancer. The percentage of subjects diagnosed with Gleason 8-10 cancers was consistent across study time periods (Years 1-2 and Years 3-4) in the Avodart group (0.5% in each time period), while in the placebo group, the percentage of subjects diagnosed with Gleason 8-10 cancers was lower during Years 3-4 than in Years 1-2 (<0.1% versus 0.5%, respectively). In a 4 year BPH study (CombAT) where there were no protocol-mandated biopsies and all diagnoses of prostate cancer were based on for-cause biopsies, the rates of Gleason 8-10 cancer were (n=8, 0.5%) for AVODART, (n=11, 0.7%) for tamsulosin and (n=5, 0.3%) for combination therapy (see section 4.4 Special Warnings and Special Precautions for Use).

**Effects on prostate specific antigen (PSA) and prostate cancer detection**

In a 4-year comparison of placebo and dutasteride in 8231 men aged 50 to 75, with a prior negative biopsy for prostate cancer and baseline PSA between 2.5 ng/mL and 10.0 ng/mL (the REDUCE study), Avodart treatment caused a decrease in mean serum PSA by approximately 50% after six months of treatment with a large variability (standard deviation of 30%) among patients. The PSA suppression observed at six months was similar in men who did or who did not develop biopsy-detectable prostate cancer during the study (see section 4.4 Special Warnings and Special Precautions for Use).

**5.2. Pharmacokinetic Properties**

*Absorption*

Following oral administration of a single 0.5 mg dutasteride dose, the time to peak serum concentrations of dutasteride is 1 to 3 hours. The absolute bioavailability is approximately 60%. The bioavailability of dutasteride is not affected by food.

*Distribution*

Dutasteride has a large volume of distribution (300 to 500 L) and is highly bound to plasma proteins (>99.5%). Following daily dosing, dutasteride serum concentrations achieve 65% of steady state concentration after 1 month and approximately 90% after 3 months.

Steady state serum concentrations (C_{ss}) of approximately 40 ng/mL are achieved after 6 months of dosing 0.5 mg once a day. Dutasteride partitioning from serum into semen averaged 11.5%.
**Elimination**

Dutasteride is extensively metabolised in vivo. *In vitro*, dutasteride is metabolised by the cytochrome P450 3A4 and 3A5 to three monohydroxylated metabolites and one dihydroxylated metabolite.

Following oral dosing of dutasteride 0.5 mg/day to steady state, 1.0% to 15.4% (mean of 5.4%) of the administered dose is excreted as unchanged dutasteride in the faeces. The remainder is excreted in the faeces as 4 major metabolites comprising 39%, 21%, 7%, and 7% each of drug-related material and 6 minor metabolites (less than 5% each).

Only trace amounts of unchanged dutasteride (less than 0.1% of the dose) are detected in human urine.

The elimination of dutasteride is dose dependent and the process appears to be described by two elimination pathways in parallel, one that is saturable at clinically relevant concentrations and one that is non-saturable.

At low serum concentrations (less than 3 ng/mL), dutasteride is cleared rapidly by both the concentration dependent and concentration independent elimination pathways. Single doses of 5 mg or less showed evidence of rapid clearance and a short half-life of 3 to 9 days.

At therapeutic concentrations, following repeat dosing of 0.5 mg/day, the slower, linear elimination pathway is dominating and the half-life is approx. 3-5 weeks.

**Elderly**

Dutasteride pharmacokinetics were evaluated in 36 healthy male subjects between the ages of 24 and 87 years following administration of a single 5 mg dose of dutasteride. No significant influence of age was seen on the exposure of dutasteride but the half-life was shorter in men under 50 years of age. Half-life was not statistically different when comparing the 50-69 year old group to the greater than 70 years old.

**Renal impairment**

The effect of renal impairment on dutasteride pharmacokinetics has not been studied. However, less than 0.1% of a steady-state 0.5 mg dose of dutasteride is recovered in human urine, so no clinically significant increase of the dutasteride plasma concentrations is anticipated for patients with renal impairment (see 4.2 Posology and Method of Administration).

**Hepatic impairment**

The effect on the pharmacokinetics of dutasteride in hepatic impairment has not been studied (see section 4.3 Contraindications). Because dutasteride is eliminated mainly
through metabolism the plasma levels of dutasteride are expected to be elevated in these patients and the half-life of dutasteride be prolonged (see 4.2 Posology and Method of Administration and 4.4 Special Warnings and Special Precautions for Use).

5.3. Preclinical Safety Data

Current studies of general toxicity, genotoxicity and carcinogenicity did not show any particular risk to humans.

Reproduction toxicity studies in male rats have shown a decreased weight of the prostate and seminal vesicles, decreased secretion from accessory genital glands and a reduction in fertility indices (caused by the pharmacological effect of dutasteride). The clinical relevance of these findings is unknown.

As with other 5-alpha-reductase inhibitors, feminisation of male foetuses in rats and rabbits has been noted when dutasteride was administered during gestation. Dutasteride has been found in blood from female rats after mating with dutasteride treated males. When dutasteride was administered during gestation to primates, no feminisation of male foetuses was seen at blood exposures sufficiently in excess of those likely to occur via human semen. It is unlikely that a male foetus will be adversely affected following seminal transfer of dutasteride.

6. PHARMACEUTICAL PARTICULARS

6.1. List of Excipients

Capsule contents: mono- and diglycerides of caprylic/capric acid, butylhydroxytoluene (E321).

Capsule shell: gelatine; glycerol; titanium dioxide (E171); iron oxide yellow (E172); triglycerides, medium chain; lecithin.

6.2. Incompatibilities

Not applicable.

6.3. Shelf Life

4 years.

6.4. Special Precautions for Storage

Do not store above 30°C.
6.5. Nature and Contents of Container

PVC/PVDC blister containing 10 soft gelatin capsules packed into containers of 30 and 90 capsules.

6.6. Instructions for Use/Handling (and disposal)

Dutasteride is absorbed through the skin, therefore women and children must avoid contact with leaking capsules. If contact is made with leaking capsules, the contact area should be washed immediately with soap and water (see 4.4 Special Warnings and Special Precautions for Use).

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