1. NASONEX® AQUEOUS NASAL SPRAY

50 micrograms/actuation nasal spray solution

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

Mometasone furoate (as the monohydrate) 50 micrograms/actuation.

Excipient(s) with known effect
This medicinal product contains 0.02 mg of benzalkonium chloride per actuation.

For the full list of excipients, see section 6.1.

3. PHARMACEUTICAL FORM

Nasal spray solution.
White to off-white opaque suspension.

4. CLINICAL PARTICULARS

4.1 Therapeutic indications

NASONEX Aqueous Nasal Spray is indicated for the treatment of symptoms associated with seasonal allergic rhinitis and perennial allergic rhinitis and the prophylaxis of seasonal allergic rhinitis in adults, adolescents and children between the ages of 3 and 11 years.

NASONEX Aqueous Nasal Spray is also indicated for use in adults and adolescents 12 years of age and older as adjunctive treatment to antibiotics for acute episodes of sinusitis.

4.2 Dose and method of administration

Dose

DO NOT EXCEED THE RECOMMENDED DOSAGE.

Seasonal Allergic Rhinitis or Perennial Allergic Rhinitis
The effect of NASONEX Aqueous Nasal Spray is not immediate. Full therapeutic benefit takes a few days to develop. Dosage should be administered as directed and not be taken by the patients at will for symptomatic relief.

In patients who have a history of moderate to severe symptoms of seasonal allergic rhinitis, prophylactic treatment with NASONEX Aqueous Nasal Spray is recommended two to four weeks prior to the anticipated start of the pollen season.

Clinically significant onset of action occurs as early as 12 hours after the first dose.

Adults (including geriatric patients) and children 12 years of age and over
The usual recommended dose for prophylaxis and treatment is two sprays (50 micrograms/spray) in each nostril once daily (total daily dose of 200 micrograms). Once symptoms are controlled, reducing the dose to one spray in each nostril (total daily dose of 100 micrograms) may be effective for maintenance.

If symptoms are inadequately controlled, the dose may be increased to four sprays in each nostril (total daily dose of 400 micrograms). Dose reduction is recommended following the control of symptoms.

Paediatric Population

Children between the ages of 3 and 11 years
The usual recommended dose is one spray (50 micrograms/spray) in each nostril once daily (total daily dose 100 micrograms).

Adjunctive Treatment of Acute Episodes of Sinusitis
Adults (including geriatric patients) and children 12 years of age and over: The usual recommended dose is two sprays (50 micrograms/spray) in each nostril twice daily (total daily dose 400 micrograms).

If symptoms are inadequately controlled, the dose may be increased to four sprays (50 micrograms /spray) in each nostril twice daily (total daily dose 800 micrograms).

Method of Administration
Shake container well before each use. **Do not** pierce the nasal applicator. After the initial priming of the NASONEX Aqueous Nasal Spray pump (10 actuations, until a uniform spray is observed), each actuation delivers approximately 100 mg of mometasone furoate suspension, containing mometasone furoate monohydrate equivalent to 50 micrograms of mometasone furoate. If the spray pump has not been used for 14 days or longer, it should be reprimed with 2 actuations, until a uniform spray is observed, before the next use.

4.3 Contraindications
- Patients with known hypersensitivity to mometasone furoate or any of the excipients
- Severe nasal infection, especially candidiasis
- Persons with haemorrhagic diathesis or with a history of recurrent nasal bleeding

4.4 Special warnings and precautions for use
NASONEX Aqueous Nasal Spray should not be used in the presence of untreated localised infection involving the nasal mucosa.

Because of the inhibitory effect of corticosteroids on wound healing, patients who have experienced recent nasal surgery or trauma should not use a nasal corticosteroid until healing has occurred.

Following 12 months of treatment with NASONEX Aqueous Nasal Spray, there was no evidence of atrophy of the nasal mucosa. Mometasone furoate tended to reverse the nasal mucosa closer to a normal histological phenotype. As with any long-term treatment, patients using NASONEX Aqueous Nasal Spray over several months or longer should be examined periodically for possible changes in the nasal mucosa, including the development of nasal ulcerations. If localised fungal infection of the nose or pharynx develops, discontinuance of NASONEX Aqueous Nasal Spray therapy or appropriate treatment may be required. Persistence of nasopharyngeal irritation may be an indication for discontinuing NASONEX Aqueous Nasal Spray.

NASONEX Aqueous Nasal Spray should be used with caution, if at all, in patients with active or quiescent tuberculous infections of the respiratory tract, or in untreated fungal, bacterial, systemic viral infections or ocular herpes simplex.

Topical corticosteroids may be absorbed in amounts that can have systemic effects. Use of excessive doses may suppress hypothalamic-pituitary-adrenal (HPA) axis function. Physicians should be alert for evidence of systemic effects, especially in chronically treated patients.

