

# NEW ZEALAND DATA SHEET

## 1. PRODUCT NAME

Rivastigmine Patch 5 (Arrotex Pharmaceuticals) 4.6mg/24 hours transdermal patch  
Rivastigmine Patch 10 (Arrotex Pharmaceuticals) 9.5mg/ 24 hours transdermal patch  
Rivastigmine Patch 15 (Arrotex Pharmaceuticals) 13.3mg/ 24 hours transdermal patch

## 2. QUALITATIVE AND QUANTITATIVE COMPOSITION

Rivastigmine Patch area (cm <sup>2</sup> )	Rivastigmine base dose load	Rivastigmine base <i>in vivo</i> release rates
5	9 mg	4.6 mg/24 hr
10	18 mg	9.5 mg/24 hr
15*	27 mg	13.3 mg/24 hr

For full list of excipients, see **section 6.1**

## 3. PHARMACEUTICAL FORM

Transdermal patch. Each patch is a thin, matrix-type transdermal patch consisting of three layers. The outside of the backing layer is beige and labelled with text for each patch dose as follows:

- RIVASTIGMINE PATCH 5 with “Rivastigmine” and “4.6mg/24 h”
- RIVASTIGMINE PATCH 10 with “Rivastigmine” and “9.5mg/24 h”
- RIVASTIGMINE PATCH 15 with “Rivastigmine” and “13.3mg/24 h”

## 4. CLINICAL PARTICULARS

### 4.1 Therapeutic indications

Treatment of patients with:

- Mild to moderately severe dementia of the Alzheimer’s type (also termed probable Alzheimer’s Disease or Alzheimer’s Disease)
- Severe dementia of the Alzheimer’s type.

### 4.2 Dose and method of administration

#### Dose

#### **Mild to moderately severe dementia of the Alzheimer’s type**

Initial dose and dose titration to the effective dose:

Treatment is started with Rivastigmine Patch 5 once a day.

After a minimum of four weeks of treatment and if well tolerated, this dose should be increased to Rivastigmine Patch 10, which is the recommended effective dose to be continued for as long as a therapeutic benefit for the patient exists.

Individual responses to rivastigmine may vary and some patients may derive additional benefit from

higher doses. Subsequent increases to Rivastigmine Patch 15 should always be based on good tolerability of the current dose and may be considered only after a minimum of four weeks of treatment at each dose level.

### **Severe dementia of the Alzheimer's type**

#### Initial dose and dose titration to the effective dose:

Treatment is started with Rivastigmine Patch 5 once a day. Subsequently the dose should be increased to Rivastigmine Patch 10 and then to Rivastigmine Patch 15 which is the demonstrated effective dose. These dose increases should always be based on good tolerability of the current dose and may be considered only after a minimum of four weeks of treatment at each dose level.

#### Interruption of treatment

Treatment should be temporarily interrupted if gastrointestinal adverse effects and/or worsening of existing extrapyramidal symptoms (e.g. tremor) are observed until these adverse effects resolve. Patch treatment can be resumed at the same dose if treatment is not interrupted for more than three days. Otherwise treatment should be re-initiated with Rivastigmine Patch 5.

If adverse effects persist on re-initiation of therapy, the dose should be temporarily reduced to the previous well-tolerated dose.

#### Switching from capsules:

Patients treated with rivastigmine capsules may be switched to rivastigmine patches as follows:

- A patient who is on a dose of < 6 mg per day oral rivastigmine can be switched to Rivastigmine Patch 5.
- A patient who is on a dose of 6 to 12 mg per day oral rivastigmine may be directly switched to Rivastigmine Patch 10.

It is recommended to apply the first patch on the day following the last oral dose.

#### Method of administration

Rivastigmine transdermal patches should be applied once a day to clean, dry, hairless, intact healthy skin on the upper or lower back, upper arm or chest, in a place which will not be rubbed by tight clothing. The patch should be replaced with a new one after 24 hours.

#### ***Important administration instructions (patients and caregivers should be instructed)***

The previous day's patch must be removed before applying a new one.

The patch should be replaced by a new one after 24 hours. Only one patch should be worn at a time (see **section 4.4** and **section 4.9**).

The patch should not be applied to skin that is red, irritated or cut. It is recommended to change the application site daily to avoid potential irritation, although consecutive patches can be applied to the same anatomic site (e.g. another spot on the upper back).

The patch should be pressed down firmly for at least 30 seconds, using the palm of the hand until the edges stick well.

If the patch falls off, a new one should be applied for the rest of the day, then it should be replaced at the same time as usual, on the next day.

The patch can be used in everyday situations, including bathing and during hot weather.

The patch should not be exposed to any external heat sources (e.g. excessive sunlight, saunas, solarium) for long periods of time.

The patch should not be cut into pieces. Patients and caregivers should be instructed accordingly.

Immediately after removing the patch, patients or caregivers must wash their hands with soap and water. In case of contact with eyes or if the eyes become red after handling the patch, patients or caregivers must rinse the area immediately with plenty of water, and seek medical advice if symptoms do not resolve.

### ***Special populations***

#### Patients with body weight below 50 kg

Caution should be exercised in titrating these patients as they may experience more adverse reactions and may be more likely to discontinue due to adverse events. Particular caution should be exercised in titrating and monitoring these patients for adverse reactions (e.g. excessive nausea or vomiting) and consider reducing the dose if such adverse reactions develop (see **section 4.4**).

#### Paediatric patients

Rivastigmine is not recommended for use in children and adolescents (aged below 18 years).

#### Hepatic impairment

Due to increased exposure in mild to moderate hepatic impairment, as observed with the oral formulation, dosing recommendations to titrate according to individual tolerability should be closely followed. Patients with clinically significant hepatic impairment might experience more adverse events. Particular caution should be exercised in titrating these patients above the recommended maintenance dose of Rivastigmine Patch 10 (see **section 4.4** and **section 5.1**).

#### Renal impairment

No dose adjustment is necessary for patients with renal impairment (see **section 5.1**).

#### Paediatric patients

Children and adolescents (age below 18 years): Rivastigmine is not recommended for use in children.

### **4.3 Contraindications**

The use of rivastigmine is contraindicated in patients with:

- known hypersensitivity to rivastigmine, other carbamate derivatives or other ingredients of the formulation (see **section 6.1**).
- previous history of application site reactions suggestive of allergic contact dermatitis with rivastigmine transdermal patch (see **section 4.4** – Application site reactions and skin reactions).

