Dexloprot Capsules

ڈیکس لوپروٹ کیپسولز

(Dexlansoprazole)

(ڈیکس لینسوپرازول)

COMPOSITION: Each capsule contains:
Dexlansoprazole Dual Delayed Release Pellets eq. to Dexlansoprazole 30mg
Dexlansoprazole Dual Delayed Release Pellets eq. to Dexlansoprazole 60mg
[As per Innovator's Specifications]

DESCRIPTION: Dexloprot, a proton pump inhibitor, is (+)-2-[(R)-{[3-methyl- 4-(2,2,2-trifluoroethoxy)pyridin-2-yl] methyl} sulfinyl]-1H benzimidazole. Dexlansoprazole is the R-enantiomer of lansoprazole (a racemic mixture of the R- and S- enantiomers). Its empirical formula is: $C_{16}H_{14}F_3N_3O_2S$, with a molecular weight of 369.36g/mol.

INDICATIONS: Dexloprot is indicated:
- For healing of all grades of erosive esophagitis (EE) for up to 8 weeks.
- To maintain healing of EE for up to 6 months.
- For the treatment of heartburn associated with non-erosive gastroesophageal reflux disease (GERD) for 4 weeks.

DOSAGE AND ADMINISTRATION: Dexloprot is available as capsules in 30mg and 60mg strengths for adult use. Directions for use in each indication are summarized in Table

Indication	Recommended Dose	Frequency
Healing of EE	60mg	Once daily for up to 8 weeks
Maintenance of Healed EE	30mg	Once daily (do not extend beyond 6 months)
Symptomatic Non-Erosive GERD	30mg	Once daily for 4 weeks

Dexloprot can be taken without regard to food.
Dexloprot should be swallowed whole.
Special Populations: No adjustment for **Dexloprot** is necessary for patients with mild hepatic impairment. Consider a maximum daily dose of 30mg for patients. If a dose is missed, administer as soon as possible. Do not take two doses at one time to make up for a missed dose.

CLINICAL PHARMACOLOGY: Mechanism of Action: Dexlansoprazole belongs to a class of antisecretory compounds, the substituted benzimidazoles, that suppress gastric acid secretion by specific inhibition of the (H+, K+)-ATPase at the secretory surface of the gastric parietal cell. Dexlansoprazole has been characterized as a gastric proton-pump inhibitor, in that it blocks the final step of acid production.
Pharmacokinetics: The dual delayed release formulation of Dexlansoprazole results in a Dexlansoprazole plasma concentration-time profile with two distinct peaks; the first peak occurs one to two hours after administration, followed by a second peak within four to five hours.
Absorption: After oral administration of Dexlansoprazole to healthy subjects and symptomatic GERD patients, mean C_{max} and AUC values of Dexlansoprazole increased approximately dose proportionally.
Effect on Food: In healthy subjects receiving Dexlansoprazole under various fed conditions compared to fasting, increases in C_{max} ranged from 12% to 55%, increases in AUC ranged from 9% to 37% and T_{max} varied (ranging from a decrease of 0.7 hours to an increase of three hours).
Distribution: Plasma protein binding of Dexlansoprazole ranged from 96% to 99% in healthy subjects. The apparent volume of distribution after multiple doses in symptomatic GERD patients was 40L.
Metabolism: Dexlansoprazole is extensively metabolized in the liver by oxidation, reduction and Subsequent formation of sulphate, glucuronide and glutathione conjugates to inactive metabolites. Oxidative metabolites are formed by the cytochrome P450 (CYP) enzyme system including hydroxylation mainly by CYP2C19 and oxidation to the sulfone by CYP3A4. In CYP2C19 intermediate and extensive metabolizers, the major plasma metabolites are 5-hydroxy Dexlansoprazole and its glucuronide conjugate, while in CYP2C19 poor metabolizers Dexlansoprazole sulfone is the major plasma metabolite.
Excretion: Following the administration of Dexlansoprazole, no unchanged Dexlansoprazole is excreted in urine. Apparent clearance (CL/F) in healthy subjects was 11.4 to 11.6L/hour respectively, after five days of 30mg or 60mg once daily administration. Dexlansoprazole is eliminated with a half-life of approximately one to two hours in healthy subjects and in patients with symptomatic GERD.

SPECIAL POPULATION: Geriatric Population: Dexlansoprazole exhibited higher systemic exposure (AUC) in geriatric subjects (34% higher) than younger patients.
Hepatic Impairment: In patients with moderate hepatic impairment (Child-Pugh Class B) the systemic exposure (AUC) of bound and unbound Dexlansoprazole was approximately two times greater compared to subjects with normal hepatic function.

CONTRAINDICATION: Dexlansoprazole is contraindicated in patients with known hypersensitivity to any component of the formulation, with rilpivirine containing products and patients with severe hepatic impairment.

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ADVERSE REACTIONS: Most Common adverse reactions are Diarrhea, abdominal pain, nausea, upper respiratory tract infection, vomiting and flatulence. For any other symptoms and reactions, please consult your doctor.