There is no evidence of HPA-axis suppression following prolonged treatment with NASONEX Aqueous Nasal Spray. However, patients who are transferred from long-term administration of systemically active corticosteroids to NASONEX Aqueous Nasal Spray require careful attention. Systemic corticosteroid withdrawal in such patients may result in adrenal insufficiency for a number of months until recovery of HPA axis function. If these patients exhibit signs and symptoms of adrenal insufficiency, systemic

corticosteroid administration should be resumed and other modes of therapy and appropriate measures instituted.

During transfer from systemic corticosteroids to NASONEX Aqueous Nasal Spray, some patients may experience symptoms of withdrawal from systemically active corticosteroids (e.g. joint and/or muscular pain, lassitude and depression initially) despite relief from nasal symptoms and will require encouragement to continue NASONEX Aqueous Nasal Spray therapy. Such transfer may also unmask pre-existing allergic conditions such as allergic conjunctivitis and eczema, previously suppressed by systemic corticosteroid therapy.

Patients receiving corticosteroids who are potentially immunosuppressed should be warned of the risk of exposure to certain infections (e.g. chickenpox, measles) and of the importance of obtaining medical advice if such exposure occurs.

Following the use of intranasal aerosolised corticosteroids, instances of nasal septum perforation or increased intraocular pressure have been reported very rarely.

Visual disturbance may be reported with systemic and topical (including, intranasal, inhaled and intraocular) corticosteroid use. If a patient presents with symptoms such as blurred vision or other visual disturbances, the patient should be considered for referral to an ophthalmologist for evaluation of possible causes of visual disturbances which may include cataract, glaucoma or rare diseases such as central serous chorioretinopathy (CSCR) which have been reported after use of systemic and topical corticosteroids

Paediatric Population
Controlled clinical trials have shown that intranasal corticosteroids may cause a reduction in growth velocity in children. This effect has been observed in the absence of laboratory evidence of HPA axis suppression, suggesting that growth velocity is a more sensitive indicator of systemic corticosteroid exposure in children than some commonly used tests of HPA-axis function. The long-term effects of this reduction in growth velocity associated with intranasal corticosteroids, including the impact on final adult height, are unknown. The potential for "catch up" growth following discontinuation of treatment with intranasal corticosteroids has not been adequately studied.

The growth of children receiving intranasal corticosteroids should be monitored routinely (e.g. via stadiometry). The potential growth effects of prolonged treatment should be weighed against the clinical benefits and the availability of safe and effective non-corticosteroid alternatives. To minimise the systemic effects of intranasal corticosteroids, each patient should be titrated to his/her lowest effective dose.

However, in a placebo-controlled clinical trial in which paediatric patients were administrated NASONEX 100 micrograms daily for one year, no reduction in growth velocity was observed.

4.5 Interaction with other medicines and other forms of interaction
NASONEX Aqueous Nasal Spray has been administered concomitantly with loratadine with no apparent effect on plasma concentrations of loratadine or its major metabolite. Mometasone furoate plasma concentrations were not detectable. The combination therapy was well tolerated.

Mometasone furoate is metabolised by CYP3A4.

Coadministration with strong CYP3A4 inhibitors (e.g. ketoconazole, itraconazole, clarithromycin, ritonavir, cobicistat-containing products) may lead to increased plasma concentrations of corticosteroids and potentially increase the risk for systemic corticosteroid side-effects. Consider the benefit of coadministration versus the potential risk of systemic corticosteroid effects, in which case patients should be monitored for systemic corticosteroid side-effects.

4.6 Fertility, pregnancy and lactation

Pregnancy (Category B3)

There are no adequate or well controlled studies in pregnant women. Low levels of systemic mometasone have been measured following nasal administration of NASONEX Aqueous Nasal Spray.

As with other nasal corticosteroid preparations, NASONEX Aqueous Nasal Spray should be used in pregnant women or nursing mothers only if the potential benefit justifies the potential risk to the mother, foetus, or infant. Infants born of mothers who received corticosteroids during pregnancy should be observed carefully for hypoadrenalism.

Breast-feeding

See section 4.6 Pregnancy.

Fertility

In studies of reproductive function, subcutaneous mometasone furoate was well tolerated at doses up to 7.5 mg/kg. At 15 mg/kg, mometasone furoate caused prolonged gestation and prolonged and difficult labor occurred with a reduction in offspring survival and body weight or body weight gain. There was no effect on fertility.

4.7 Effects on ability to drive and use machines

No studies on the ability to drive and use machines have been performed.

4.8 Undesirable effects

Seasonal Allergic Rhinitis or Perennial Allergic Rhinitis

Treatment-related local adverse events reported in clinical studies include headache (8%), epistaxis i.e. frank bleeding, blood-tinged mucus, and blood flecks (8%), pharyngitis (4%), nasal burning (2%), nasal irritation (2%) and nasal ulceration (1%), which are typically observed with the use of a corticosteroid nasal spray. Epistaxis was generally self-limiting and mild in severity, and occurred at a higher incidence compared to placebo (5%), but at a comparable or lower incidence compared to other active control nasal corticoids used in clinical studies (up to 15%). The incidence of all other effects was comparable with that of placebo.