### **4.4 Special warnings and precautions for use**

#### **Medication misuse and dosing errors resulting in overdose**

Medication misuse and dosing errors with rivastigmine patches have resulted in serious adverse reactions; some cases have required hospitalisation, and rarely led to death (see **section 4.9**). The majority of medication misuse and dosing errors have involved not removing the old patch when putting on a new one and the use of multiple patches at one time. Patients and their caregivers must be instructed on important administration instructions for rivastigmine patch (see **section 4.2**).

#### **Gastrointestinal disorders**

The incidence and severity of adverse reactions generally increase with increasing doses, particularly at dose changes. If treatment is interrupted for more than three days, it should be re-initiated with Rivastigmine Patch 5.

Gastrointestinal disorders such as nausea, vomiting and diarrhoea may occur when initiating treatment and/or increasing the dose. They may respond to a dose reduction. In other cases, use of rivastigmine patches has been discontinued. Patients who show signs or symptoms of dehydration resulting from prolonged vomiting or diarrhoea can be managed with iv fluids and dose reduction or discontinuation if recognized and treated promptly. Dehydration can be associated with serious outcomes (see **section 4.8**).

#### **Weight loss**

Patients with Alzheimer's disease may lose weight whilst taking cholinesterase inhibitors, including rivastigmine. The patient's weight should be monitored during therapy with rivastigmine patches.

#### **Other adverse reactions from increased cholinergic activity**

As with other cholinergic substances care must be taken when prescribing rivastigmine patches to patients:

- with sick sinus syndrome or conduction defects (sino-atrial block, atrio-ventricular block) (see section 4.8).
- with active gastric or duodenal ulcers or patients predisposed to these conditions because gastric acid secretions may be increased.
- predisposed to urinary obstruction and seizures because cholinomimetics may induce or exacerbate these diseases.
- with a history of asthma or obstructive pulmonary disease.

Like other cholinomimetics, rivastigmine may induce or exacerbate extrapyramidal symptoms.

### **Application site reactions and skin reactions**

Skin application site reactions may occur with rivastigmine patch and are usually mild or moderate in intensity (see **section 4.8** – Application site reactions). These reactions are not in themselves an indication of sensitisation. However, use of rivastigmine patch may lead to allergic contact dermatitis.

Allergic contact dermatitis should be suspected if application site reactions spread beyond the patch size, if there is evidence of a more intense local reaction (e.g. increasing erythema, edema, papules, vesicles) and if symptoms do not significantly improve within 48 hours after patch removal. In these cases, treatment should be discontinued (see **section 4.3**).

In patients who develop application site reactions suggestive of allergic contact dermatitis to rivastigmine patch and who still require rivastigmine; treatment should be switched to oral rivastigmine only after negative allergy testing and under close medical supervision. It is possible that some patients sensitised to rivastigmine by exposure to rivastigmine patch may not be able to take rivastigmine in any form.

There have been isolated post-marketing reports of patients experiencing allergic dermatitis (disseminated) when administered rivastigmine irrespective of the route of administration (oral, transdermal). In these cases, treatment should be discontinued (see **section 4.3**). Patients and caregivers should be instructed accordingly.

### **Special populations**

#### **Patients with body weight below 50 kg**

Patients with body mass below 50 kg may experience more adverse reactions and may be more likely to discontinue due to adverse events. Carefully titrate and monitor these patients for adverse reactions (e.g. excessive nausea or vomiting) and consider reducing the dose if such adverse reactions develop (see **section 4.2**).

#### **Paediatric patients**

Rivastigmine is not recommended for use in children and adolescents (aged below 18 years).

#### **Hepatic impairment**

Patients with clinically significant hepatic impairment may experience more adverse reactions. Dosing recommendations to titrate according to individual tolerability should be closely followed. Particular caution should be exercised in titrating these patients (see **section 4.2** and **section 5.1**).

### **4.5 Interactions with other medicines and other forms of interaction**

No specific interaction studies have been conducted with rivastigmine patches.

Rivastigmine is metabolised mainly through hydrolysis by esterases. Minimal metabolism occurs via the major cytochrome P450 isoenzymes thus, no pharmacokinetic interactions are anticipated with other drugs metabolised by these enzymes.

## **Anticipated interactions resulting in a concomitant use not recommended**

### Metoclopramide

Considering the possibility of an additive extra-pyramidal effect the concomitant use of metoclopramide and rivastigmine is not recommended.

### Drugs acting on cholinergic system

In view of its pharmacodynamic effects, rivastigmine should not be given concomitantly with other cholinomimetic drugs due to possible additive effect. Rivastigmine might also interfere with the activity of anticholinergic medications (e.g. oxybutynin, tolterodine).

### Succinylcholine-type muscle relaxants

As a cholinesterase inhibitor, rivastigmine may exaggerate the effects of succinylcholine-type muscle relaxants during anaesthesia.

## **Observed interactions to be considered**

### Beta-blockers

Additive effects leading to bradycardia (which may result in syncope) have been reported with the combined use of various beta-blockers (including atenolol) and rivastigmine. Cardioselective beta-blockers are expected to be associated with the greatest risk, but reports have also been received in patients using other beta-blockers.

### Interaction with nicotine

A population pharmacokinetic analysis showed that nicotine use increases the oral clearance of rivastigmine by 23% in patients with Alzheimer's dementia (n=75 smokers and 549 non-smokers) following rivastigmine oral capsule doses of up to 12 mg/day.

## **Interactions with commonly used concomitant drugs**

No pharmacokinetic interaction was observed between rivastigmine and digoxin, warfarin, diazepam or fluoxetine in studies in healthy volunteers. The increase in prothrombin time induced by warfarin is not affected by administration of rivastigmine. No untoward effects on cardiac conduction were observed following concomitant administration of digoxin and rivastigmine.

Concomitant administration of rivastigmine with commonly prescribed medications, such as antacids, antiemetics, antidiabetics, centrally acting anti-hypertensives, calcium channel blockers, inotropic drugs, antianginals, non-steroidal anti-inflammatory drugs, oestrogens, analgesics, benzodiazepines and antihistamines, was not associated with an alteration in the kinetics of rivastigmine or an increased risk of clinically relevant untoward effects.

## **4.6 Fertility, pregnancy and lactation**

### Women of child-bearing potential

There is no information available on the effects of rivastigmine in women of child-bearing potential.

### Pregnancy

In pregnant animals, rivastigmine and/or metabolites crossed the placenta. It is not known if this occurs in humans. In animal studies, rivastigmine was not teratogenic. However, the safety of rivastigmine patches in human pregnancy has not been established, and it should only be given to pregnant women if the potential benefit outweighs the potential risk for the foetus.

