

New Zealand Datasheet

1 PRODUCT NAME

ONREX Tablets

2 QUALITATIVE AND QUANTITATIVE COMPOSITION

Ondansetron hydrochloride dihydrate tablets 4mg and 8mg.

3 PHARMACEUTICAL FORM

ONREX tablets 4 mg: White, circular, biconvex, film coated tablet debossed with '4' on one face and plain on the other. Each tablet contains ondansetron 4 mg (as hydrochloride dihydrate).

ONREX tablets 8 mg: White, circular, biconvex, film coated tablet debossed with '8' on one face and with a central breakline on the other. Each tablet contains ondansetron 8mg (as hydrochloride dihydrate).

4 CLINICAL PARTICULARS

4.1 Therapeutic indications

ONREX tablets are indicated for the management of nausea and vomiting induced by cytotoxic chemotherapy and radiotherapy. Onrex tablets are also indicated for the prevention of post-operative nausea and vomiting.

4.2 Dose and method of administration

Chemotherapy and Radiotherapy Induced Nausea and Vomiting

Adults

The emetogenic potential of cancer treatment varies according to the doses and combinations of chemotherapy and radiotherapy regimens used.

Emetogenic Chemotherapy and Radiotherapy:

The recommended oral dose is 8mg 1 to 2 hours before treatment, followed by 8mg orally 12 hours later.

To protect against delayed or prolonged emesis after the first 24 hours, oral treatment with ONREX tablets should be continued for up to 5 days after a course of treatment. The recommended oral dose is 8mg to be taken twice daily.

Highly Emetogenic Chemotherapy:

To protect against delayed or prolonged emesis after the first 24 hours, oral treatment with ONREX tablets should be continued for up to 5 days after a course of treatment. The recommended oral dose is 8mg to be taken twice daily.

Children and Adolescents (aged 6 months to 17 years)

In children with a body surface area of 0.6 to 1.2 m² ondansetron is administered as a single intravenous dose of 5 mg/m² immediately before chemotherapy, followed by 4 mg orally twelve hours later. 4 mg orally twice daily can be continued for up to 5 days after a course of treatment.

For children with a body surface area of greater than 1.2 m² an initial i.v. dose of 8 mg is administered immediately before chemotherapy, followed by 8 mg orally 12 hours later. 8mg orally twice daily can be continued for up to five days after a course of treatment.

Alternatively, in children aged 6 months or older, ondansetron is administered as a single i.v. dose of 0.15 mg/kg (not to exceed 8mg) immediately before chemotherapy. This dose may be repeated every four hours for a total of three doses. 4 mg orally twice daily can be continued for up to five days after a course of treatment. Adult doses must not be exceeded.

Elderly

ONREX tablets are well tolerated by patients over 65 years and no alteration of dosage, dosing frequency or route of administration are required.

Post-Operative Nausea and Vomiting

Adults

For prevention of post-operative nausea and vomiting, the recommended oral dose is 16mg given one hour prior to anaesthesia.

For treatment of established post-operative nausea and vomiting ondansetron administration by injection is recommended.

Children and Adolescents (aged 1 month to 17 years)

No studies have been conducted on the use of orally administered ondansetron in the prevention or treatment of post-operative nausea and vomiting, ondansetron may be administered by slow intravenous injection.

Elderly

There is limited experience in the use of ONREX tablets in the prevention and treatment of post-operative nausea and vomiting in the elderly, however ONREX tablets are well tolerated in patients over 65 years receiving chemotherapy.

Patients with renal impairment

No alteration of daily dosage or frequency of dosing, or route of administration are required.

Patients with hepatic impairment

Clearance of ondansetron is significantly reduced and serum half-life significantly prolonged in subjects with moderate or severe impairment of hepatic function. In such patients a total daily dose of 8mg should not be exceeded.

Patients with poor sparteine/debrisoquine metabolism

The elimination half-life of ondansetron is not altered in subjects classified as poor metabolisers of sparteine and debrisoquine. Consequently, in such patients repeat dosing will give drug exposure levels no different from those of the general population. No alteration of daily dosage or frequency of dosing are required.

4.3 Contraindications

Hypersensitivity to any component of the preparation.

4.4 Special warnings and precautions for use

Hypersensitivity reactions have been reported in patients who have exhibited hypersensitivity to other selective 5HT₃ receptor antagonists.