In the paediatric population, the most common adverse effects were epistaxis (6%), headache (3%), nasal irritation (2%) and sneezing (2%).

Rarely, immediate hypersensitivity reactions (e.g. bronchospasm, dyspnoea) may occur after intranasal administration of mometasone furoate monohydrate. Very rarely, anaphylaxis and angioedema have been reported.

Disturbances of taste and smell have been reported very rarely.

Growth suppression has been reported in association with administration of intranasal corticosteroids (see Section 4.4 Special warnings and precautions for use, Paediatric population).

Adjunctive Treatment of Acute Episodes of Sinusitis

In adults and adolescent patients receiving NASONEX Aqueous Nasal Spray treatment-related adverse events which occurred at an incidence comparable to placebo, included headache (2%), pharyngitis (1%), nasal burning (1%) and nasal irritation (1%). Epistaxis was mild in severity (5%).

Vision blurred has been reported.

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://nzphvc.otago.ac.nz/reporting/.

4.9 Overdose

Because the systemic bioavailability of NASONEX Aqueous Nasal Spray is low and has been estimated as <1%, overdose is unlikely to require any therapy other than observation. Treatment can be reinitiated at the usual recommended dose.

Inhalation or oral administration of excessive doses of corticosteroids may lead to suppression of HPA axis function.

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: Decongestants and Other Nasal Preparations for Topical Use-Corticosteroids
ATC code: R01AD90

Mometasone furoate is a topical glucocorticosteroid with local anti-inflammatory properties at doses that are not systemically active.

5.2 Pharmacokinetic properties

Systemic bioavailability of mometasone furoate was investigated in 24 healthy volunteers following intranasal administration of 400 micrograms of the suspension. Mometasone was detectable in plasma (at sporadic time points) in only 4 of the 24 subjects, despite the use of a sensitive assay with a limit of quantitation of 50 picograms/mL. Thus, there were no relevant pharmacokinetic data for this dosage form.

Systemic absorption of mometasone furoate suspension administered as aqueous nasal spray, 200 micrograms single dose, was measured using a sensitive assay with a lower quantitation limit of 0.25 picograms/mL. Mean C max was 5.77 picograms/mL (CV% 32) and mean AUC (0-12hr) 29.6 picograms.hr/mL (CV% 37). When compared with dose adjusted PK data for IV mometasone administration from earlier studies with a quantitation limit of 50 picograms/mL and longer sampling duration, the estimated relative systemic (or 'absolute') bioavailability is <1%. The bioavailability of mometasone following intranasal administration is low.

Systemic effects were not detected in adults, adolescents, or children following the administration of mometasone furoate aqueous nasal spray.

Mometasone furoate suspension is very poorly absorbed from the gastrointestinal tract, and the small amount that may be swallowed and absorbed undergoes extensive first-pass metabolism prior to excretion in urine and bile.

In studies utilising nasal antigen challenge, NASONEX Aqueous Nasal Spray has shown anti-inflammatory activity in both the early- and late-phase allergic responses. This has been demonstrated by decreases (vs. placebo) in histamine and eosinophil activity and reductions (vs. baseline) in eosinophils, neutrophils, and epithelial cell adhesion proteins.

5.3 Preclinical safety data

No toxicologic effects unique to mometasone furoate exposure were demonstrated during the course of preclinical testing. All observed effects are typical of this class of compounds and are related to exaggerated pharmacologic effects of glucocorticoids.

6. PHARMACEUTICAL PARTICULARS

6.1 List of excipients

NASONEX Aqueous Nasal Spray contains dispersible cellulose BP 65 cps, glycerol, citric acid, sodium citric dihydrate, polysorbate 80, and purified water with benzalkonium chloride 0.2 mg/g as preservative. NASONEX Aqueous Nasal Spray does not contain fluorocarbon propellants.

6.2 Incompatibilities

Not applicable.

6.3 Shelf life

36 months.

6.4 Special precautions for storage

Store below 25°C. Do not freeze.

6.5 Nature and contents of container

Boxes of 1 metered atomising pump unit containing mometasone furoate (as the monohydrate) 50 micrograms/actuation.

Pack sizes of 40, 65, and 140 metered doses.

NASONEX Aqueous Nasal Spray is currently not available in New Zealand.

6.6 Special precautions for disposal

No special requirements for disposal.

Any unused medicinal product or waste material should be disposed of in accordance with local requirements.

7. MEDICINE SCHEDULE

Prescription Medicine.

8. SPONSOR

Organon New Zealand Limited
P O Box 99 851
Newmarket
Auckland 1149

Tel: 0800 111 700

9. DATE OF FIRST APPROVAL

02 April 1998

10. DATE OF REVISION OF THE TEXT

1 December 2020

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SUMMARY TABLE OF CHANGES

Date Changed	Summary of the Changes
01-Dec-2020	Section 8: Amend sponsor details due to transfer of sponsorship