### Breast-feeding

In animals, rivastigmine and/or metabolites were excreted in breast milk. It is not known if rivastigmine patches is excreted into human milk, and patients on rivastigmine should therefore not breast-feed.

### Fertility

In male and female rats, no adverse effects of rivastigmine were observed on fertility or reproductive performance of either the parent generation or the offspring of the parents. There is no information available on the effects of rivastigmine on human fertility.

## **4.7 Effects on ability to drive and use machines**

Alzheimer's disease dementia may cause gradual impairment of driving performance or compromise the ability to use machinery. Rivastigmine may induce dizziness and somnolence, mainly when initiating treatment or increasing the dose. Therefore, in patients with dementia treated with rivastigmine, the ability to continue driving or operating complex machines should be routinely evaluated by the treating physician.

## **4.8 Undesirable effects**

The overall incidence of adverse events in patients treated with Rivastigmine Patch 10 was lower than the rate in patients who received rivastigmine capsule treatment. Nausea and vomiting were the most common adverse events in patients who received active treatment, and occurred at similar rates in both rivastigmine patch and capsule groups. However, the rates of both of these events were substantially lower with Rivastigmine Patch 10 group. The most commonly reported adverse drug reactions are gastrointestinal including nausea and vomiting, especially during titration.

Adverse reactions in Table 1 are ranked under headings of frequency, the most frequent first, using the following convention: Very common ( $\geq 1/10$ ); common ( $\geq 1/100$ ,  $< 1/10$ ); uncommon ( $\geq 1/1,000$ ,  $< 1/100$ ); rare ( $\geq 1/10,000$ ,  $< 1/1,000$ ); very rare ( $< 1/10,000$ ), including isolated reports.

**Table 1. Adverse drug reactions reported in 2687 patients with Alzheimer’s dementia treated for 24 weeks to 48 weeks in randomised controlled clinical studies with rivastigmine patches at all doses**

<b>Metabolism and nutrition disorders</b>	
Common	Anorexia, decreased appetite
Uncommon	Dehydration
<b>Psychiatric disorders</b>	
Common	Anxiety, depression, insomnia
Uncommon:	Agitation, delirium, hallucinations, aggression
<b>Nervous system disorders</b>	
Common:	Dizziness, headache
Uncommon:	Cerebrovascular accident, syncope, somnolence*, psychomotor hyperactivity
<b>Cardiac disorders</b>	
Uncommon:	Cardiac arrhythmia (e.g. bradycardia, supraventricular extrasystole)
<b>Gastrointestinal disorders</b>	
Very common:	Nausea
Common:	Vomiting, Diarrhoea, dyspepsia, abdominal pain
Uncommon:	Gastric ulcer, gastrointestinal haemorrhage (e.g. haemorrhagic duodenitis)
<b>Renal and urinary disorders</b>	
Common	Urinary incontinence
<b>Skin and subcutaneous tissue disorders</b>	
Uncommon:	Hyperhidrosis
<b>General disorders and administration site conditions</b>	
Common:	Application site reactions, application site erythema**, application site pruritus, application site oedema**, fatigue, asthenia
Uncommon:	Contact dermatitis**, malaise
Rare	Fall
<b>Investigations</b>	
Common:	Weight decrease
<b>Infections and infestations</b>	
Common	Urinary tract infection

\* In a 24-week controlled study in Chinese patients somnolence was reported as “common”.

\*\* In a 24-week controlled study in Japanese patients, application site erythema, application site oedema, application site pruritus and contact dermatitis were reported as “very common”.



**Adverse drug reactions from post-marketing spontaneous reports**

The following additional adverse drug reactions have been identified based on post-marketing spontaneous reports. Because these reactions are reported voluntarily from a population of uncertain size, it is not always possible to reliably estimate their frequency.

Rarely reported	hypertension, application site hypersensitivity, pruritus, rash, erythema, urticaria, blister, dermatitis allergic
Very rarely reported	tachycardia, atrioventricular block, atrial fibrillation, pancreatitis, seizure. Worsening of Parkinson’s disease has been observed in patients with Parkinson’s disease who were treated with rivastigmine patches
Frequency not known	hepatitis, restlessness, sick sinus syndrome, allergic dermatitis (disseminated), extrapyramidal symptoms in patients with Alzheimer’s dementia, tremor, nightmares

**Additional adverse drug reactions which have been reported with rivastigmine capsules or oral solution**

Very rare	severe vomiting associated with oesophageal rupture.
Rare	angina pectoris, myocardial infarction, duodenal ulcers
Uncommon	abnormal liver function tests
Common	confusion

**Information from clinical trials in patients with Alzheimer’s dementia treated with Rivastigmine Patches**

The adverse drug reactions in Table 2 were reported in patients with mild to moderate Alzheimer’s dementia treated with rivastigmine patches. The adverse drug reactions in Table 3 were reported in patients with severe Alzheimer’s dementia treated with Rivastigmine Patch 15.

**Table 2. Adverse drug reactions (≥2% in all Rivastigmine Patch groups) from the 24-week double-blind placebo controlled clinical trial conducted with Rivastigmine patches in patients with mild to moderate Alzheimer’s dementia**

	Rivastigmine Patch 10 group n (%)	Rivastigmine Patch 20 group n (%)	Rivastigmine capsules 12 mg/day n (%)	Placebo n (%)	All Rivastigmine patches group
Total patients studied	291	303	294	302	594
Total patients with AE(s)	147 (50.5)	200 (66.0)	186 (63.3)	139 (46.0)	347(58.4)
Nausea	21 (7.2)	64 (21.1)	68 (23.1)	15 (5.0)	85(14.3)
Vomiting	18 (6.2)	57 (18.8)	50 (17.0)	10 (3.3)	75(12.6)
Diarrhoea	18 (6.2)	31 (10.2)	16 (5.4)	10 (3.3)	49(8.2)
Weight decreased	8 (2.7)	23 (7.6)	16 (5.4)	4 (1.3)	31(5.2)
Dizziness	7 (2.4)	21 (6.9)	22 (7.5)	7 (2.3)	28(4.7)
Decreased appetite	2 (0.7)	15 (5.0)	12 (4.1)	3 (1.0)	17(2.9)
Headache	10 (3.4)	13 (4.3)	18 (6.1)	5 (1.7)	23(3.9)
Anorexia	7 (2.4)	12 (4.0)	14 (4.8)	3 (1.0)	19(3.2)
Depression	11 (3.8)	12 (4.0)	13 (4.4)	4 (1.3)	23(3.9)
Insomnia	4 (1.4)	12 (4.0)	6 (2.0)	6 (2.0)	16(2.7)
Abdominal pain	7 (2.4)	11 (3.6)	4 (1.4)	2 (0.7)	18(3.0)
Asthenia	5 (1.7)	9 (3.0)	17 (5.8)	3 (1.0)	14(2.4)
Anxiety	9 (3.1)	8 (2.6)	5 (1.7)	4 (1.3)	17(2.9)
Fatigue	5 (1.7)	7 (2.3)	2 (0.7)	4 (1.3)	12(2.0)