Ondansetron prolongs the QT interval in a dose-dependent manner (see section 5.1 Pharmacodynamic properties). In addition, post-marketing cases of Torsade de Pointes have been reported in patients using ondansetron. Avoid ondansetron in patients with congenital long QT syndrome. Ondansetron should be administered with caution to patients who have or may develop prolongation of QTc. These conditions include patients with electrolyte abnormalities, or patients taking other medicinal products that lead to QT prolongation.

Hypokalaemia and hypomagnesaemia should be corrected prior to ondansetron administration.

Cases of myocardial ischemia have been reported in patients treated with ondansetron. In some patients, especially in the case of intravenous administration, symptoms appeared immediately after administration of ondansetron. Patients should be alerted to the signs and symptoms of myocardial ischemia.

As ondansetron is known to increase large bowel transit time, patients with signs of subacute intestinal obstruction should be monitored following administration.

4.5 Interaction with other medicines and other forms of interaction

Caution should be exercised when ondansetron is coadministered with drugs that prolong the QT interval and/or cause electrolyte abnormalities (see Section 4.4 SPECIAL WARNINGS AND PRECAUTIONS FOR USE).

There is no evidence that ondansetron either induces or inhibits the metabolism of other drugs commonly co-administered with it. Specific studies have shown that there are no pharmacokinetic interactions when ondansetron is administered with alcohol, temazepam, frusemide, tramadol or propofol.

Ondansetron is metabolised by multiple hepatic cytochrome P-450 enzymes: CYP3A4, CYP2D6 and CYP1A2. Due to the multiplicity of metabolic enzymes capable of metabolising ondansetron, enzyme inhibition or reduced activity of one enzyme (e.g. CYP2D6 genetic deficiency) is normally compensated by other enzymes and should result in little or no significant change in overall ondansetron clearance or dose requirement.

Phenytoin, Carbamazepine and Rifampicin

In patients treated with potent inducers of CYP3A4 (i.e. phenytoin, carbamazepine, and rifampicin), the oral clearance of ondansetron was increased and ondansetron blood concentrations were decreased.

Tramadol

Data from small studies indicate that ondansetron may reduce the analgesic effect of tramadol.

4.6 Fertility, pregnancy and lactation

Pregnancy

The safety of ondansetron for use in human pregnancy has not been established. Evaluation of experimental animal studies does not indicate direct or indirect harmful effects with respect to the development of the embryo, or foetus, the course of gestation and peri- and post-natal development. However, as animal studies are not always predictive of human response the use of ondansetron in pregnancy is not recommended.

Breast feeding

Tests have shown that ondansetron passes into the milk of lactating animals. It is therefore recommended that mothers receiving ondansetron should not breast-feed their babies.

4.7 Effects on ability to drive and use machines

In psychomotor testing ondansetron does not impair performance nor cause sedation.

4.8 Undesirable effects

Adverse events are listed below by system organ class and frequency. Frequencies are defined as: very common ($\geq 1/10$), common ($\geq 1/100$ and $< 1/10$), uncommon ($\geq 1/1000$ and $< 1/100$), rare ($\geq 1/10,000$ and $< 1/1000$) and very rare ($< 1/10,000$) including isolated reports. Very common, common and uncommon events were generally determined from clinical trial data. The incidence in placebo was taken into account. Rare and very rare events were generally determined from post-marketing spontaneous data.

The following frequencies are estimated at the standard recommended doses of ondansetron according to indication and formulation.

Immune system disorders

Rare: Immediate hypersensitivity reactions sometimes severe, including anaphylaxis.

Nervous system disorders

Very common: Headache.

Uncommon: Seizures, movement disorders (including extrapyramidal reactions such as oculogyric crisis, dystonic reactions and dyskinesia have been observed without definitive evidence of persistent clinical sequelae).

Rare: Dizziness during rapid i.v. administration.

Eye disorders

Rare: Transient visual disturbances (eg. blurred vision) predominantly during i.v. administration.

Very rare: transient blindness predominantly during intravenous administration.

The majority of the blindness cases reported resolved within 20 minutes. Most patients had received chemotherapeutic agents, which included cisplatin. Some cases of transient blindness were reported as cortical in origin.

Cardiac disorders

Uncommon: Arrhythmias, chest pain, with or without ST segment depression, bradycardia.

Rare: QTc prolongation (including Torsade de Pointes)

Not known: Myocardial ischaemia

Vascular disorders

Common: Sensation of warmth or flushing.

Uncommon: Hypotension.

Respiratory, thoracic and mediastinal disorders

Uncommon: Hiccups.