ADMINISTRATION ADVICE:
- For patients that have difficulty swallowing capsules, the contents of a capsule can be sprinkled on apple sauce or empty the content of capsule in to a clean container with 20ml of water and withdraw the entire mixture in to an oral syringe. - Administer immediately in to the mouth. Refill the syringe with 10ml of water, swirl gently and administer. - Repeat this step one more time.

Administration with water via a nasogastric tube:
- Open the capsule and empty the content of capsule in to a clean container with 20ml of water. - Withdraw the entire mixture in to a catheter-tip syringe, swirl the syringe gently in order to keep the granules from settling and immediately inject the mixture through the nasogastric tube in to the stomach. - Do not save the water and granule mixture for later use. - Refill the syringe with 10ml of water, swirl gently and flush the tube. - Refill the syringe again with 10ml of water, swirl gently and administer.

PRECAUTIONS:
- Use of proton pump inhibitors (PPIs) may increase risk of Clostridium difficile-associated diarrhea, especially in hospitalized patients. Patients should use the lowest dose and shortest duration of PPI therapy appropriate to the condition being treated.
- Increased incidence of osteoporosis-related bone fractures of the hip, spine or wrist may occur with proton pump inhibitor (PPI) therapy. Patients should use the lowest dose and shortest duration of PPI therapy appropriate to the conditions being treated. Patients at risk for osteoporosis-related fractures should be managed according to established treatment guidelines. - Consider obtaining serum magnesium concentrations prior to beginning long-term therapy, especially if taking concomitant digoxin, diuretics or other drugs known to cause hypomagnesemia. - Acute interstitial nephritis has been observed in patients taking PPIs including Dexlansoprazole; may occur at any time during therapy.
Discontinue Dexlansoprazole, if acute interstitial nephritis develops.
- Prolonged treatment may lead to vitamin B_{12} malabsorption and subsequent vitamin B_{12} deficiency. - Use of PPIs may increase risk of gastrointestinal infections. - Symptomatic response with Dexlansoprazole does not preclude the presence of gastric malignancy.

DRUG INTERACTIONS: Antiretrovirals: Rilpivirine, atazanavir and nelfinavir when used concomitantly with Dexlansoprazole may reduce antiviral effect and promote the development of drug resistance.
Saquinavir: Saquinavir when used concomitantly with Dexlansoprazole may increase toxicity of the antiretroviral drugs.
Warfarin: Concomitant use of PPI's with warfarin may increase INR and prothrombin time in patients which may lead to abnormal bleeding and even death.
Methotrexate: Concomitant use of PPIs with methotrexate may elevate and prolong serum concentrations of methotrexate and/or its metabolite hydroxymethotrexate, possibly leading to methotrexate toxicities.
Digoxin: Potential for increased exposure of digoxin. Monitor digoxin concentration.
Drugs Dependent on Gastric pH for Absorption (e.g., iron salts, erlotinib, dasatinib, nilotinib, mycophenoloate mofetil, ketoconazole/itraconazole): Dexlansoprazole can reduce the absorption of other drugs due to its effect on reducing intragastric acidity.
Tacrolimus: Potentially increased exposure of tacrolimus, especially in transplant patients who are intermediate or poor metabolizers of CYP2C19.
Interactions with Investigations of Neuroendocrine Tumors: CgA levels increase secondary to PPI-induced decreases in gastric acidity. The increased CgA level may cause false positive results in diagnostic investigations for neuro endocrine tumors.
Interaction with Secretin Stimulation Test: Hyper-response in gastrin secretion in response to secretin stimulation test, falsely suggesting gastrinoma.
False Positive Urine Tests for THC: There have been reports of false positive urine screening tests for tetrahydrocannabinol (THC) in patients receiving PPIs.
CYP2C19 or CYP3A4 Inducers (St. John's Wort, rifampin): Decreased exposure of dexlansoprazole when used concomitantly with strong inducers.
CYP2C19 or CYP3A4 Inhibitors (Voriconazole): Increased exposure of Dexlansoprazole is expected when used concomitantly with strong inhibitors.

OVERDOSAGE: Serious and non-serious adverse events of hypertension have been reported in association with twice daily doses of Dexlansoprazole 60mg include hot flashes, contusion, oropharyngeal pain and weight loss. Dexlansoprazole is not expected to be removed from the circulation by hemodialysis.
In the event of over-exposure, treatment should be symptomatic and supportive.

INSTRUCTIONS: Store below 30° C. Protect from light, heat and moisture. Keep out of the reach of children.

PRESENTATION:
Dexloprot (Dexlansoprazole) Capsules 30mg are available in pack of 30's.
Dexloprot (Dexlansoprazole) Capsules 60mg are available in pack of 30's

ہدایات: ۳۰ ڈگری سینٹی گریڈ سے کم درجہ حرارت پر رکھیں۔ گرمی، روشنی اور نمی سے بچائیں۔ بچوں کی پہنچ سے دور رکھیں۔

PHARMA
Manufactured by:
NABIQASIM INDUSTRIES (PVT.) LTD.
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Karachi-Pakistan.

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