**Table 3. Adverse drug reactions ( $\geq 5\%$  in either rivastigmine patch groups) from the 24-week double-blind randomized controlled clinical trial conducted with Rivastigmine Patch 15 in patients with severe Alzheimer’s dementia**

Preferred term	Patch 15 group n (%)	Patch 5 group n (%)
Total patients studied	355	359
Total number of patients with AE(s)	265 (74.6)	263 (73.3)
Application site erythema	47 (13.2)	42 (11.7)
Agitation	41 (11.5)	51 (14.2)
Urinary tract infection	29 (8.2)	34 (9.5)
Fall	127 (7.6)	21 (5.8)
Insomnia	25 (7.0)	15 (4.2)
Vomiting	25 (7.0)	9 (2.5)
Diarrhoea	23 (6.5)	19 (5.3)
Weight decreased	23 (6.5)	11 (3.1)
Nausea	22 (6.2)	10 (2.8)
Depression	17 (4.8)	15 (4.2)
Decreased appetite	17 (4.8)	5 (1.4)
Anxiety	16 (4.5)	16 (4.5)
Hallucination	7 (2.0)	16 (4.5)

#### **Application site reactions (skin irritation)**

In double-blind controlled clinical trials, application site reactions were mostly mild to moderate in severity. The incidence of application site skin reactions leading to discontinuation was observed in  $\leq 2.3\%$  of rivastigmine patch patients. This number was 4.9% and 8.4% in the Chinese population and Japanese population, respectively.

Cases of skin irritation were captured separately on an investigator-rated skin irritation scale. Skin irritation, when observed, was mostly slight or mild in severity and was rated as severe in  $\leq 2.2\%$  of rivastigmine patch patients in a double-blind controlled study and in  $\leq 3.7\%$  of rivastigmine patch patients in a double-blind controlled study in Japanese patients.

See **section 4.4** – Skin application site and skin 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 <http://nzphvc.otago.ac.nz/reporting/>

### **4.9 Overdose**

#### **Symptoms**

Most cases of accidental overdosage have not been associated with any clinical signs or symptoms and almost all of the patients concerned continued rivastigmine treatment. Where symptoms have occurred, they have included nausea, vomiting, diarrhoea, abdominal pain, dizziness, tremor, headache,

somnolence, bradycardia, confusional state, hyperhidrosis, hypertension, hallucinations and malaise. Overdosage with cholinesterase inhibitors can result in cholinergic crisis characterized by severe nausea, vomiting, salivation, sweating, bradycardia, hypotension, respiratory depression, and convulsions. Muscle weakness is a possibility and may result in death if respiratory muscles are involved. Due to the known vagotonic effect of cholinesterase inhibitors on heart rate, bradycardia and/or syncope may also occur.

Overdose with rivastigmine patches resulting from misuse/medication errors (application of multiple patches at a time) has been reported in the post-marketing setting and rarely in clinical trials. Fatal outcome has been rarely reported with rivastigmine overdose and relationship to rivastigmine was unclear. Symptoms of overdose and outcome vary from patient to patient and the severity of the outcome is not predictably related to the amount of the overdose.

### **Treatment**

As rivastigmine has a plasma half-life of about 3.4 hours and duration of acetylcholinesterase inhibition of about 9 hours, it is recommended that in cases of asymptomatic overdose all rivastigmine patches should be immediately removed and no further patch should be applied for the next 24 hours. In overdose accompanied by severe nausea and vomiting, the use of antiemetics should be considered. Symptomatic treatment for other adverse events should be given as necessary.

In massive overdose, atropine can be used. An initial dose of 0.03 mg/kg i.v atropine sulphate is recommended, with subsequent doses based on clinical response. Use of scopolamine as an antidote is not recommended.

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: brain-selective cholinesterase inhibitor ATC code: N06DA03

#### **Mechanism of action**

##### ***Pharmacodynamics (PD)***

Pathological changes in dementia such as Alzheimer's Disease involve cholinergic neuronal pathways that project from the basal forebrain to the cerebral cortex and hippocampus. These pathways are known to be involved in attention, learning and memory and other cognitive processes. Rivastigmine, a brain-selective acetyl- and butyryl-cholinesterase inhibitor of the carbamate type, is thought to facilitate cholinergic neurotransmission by slowing the degradation of acetylcholine released by functionally intact cholinergic neurons. Data from animal studies indicate that rivastigmine selectively increases the availability of acetylcholine in the cortex and hippocampus. Thus, rivastigmine may have an ameliorative effect on cholinergic-mediated cognitive deficits associated with Alzheimer's Disease and with Parkinson's disease. In addition, there is some evidence that cholinesterase inhibition could slow the formation of amyloidogenic beta-amyloid-precursor protein (APP) fragments, and thus of amyloid plaques, which are one of the main pathological features of Alzheimer's Disease.

Rivastigmine interacts with its target enzymes by forming a covalently bound complex that temporarily inactivates the enzymes. In healthy young men, an oral 3.0 mg dose decreases acetylcholinesterase (AChE) activity in cerebro spinal fluid (CSF) by approximately 40% within the first 1.5 hours after

administration. Activity of the enzyme returns to baseline levels about 9 hours after the maximum inhibitory effect has been achieved. Butyrylcholinesterase (BuChE) activity in CSF was transiently inhibited and was no longer different from baseline after 3.6 hours in healthy young volunteers. In patients with Alzheimer's Disease (AD), inhibition of acetylcholinesterase in CSF by rivastigmine was dose-dependent up to 6 mg given twice daily, the highest dose tested. Inhibition of BuChE activity in CSF of AD patients by rivastigmine was similar to that of AChE, with a change from baseline of more than 60% after 6 mg given twice daily. The effect of rivastigmine on AChE and BuChE activity in CSF was sustained after 12 months administration, the longest time studied. Statistically significant correlations were found between the degree of inhibition by rivastigmine of AChE and BuChE in the CSF and changes on a compound measure of cognitive performance in AD patients; however, only BuChE inhibition in CSF was significantly and consistently correlated with improvements in speed-, attention- and memory-related subtests.