Gastrointestinal disorders

Common: Constipation.

Hepatobiliary disorders

Uncommon: Asymptomatic increases in liver function tests#.

#These events were observed commonly in patients receiving chemotherapy with cisplatin.

General disorders and administration site conditions

Common: Local i.v. injection site reactions.

Reporting of suspected adverse reactions

Reporting suspected adverse reactions after authorisation of the medicine is important. It allows continued monitoring of the benefit/risk balance of the medicine. Healthcare professionals are asked to report any suspected adverse reactions <https://pophealth.my.site.com/carmreportnz/s/>.

4.9 Overdose

Ondansetron prolongs QT interval in a dose-dependent fashion. ECG monitoring is recommended in cases of overdose.

There is limited experience of ondansetron overdose. In the majority of cases symptoms were similar to those already reported in patients receiving recommended doses. (See Adverse Effects). There is no specific antidote for ondansetron, therefore in cases of suspected overdose, symptomatic and supportive therapy should be given as appropriate.

The use of ipecacuanha to treat overdose with ondansetron is not recommended as patients are unlikely to respond due to the anti-emetic action of ondansetron itself.

For advice on the management of overdose please contact the National Poisons Centre on 0800 POISON (0800 764766).

5 PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: Anti-emetics and anti-nauseants, Serotonin (5-HT₃) antagonists.
ATC Code: A04AA01

Ondansetron is a potent, highly selective 5HT₃ receptor-antagonist. Its precise mode of action in the control of nausea and vomiting is not known. Chemotherapeutic agents and radiotherapy may cause release of 5HT in the small intestine initiating a vomiting reflex by activating vagal afferents via 5HT₃ receptors. Ondansetron blocks the initiation of this reflex.

Activation of vagal afferents may also cause a release of 5HT in the area postrema, located on the floor of the fourth ventricle, and this may also promote emesis through a central mechanism. Thus, the effect of ondansetron in the management of the nausea and vomiting induced by cytotoxic chemotherapy and radiotherapy is probably due to antagonism of 5HT₃ receptors on neurons located both in the peripheral and central nervous system. The mechanisms of action in post-operative nausea and vomiting are not known but there may be common pathways with cytotoxic induced nausea and vomiting.

Ondansetron does not alter plasma prolactin concentrations.

The effect of ondansetron on the QTc interval was evaluated in a double blind, randomised, placebo and positive (moxifloxacin) controlled, crossover study in 58 healthy adult men and women.

Ondansetron doses included 8 mg and 32 mg infused intravenously over 15 minutes. At the highest tested dose of 32 mg, the maximum mean (upper limit of 90% CI) difference in QTcF from placebo after baseline-correction was 19.6 (21.5) msec. At the lower tested dose of 8 mg, the maximum mean (upper limit of 90% CI) difference in QTcF from placebo after baseline-correction was 5.8 (7.8) msec.

In this study, there were no QTcF measurements greater than 480 msec and no QTcF prolongation was greater than 60 msec. No significant changes were seen in the measured electrocardiographic PR or QRS intervals

5.2 Pharmacokinetic properties

Following oral administration, ondansetron is passively and completely absorbed from the gastrointestinal tract and undergoes first pass metabolism. Peak plasma concentrations are attained approximately 1.5 hours after dosing. For doses above 8mg, the increase in ondansetron systemic exposure with dose is greater than proportional; this may reflect some reduction in first pass metabolism at higher oral doses.

Bioavailability is slightly enhanced by the presence of food but unaffected by antacids. The disposition of ondansetron following oral, intramuscular or intravenous dosing is similar with a terminal elimination half life of about 3 hours and steady state volume of distribution of about 140L. Ondansetron is not highly protein bound (70-76%). Ondansetron is cleared from the systemic circulation predominantly by hepatic metabolism through multiple enzymatic pathways. Less than 5% of the absorbed dose is excreted unchanged in the urine. The absence of the enzyme CYP2D6 (the debrisoquine polymorphism) has no effect on ondansetron's pharmacokinetics. The pharmacokinetic properties of ondansetron are unchanged on repeat dosing. Studies in healthy elderly volunteers have shown slight, but clinically insignificant, age-related increases in both oral bioavailability and half-life of ondansetron.

Gender differences were shown in the disposition of ondansetron, with females having a greater rate and extent of absorption following an oral dose and reduced systemic clearance and volume of distribution (adjusted for weight).