### **Clinical efficacy and safety**

#### ***Alzheimer's Dementia***

The efficacy of rivastigmine patches (10, 15, and 20) in patients with mild to moderately severe dementia of the Alzheimer's type has been demonstrated in a 24-week double-blind, placebo- controlled core study and its open-label extension phase and in a 48-week double blind active comparator study.

#### **Mild to Moderate Alzheimer's dementia**

##### **24-week placebo-controlled study**

Patients involved in a placebo-controlled study had an MMSE (Mini-Mental State Examination) score of 10–20. Efficacy was established by the use of independent, domain-specific assessment tools which were applied at regular intervals during the 24-week treatment period. These include the ADAS-Cog (a performance-based measure of cognition), the ADCS-CGIC (a comprehensive global assessment of the patient by the physician incorporating caregiver input), and the ADCS-ADL (a caregiver-rated assessment of the activities of daily living including personal hygiene, feeding, dressing, household chores such as shopping, retention of ability to orient oneself to surroundings as well as involvement in activities related to finances). The 24-week results for the three assessment tools are summarised in Table 4.

The results for clinically relevant responders from the 24-week study are provided in Table 5. Clinically relevant improvement was defined a priori as at least 4-point improvement on the ADAS-cog, no worsening on the ADCS-CGIC, and no worsening on the ADCS-ADL.

**Table 4. 24-week results for the three assessment tools in patients with mild to moderate Alzheimer’s dementia**

	Rivastigmine Patch 10	Rivastigmine Patch 20	Rivastigmine capsule 12 mg/day	Placebo
<b>ITT-LOCF population</b>	<b>N = 251</b>	<b>N = 264</b>	<b>N = 256</b>	<b>N = 282</b>
ADAS-Cog	(n=248)	(n=262)	(n=253)	(n=281)
Mean baseline ±SD	27.0 ±10.3	27.4 ± 9.7	27.9 ±9.4	28.6 ±9.9
Mean change at week 24 ±SD	-0.6 ±6.4	-1.6 ±6.5	-0.6 ±6.2	1.0 ± 6.8
p-value versus placebo	0.005* <sup>1</sup>	<0.001* <sup>1</sup>	0.003* <sup>1</sup>	
ADCS-CGIC	(n=248)	(n=260)	(n=253)	(n=278)
Mean score ±SD	3.9 ±1.20	4.0 ±1.27	3.9 ±1.25	4.2 ±1.26
p-value versus placebo	0.010* <sup>2</sup>	0.054 <sup>2</sup>	0.009* <sup>2</sup>	
ADCS-ADL	(n=247)	(n=263)	(n=254)	(n=281)
Mean baseline ±SD	50.1 ±16.3	47.6 ±15.7	49.3 ±15.8	49.2 ±16.0
Mean change at week 24 ±SD	-0.1 ±9.1	0.0 ±11.6	-0.5 ±9.5	-2.3 ±9.4
p-value versus placebo	0.013* <sup>1</sup>	0.017* <sup>1</sup>	0.039* <sup>1</sup>	

\*  $p \leq 0.05$  versus placebo

ITT: Intent-To-Treat; LOCF: Last Observation Carried Forward

<sup>1</sup> Based on ANCOVA with treatment and country as factors and baseline value as a covariate. Negative ADAS-Cog changes indicate improvement. Positive ADCS-ADL changes indicate improvement.

<sup>2</sup> Based on CMH test (van Elteren test) blocking for country. ADCS-CGIC scores <4 indicate improvement.

**Table 5. Results for clinically relevant responders from the 24-week placebo-controlled study in patients with mild to moderate Alzheimer’s dementia**

	Patients with Clinically Significant Response (%)			
	Rivastigmine Patch 10	Rivastigmine Patch 20	Rivastigmine capsule 12mg/day	Placebo
At least 4 points improvement on ADAS-Cog with no worsening on ADCS-CGIC and ADCS-ADL	17.4*	20.2**	19.0**	10.5

\* $p < 0.05$ , \*\* $p < 0.01$  versus placebo

Similar results were observed with Rivastigmine Patch 10 in separately conducted controlled studies in Chinese and Japanese patients with mild to moderately severe Alzheimer’s dementia.

#### 48-week active comparator controlled study

Patients involved in the active comparator controlled study had an initial baseline MMSE (Mini-Mental State Examination) score of 10–24. The study was designed to compare the efficacy of the Rivastigmine Patch 15 versus the Rivastigmine Patch 10 during a 48-week double blind treatment phase in Alzheimer’s disease patients who demonstrated functional and cognitive decline after an initial 24-48 week open-label treatment phase while on a maintenance dose of Rivastigmine Patch 10. Functional decline was assessed by the investigator and cognitive decline was defined as a decrease in the MMSE score of  $\geq 2$  points from the previous visit or a decrease of  $\geq 3$  points from baseline. Efficacy was established by the use of independent, domain-specific assessment tools which were applied at regular intervals during the 48-week treatment period. These include the ADAS-Cog (a performance-based measure of cognition) and the ADCS-instrumental ADL (a subscale from the ADCS-ADL activities of daily living scale assessing instrumental activities which are thought to involve more complex cognitive activities and represent

clinically meaningful functional activities of daily living, which include maintaining finances, meal preparation, shopping, ability to orient oneself to surroundings, able to be left unattended, etc.). The 48-week results for the two assessment tools are summarized in Table 6.

### Severe Alzheimer’s dementia

#### 24-week controlled study

Patients involved in the controlled study had at baseline an MMSE (mini-Mental State Examination) score of  $\geq 3$  and  $\leq 12$ . The study was designed to compare the efficacy of Rivastigmine Patch 15 versus Rivastigmine Patch 5 during a 24-week double-blind treatment phase in severe Alzheimer’s disease. Efficacy was established by the use of independent, domain-specific assessment tools. These include the SIB<sub>1</sub>, the ADCS-ADL-SIV<sub>2</sub> and the ADCS-CGIC<sub>3</sub>. The 24-week results for the three assessment tools are summarised in Table 7.

**Table 6. Mean change from double-blind baseline in ADAS-Cog and ADCS-IADL scores over time in patients with mild to moderate Alzheimer’s dementia.**

Population visit			Patch 15	Patch 10	Patch 15 – Patch 10		
			N=265	N=271	DLSM	95% CI	p-value
			Mean	Mean			
<b>ADAS-Cog</b>			(n=264)	(n=268)			
<b>LOCF</b>		Baseline	34.4	34.9			
	DB-week 12	Value	34.2	35.5			
		Change	-0.2	0.6	-0.9	(-0.2, 0.1)	0.091
	DB-week 24	Value	35.4	37.1			
		Change	1.0	2.2	-1.3	(-2.5, -0.2)	0.027*
	DB-week 48	Value	38.5	39.7			
		Change	4.1	4.9	-0.8	(-2.1, 0.5)	0.227
<b>ADAS-IADL</b>			(n=265)	(n=271)			
<b>LOCF</b>		Baseline	27.5	25.8			
	Week 8	Value	27.3	25.0			
		Change	-0.2	-0.8	0.8	(-0.2, 1.9)	0.114
	Week 12	Value	27.5	25.4			
		Change	0.1	-0.4	0.7	(-0.5, 1.8)	0.252
	Week 16	Value	26.7	24.0			
		Change	-0.7	-1.8	1.3	(0.2, 2.5)	0.025*
	Week 24	Value	26.0	22.9			
		Change	-1.5	-2.8	1.7	(0.5, 2.9)	0.005*
	Week 32	Value	25.2	21.7			
		Change	-2.2	-4.0	2.1	(0.9, 3.4)	<0.001*
	Week 48	Value	23.1	19.6			
		Change	-4.4	-6.2	2.2	(0.8, 3.6)	0.002*

ANCOVA - analysis of covariance, CI – confidence interval, DB – double blind

DLSM – difference in least square means, LOCF – Last Observation Carried Forward.

ADAS-cog scores: A negative difference in DLSM indicates greater improvement in Rivastigmine 15 cm<sup>2</sup> as compared to Rivastigmine 10 cm<sup>2</sup>

ADCS-IADL scores: A positive difference in DLSM indicates greater improvement in Rivastigmine 15 cm<sup>2</sup> as compared to Rivastigmine 10 cm<sup>2</sup>

n = number of patients with an assessment at baseline and the corresponding visit.

The DLSM, 95% CI, and p-value are based on an ANCOVA model adjusted for country and baseline

\* p < 0.05

1 Severe Impairment Battery (SIB) test is a 40-item scale with a range of possible scores from 0 to 100, with lower scores reflecting lower levels of cognitive function.

2 Alzheimer’s Disease Cooperative Study Activity of Daily Living-Severe Impairment Version (ADCS-ADL-SIV) is a caregiver-based scale consisting of 19 items designed to assess the patient’s performance of both basic and instrumental activities of daily living, which had been used in several studies in moderate to severe Alzheimer’s dementia. The total score ranges from 0 – 54, with lower scores indicating poorer function.

3 Alzheimer’s Disease Cooperative Study-Clinical Global Impression of Change (ADCS-CGIC) is a comprehensive global assessment of the patient by the physician incorporating caregiver input.

**Table 7. 24-week results for the three assessment tools in patients with severe Alzheimer’s dementia**

<b>MFAS-LOCF population</b>	<b>Rivastigmine Patch 15 N = 338</b>	<b>Rivastigmine Patch 5 N = 335</b>
<b>SIB<sup>1</sup></b>	(n=336)	(n=334)
Mean baseline ± SD	69.3 ± 21.54	68.3 ± 22.79
Mean change at week 24 ±SD	-1.7 ± 0.79	-6.6 ± 0.79
LS Means difference (95% CI) <sup>[a]</sup>	4.9 (2.80, 6.95)	
p-value <sup>[a]</sup>	<0.0001*	
<b>ADCS-ADL-SIV<sup>2</sup></b>	(n=333)	(n=319)
Mean baseline ± SD	29.7 ± 11.29	29.1 ± 11.94
Mean change at week 24 ± SD	-2.4 ± 0.41	-3.6 ± 0.42
LS Means difference (95% CI) <sup>[a]</sup>	1.2 (0.16, 2.32)	
p-value <sup>[a]</sup>	0.0247*	
<b>ADCS-CGIC<sup>3</sup></b>	(n=313)	(n=315)
No change or improvement n (%)	184 (58.8)	143 (45.4)
Difference (95% CI) <sup>[b]</sup>	13.4 (5.65, 21.13)	
p-value <sup>[c]</sup>	0.0013*	

\* p ≤ 0.05; MFAS: Modified Full Analysis Set; LOCF: Last Observation Carried Forward; ADCS-CGIC: number (percent) of patients with no change or improvement in total score;

LS: Least Squares

[a] Obtained from an ANCOVA model with treatment and pooled center as factors, and baseline score (SIB or ADCS-ADL-SIV, respectively) as a covariate

[b] 95% confidence interval (CI) based on the normal approximation

[c] From Cochran-Mantel-Haenszel (CMH) chi-square test, adjusting for pooled center.