In a clinical study, 51 paediatric patients aged 1 to 24 months received either 0.1 or 0.2 mg/kg ondansetron prior to undergoing surgery. Patients aged 1 to 4 months had a clearance when normalised to body weight that was approximately 30% slower than in patients aged 5 to 24 months but comparable to the patients aged 3 to 12 years. The half-life in the 1 to 4 month patient population was reported to average 6.7 hours compared to 2.9 hours for patients in the 5 to 24 month and 3 to 12 year age range. No dose adjustment is necessary for patients aged 1 to 4 months as only a single i.v. dose of ondansetron is recommended for the treatment of postoperative nausea and vomiting. The differences in pharmacokinetic parameters can be explained in part by the higher volume of distribution in the 1 to 4 month patient population.

In a study of 21 paediatric patients aged between 3 and 12 years undergoing elective surgery with general anaesthesia, the absolute values for both the clearance and volume of distribution of ondansetron following a single intravenous dose of 2 mg (3-7 years old or 4 mg (8-12 years old) were reduced. The magnitude of the change was age-related, with clearance falling from about 300 mL/min at 12 years of age to 100 mL/min at 3 years. Volume of distribution fell from about 75 L at 12 years to 17 L at 3 years. Use of weight-based dosing (0.1 mg/kg up to 4 mg maximum) compensates for these changes and is effective in normalising systemic exposure in paediatric patients.

Population pharmacokinetic analysis was performed on 74 patients aged 6 to 48 months following administration of 0.15 mg/kg i.v. ondansetron every 4 hours for three doses for the treatment of chemotherapy induced nausea and vomiting and 41 surgery patients aged 1 to 24 months following administration of a single 0.1 mg/kg or 0.2 mg/kg i.v. dose of ondansetron. Based on the population pharmacokinetic parameters for subjects aged 1 month to 48 months, administration of a 0.15 mg/kg i.v. dose of ondansetron every 4 hours for 3 doses would result in a systemic exposure (AUC) comparable to that observed in paediatric surgery subjects aged 5 to 24 months and previous paediatric studies in cancer (aged 4 to 18 years) and surgical (aged 3 to 12 years) subjects, at similar doses.

In patients with moderate renal impairment (creatinine clearance 15-60 mL/min), both systemic clearance and volume of distribution are reduced, resulting in a slight, but clinically insignificant, increase in elimination half-life (5.4 h). A study in patients with severe renal impairment who required regular haemodialysis (studied between dialyses) showed ondansetron's pharmacokinetics to be essentially unchanged. In patients with severe hepatic impairment, ondansetron's systemic clearance is markedly reduced with prolonged elimination half-lives (15-32 h) and an oral bioavailability approaching 100% due to reduced pre-systemic metabolism.

5.3 Preclinical safety data

Preclinical data revealed no special hazard for humans based on conventional studies of repeated dose toxicity, genotoxicity and carcinogenic potential.

Ondansetron and its metabolites accumulate in the milk of rats, milk/plasma-ratio was 5.2:1.

A study in cloned human cardiac ion channels has shown ondansetron has the potential to affect cardiac repolarisation via blockade of HERG potassium channels.

6 PHARMACEUTICAL PARTICULARS

6.1 List of excipients

- Lactose
- Microcrystalline cellulose
- Maize Starch
- Magnesium stearate
- Opadry Y – 1- 7000 white (Contains hydroxy propyl cellulose 2910, Titanium Dioxide E171, Macrogol/ PEG400)

Does not contain gluten

6.2 Incompatibilities

Not applicable.

6.3 Shelf life

Shelf life is 36 months (3 years) from manufacture.

6.4 Special precautions for storage

Store below 25°C.

6.5 Nature and contents of container

ONREX tablets 4mg: 10 tablets or 50 tablets in foil blisters.

ONREX tablets 8mg: 10 tablets or 50 tablets in foil blisters.

6.6 Special precautions for disposal and other handling

Not applicable.

7 MEDICINE SCHEDULE

Prescription Medicine

8 SPONSOR

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9 DATE OF FIRST APPROVAL

18 October 2007

10 DATE OF REVISION OF THE TEXT

30 May 2024

SUMMARY TABLE OF CHANGES

Section changed	Summary of new information
4.4	Addition of QT prolongation and Myocardial ischaemia warnings
4.5	Inclusion of QT prolongation information
4.8	Reporting of suspected adverse reactions: Updated reporting URL
4.9	Inclusion of QT prolongation information
5.1	Inclusion of QT prolongation study information
8	Addition of sponsor email address