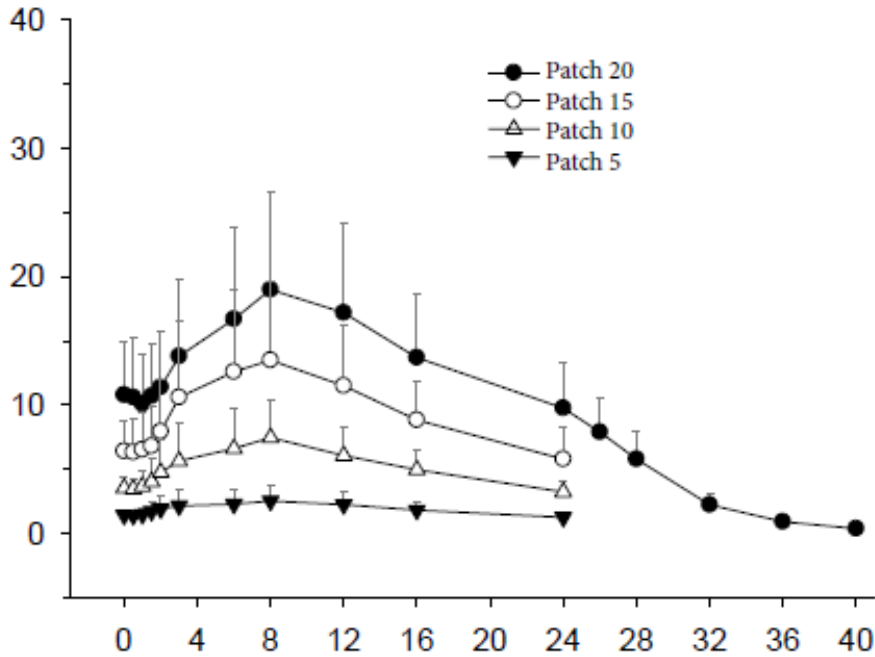
## **5.2 Pharmacokinetics (PK)**

### ***Absorption***

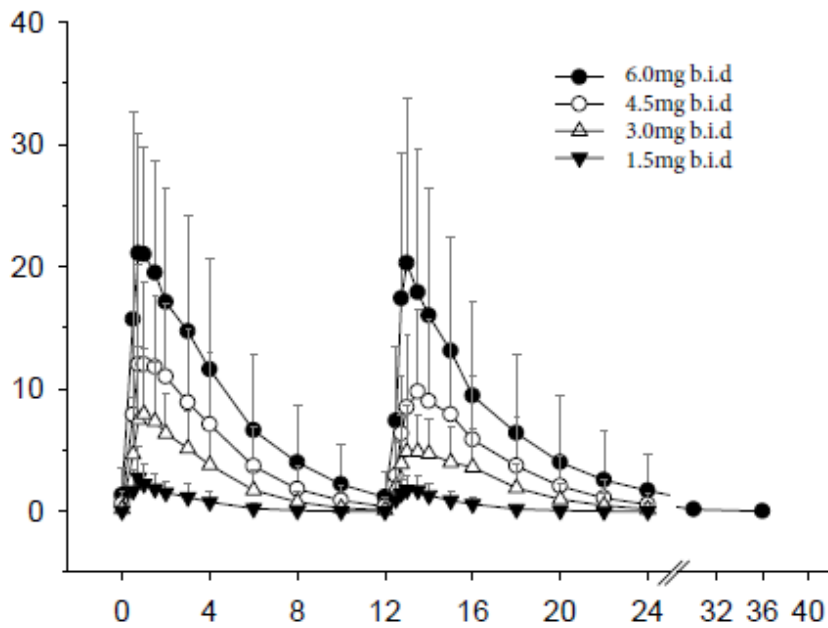
Absorption of rivastigmine from rivastigmine patches is slow. After the first dose, detectable plasma concentrations are observed after a lag time of 0.5-1 hour. Concentrations then rise slowly and typically after 8 hours reach levels close to maximum, although maximum values ( $C_{max}$ ) are often reached at later times (10-16 hours). After the peak, plasma concentrations slowly decrease over the remainder of the 24-hour period of application. With multiple dosing (such as at steady state), after the previous patch is replaced with a new one, plasma concentrations initially decrease slowly for about 40 min on average, until absorption from the newly applied patch becomes faster than the elimination, and plasma levels begin to rise again to reach a new peak at approximately 8 hours. At steady state, trough levels are approximately 50% of peak levels, in contrast to oral dosing, with which concentrations fall off to virtually zero between doses (see Figure 1). This time course of plasma concentrations is observed with all patch strengths (sizes) in the investigated range of Rivastigmine Patch 5 to Rivastigmine Patch 20. Although less pronounced than with the oral formulation, exposure to rivastigmine ( $C_{max}$  and AUC) increased over-proportionally with rising patch doses. Escalating from Rivastigmine Patch 5 to Rivastigmine Patch 20, the increase in rivastigmine AUC relative to the lowest dose of Rivastigmine Patch 5 was 2.6, 4.9 and 7.8 fold for Rivastigmine Patch 10, Rivastigmine Patch 15 and Rivastigmine Patch 20, respectively. The fluctuation index (FI), i.e. a measure of the relative difference between peak and trough concentrations ( $(C_{max} - C_{min})/C_{avg}$ ), was in the range 0.57 to 0.77 for the patch, thus demonstrating a much smaller fluctuation between trough and peak concentrations than for the oral formulation (FI = 3.96 to 6.24). As determined by compartmental modelling the Rivastigmine Patch 20 exhibited exposure (AUC<sub>24h</sub>) in a typical patient

equivalent to that which would be provided by an oral dose of about 9 to 10 mg twice daily (i.e. 18 to 20 mg/day), while Rivastigmine Patch 10 exhibited exposure equivalent to that provided by an oral dose of about 6 mg twice daily (i.e. 12 mg/day).

**Figure 1 Rivastigmine plasma concentrations following dermal 24-hour patch application**



**Figure 2 Rivastigmine plasma concentrations following oral (twice daily) capsule**





In a single dose study directly comparing the patch versus oral administration, the inter-subject variability in rivastigmine pharmacokinetic parameters (normalised to dose/kg bodyweight) was 43% ( $C_{max}$ ) and 49% ( $AUC_{0-24h}$ ) after the patch versus 74% and 103%, respectively, after the oral capsule. Similarly, inter-subject variability in rivastigmine pharmacokinetic parameters was lower after the patch than after the oral capsule in a steady-state study in Alzheimer's dementia patients given repeated doses. The inter-patient variability was at most 45% ( $C_{max}$ ) and 43% ( $AUC_{0-24h}$ ) after the patch, while 71% and 73%, respectively, after the oral form.

A relationship between drug exposure at steady state (rivastigmine and metabolite NAP226-90) and bodyweight was observed in Alzheimer's dementia patients. Compared to a patient with a body weight of 65 kg, the rivastigmine steady-state concentrations in a patient with a body weight of 35 kg would be approximately doubled, while for a patient with a body weight of 100 kg the concentrations would be approximately halved. The effect of bodyweight on drug exposure suggests special attention to patients with very low body weight during up-titration (see Dosage and administration).

Rivastigmine was well released from the transdermal system over a 24-hour dermal application with approximately 50% of the drug load released from the system. Exposure ( $AUC_{\infty}$ ) to rivastigmine (and metabolite NAP266-90) was highest when the patch was applied to the upper back, chest, or upper arm. Two other sites (abdomen and thigh) could be used if none of the three other sites is available, but the practitioner should keep in mind that the rivastigmine plasma exposure associated with these sites was approximately 20-30% lower.

There was no relevant accumulation of rivastigmine or the metabolite NAP226-90 in plasma in patients with Alzheimer's disease, except that with patch treatment plasma levels on the second day were higher than on the first.

### ***Distribution***

Rivastigmine is weakly bound to plasma proteins (approximately 40%). It readily crosses the blood-brain barrier and has an apparent volume of distribution in the range of 1.8-2.7 l/kg.

### ***Biotransformation***

Rivastigmine is rapidly and extensively metabolised with an apparent elimination half-life in plasma of approximately 3.4 hours after patch removal. Elimination was absorption rate limited (flip-flop kinetics), which explains the longer  $t_{1/2}$  after patch (3.4 h) versus oral or i.v. administrations (1.4 to 1.7 h). Metabolism is primarily via cholinesterase-mediated hydrolysis to the decarbamylated metabolite. In vitro, this metabolite shows minimal inhibition of acetylcholinesterase (<10%). Based on in vitro studies, no pharmacokinetic drug interactions are expected with drugs metabolized by the following cytochrome isoenzymes: CYP1A2, CYP2D6, CYP3A4/5, CYP2E1, CYP2C9, CYP2C8, CYP2C19, or CYP2B6. Based on evidence from animal studies, the major cytochrome P450 isoenzymes are minimally involved in rivastigmine metabolism. Total plasma clearance of rivastigmine was approximately 130 litres/h after a 0.2 mg intravenous dose and decreased to 70 litres/h after a 2.7 mg intravenous dose, which is consistent with the non-linear, over-proportional pharmacokinetics of rivastigmine due to saturation of its elimination.

The metabolite-to-parent  $AUC_{\infty}$  ratio was around 0.7 after patch versus 3.5 after oral administration, indicating that much less metabolism occurred after dermal treatment. Less NAP226-90 is formed following patch application, presumably because of the lack of presystemic (hepatic first pass) metabolism.

### ***Elimination***

Unchanged rivastigmine is found in trace amounts in the urine; renal excretion of the metabolites is the major route of elimination. Following administration of <sup>14</sup>C-rivastigmine, renal elimination was rapid and essentially complete (>90 %) within 24 hours. Less than 1% of the administered dose is excreted in the faeces.

### ***Special population***

#### **Elderly subjects**

Age had no impact on the exposure to rivastigmine in Alzheimer's disease patients treated with rivastigmine patches.

#### **Subjects with hepatic impairment**

No study was conducted with the rivastigmine patches in subjects with hepatic impairment. After oral administration, the C<sub>max</sub> of rivastigmine was approximately 60% higher and the AUC of rivastigmine was more than twice as high in subjects with mild to moderate hepatic impairment than in healthy subjects. Following a single 3-mg oral dose or multiple 6-mg twice a day oral doses, the mean oral clearance of rivastigmine was approximately 60 - 65 % lower in mild (n=7, Child-Pugh score 5-6) and moderate (n=3, Child-Pugh score 7-9) hepatically impaired patients (n=10, biopsy proven) than in healthy subjects (n=10). These pharmacokinetic changes had no effect on either the incidence or severity of adverse effects (see **section 4.2** and **section 4.4**).

#### **Subjects with renal impairment**

No study was conducted with the rivastigmine patches in subjects with renal impairment. Based on population analysis creatinine clearance did not show any clear effect on steady state concentrations of rivastigmine or its metabolite. No dosage adjustment is necessary in patients with renal impairment (see **section 4.2**).

## **5.3 Non-clinical safety data**

### **Acute toxicity**

The estimated oral LD<sub>50</sub> values in mice were 5.6 mg base/kg (males) and 13.8 mg base/kg (females). The estimated oral LD<sub>50</sub> values in rats were 8.1 mg base/kg (males) and 13.8 mg base/kg (females).

### **Repeated dose toxicity**

Oral and topical repeated-dose toxicity studies in mice, rats, rabbits, dogs and minipigs revealed only effects associated with an exaggerated pharmacological action. No target organ toxicity was observed. Oral and topical dosing in animal studies was limited due to the sensitivity of the animal models used.

### **Mutagenicity**

Rivastigmine was not mutagenic in *in vitro* tests for gene mutations and primary DNA damage and chromosomal damage *in vivo*. In tests for chromosomal damage *in vitro*, a small increase in the number of cells carrying chromosomal aberrations occurred at very high concentrations. However, as there was no evidence of clastogenic activity in the more relevant *in vivo* micronucleus test assessing chromosomal damage test, it is most likely that the *in vitro* findings were false positive observations. In addition, the

major metabolite NAP226-90 did not induce structural chromosome aberrations in an in vitro test indicating that the compound has no genotoxic potential.

### **Carcinogenicity**

No evidence of carcinogenicity was found in oral and topical studies in mice and in an oral study in rats at the maximum tolerated dose. The exposure to rivastigmine and its metabolites was approximately equivalent to human exposure with highest doses of rivastigmine capsules and patches.

### **Reproductive toxicity**

Oral studies in pregnant rats and rabbits with dose levels up to 2.3 mg base/kg/day gave no indication of teratogenic potential on the part of rivastigmine. Similarly, there was no evidence of adverse effects of rivastigmine on fertility, reproductive performance or in utero or postnatal growth and development in rats at given dose levels up to 1.1 mg base/kg/day (see **section 4.6**). Specific dermal studies in pregnant animals have not been conducted.

### **Local tolerance**

Rivastigmine patches were not phototoxic and are considered to be a non-sensitizer. In some other dermal toxicity studies, a mild irritant effect on the skin of laboratory animals, including controls, was observed. This may indicate a potential for rivastigmine patches to induce mild erythema in patients. A mild eye/mucosal irritation potential of rivastigmine was identified in a rabbit study (see **section 4.2**).

## **6 PHARMACEUTICAL PARTICULARS**

### **6.1 List of excipients**

Durotak 87-235A, Bio-PSA 7-4302 silicone adhesive and acrylates copolymer.

### **6.2 Incompatibilities**

To prevent interference with the adhesive properties of the patch, no cream, lotion or powder should be applied to the skin area where the rivastigmine transdermal patch is to be applied.

### **6.3 Shelf life**

24 months.

### **6.4 Special precautions for storage**

Store below 25°C.

Keep the patch in the sachet until use.

Rivastigmine Patch must be kept out of the reach and sight of children.

### **6.5 Nature and contents of container**

Rivastigmine Patches are individually sealed in child-resistant sachets made of a paper/polyester /aluminium/polyacrylonitrile material. The sachets are packed into cartons of 7 or 30 sachets.

## **6.6 Special precautions for disposal**

Used patches should be folded, with the adhesive surfaces pressed together, and discarded safely and out of the reach and sight of children.

## **7 MEDICINE SCHEDULE**

Prescription Medicine

## **8 SPONSOR**

Arrotex Pharmaceuticals (NZ) Limited  
C/o Quigg Partners  
Level 7, The Bayleys Building  
36 Brandon Street  
Wellington 6011  
New Zealand

Contact number: +64 3 4779 669

## **9 DATE OF FIRST APPROVAL**

14<sup>th</sup> June 2019

## **10 DATE OF REVISION OF THE TEXT**

12<sup>th</sup> July 2021

## **SUMMARY TABLE OF CHANGES**

<b>Section changed</b>	<b>Summary of new information</b>
<b>8</b>	Sponsor details update