Patients with renal impairment
The dosing recommendations described in “Use in adults” apply to patients with mild to moderate renal impairment (creatinine clearance = 30-80 mL/min). Since sildenafil clearance is reduced in patients with severe renal impairment (creatinine clearance <30 mL/min) a 25 mg dose should be considered. Based on efficacy and tolerability, the dose may be increased step-wise to 50 mg up to 100 mg as necessary.

Patients with hepatic impairment
Since sildenafil clearance is reduced in patients with hepatic impairment (e.g. cirrhosis) a 25 mg dose should be considered. Based on efficacy and tolerability, the dose may be increased step-wise to 50 mg up to 100 mg as necessary.

Paediatric population
SILAFIL is not indicated for individuals below 18 years of age.

Use in patients taking other medicinal products
With the exception of ritonavir for which co-administration with sildenafil is not advised (see Section 4.4) a starting dose of 25 mg should be considered in patients receiving concomitant treatment with CYP3A4 inhibitors (see section 4.5). In order to minimise the potential of developing postural hypotension in patients receiving alpha-blocker treatment patients should be stabilised on alpha-blocker therapy prior to initiating sildenafil treatment. In addition, initiation of sildenafil at a dose of 25 mg should be considered (see sections 4.4 and 4.5).

Method of administration
For oral use.

4.3 Contraindications
Hypersensitivity to the active substance or to any of the excipients listed in section 6.1.
Consistent with its known effects on the nitric oxide/cyclic guanosine monophosphate (cGMP) pathway (see section 5.1), sildenafil was shown to potenti-
manifesting as severely impaired autonomic control of blood pressure.
SILAFIL potentiates the hypotensive effect of nitrates (see section 4.3).
Serious cardiovascular events, including myocardial infarction, unstable angina, sudden cardiac death, ventricular arrhythmia, cerebrovascular haemorrhage, transient ischaemic attack, hypertension and hypotension have been reported post-marketing in temporal association with the use of SILAFIL. Most, but not all, of these patients had pre-existing cardiovascular risk factors. Many events were reported to occur during or shortly after sexual intercourse and a few were reported to occur shortly after the use of SILAFIL without sexual activity. It is not possible to determine whether these events are related directly to these factors or to other factors.

Priapism
Agents for the treatment of erectile dysfunction, including sildenafil, should be used with caution in patients with anatomical deformation of the penis (such as angulation, cavernosal fibrosis or Peyronie’s disease), or in patients who have conditions which may predispose them to priapism (such as sickle cell anaemia, multiple myeloma or leukaemia).

Prolonged erections and priapism have been reported with sildenafil in post-marketing experience. In the event of an erection that persists for longer than 4 hours, the patient should seek immediate medical assistance. If priapism is not treated immediately, penile tissue damage and permanent loss of potency could result.

Concomitant use with other PDE5 inhibitors or other treatments for erectile dysfunction
The safety and efficacy of combinations of sildenafil with other PDE5 inhibitors, or other pulmonary arterial hypertension (PAH) treatments containing sildenafil (REVATIO), or other treatments for erectile dysfunction have not been studied. Therefore the use of such combinations is not recommended.

Effects on vision
Cases of visual defects have been reported spontaneously in connection with the intake of sildenafil.
and other PDE5 inhibitors (see section 4.8). Cases of non-arteritic anterior ischaemic optic neuropathy, a rare condition, have been reported spontaneously and in an observational study in connection with the intake of sildenafil and other PDE5 inhibitors (see section 4.8). Patients should be advised that in the event of any sudden visual defect, they should stop taking SILAFIL and consult a physician immediately (see section 4.3).

Concomitant use with ritonavir
Co-administration of sildenafil with ritonavir is not advised (see section 4.5).

Concomitant use with alpha-blockers
Caution is advised when sildenafil is administered to patients taking an alpha-blocker, as the co-administration may lead to symptomatic hypotension in a few susceptible individuals (see section 4.5). This is most likely to occur within 4 hours post sildenafil dosing. In order to minimise the potential for developing postural hypotension, patients should be hemodynamically stable on alpha-blocker therapy prior to initiating sildenafil treatment. Initiation of sildenafil at a dose of 25mg should be considered (see section 4.2). In addition, physicians should advise patients what to do in the event of postural hypotensive symptoms.

Effect on bleeding
Studies with human platelets indicate that sildenafil potentiates the anti-aggregatory effect of sodium nitroprusside in vitro. There is no safety information on the administration of sildenafil to patients with bleeding disorders or active peptic ulceration. Therefore sildenafil should be administered to these patients only after careful benefit-risk assessment.

The film coating of the tablet contains lactose. SILAFIL should not be administered to men with rare hereditary problems of galactose intolerance, Lapp lactase deficiency or glucose-galactose malabsorption.

Women
SILAFIL is not indicated for use by women.
When a single 100 mg dose of sildenafil was administered with erythromycin, a moderate CYP3A4 inhibitor, at steady state (500 mg twice daily for 5 days), there was a 182% increase in sildenafil systemic exposure (AUC). In normal healthy male volunteers, there was no evidence of an effect of azithromycin (500 mg daily for 3 days) on the AUC, $C_{\text{max}}$, $t_{\text{max}}$, elimination rate constant, or subsequent half-life of sildenafil or its principal circulating metabolite. Cimetidine (800 mg), a cytochrome P450 inhibitor and non-specific CYP3A4 inhibitor, caused a 56% increase in plasma sildenafil concentrations when co-administered with sildenafil (50 mg) to healthy volunteers.

Grapefruit juice is a weak inhibitor of CYP3A4 gut wall metabolism and may give rise to modest increases in plasma levels of sildenafil.

Single doses of antacid (magnesium hydroxide/aluminium hydroxide) did not affect the bioavailability of sildenafil.

Although specific interaction studies were not conducted for all medicinal products, population pharmacokinetic analysis showed no effect of concomitant treatment on sildenafil pharmacokinetics when grouped as CYP2C9 inhibitors (such as tolbutamide, warfarin, phenytoin), CYP2D6 inhibitors (such as selective serotonin reuptake inhibitors, tricyclic antidepressants), thiazide and related diuretics, loop and potassium sparing diuretics, angiotensin converting enzyme inhibitors, calcium channel blockers, beta-adrenoreceptor antagonists or inducers of CYP450 metabolism (such as rifampicin, barbiturates). In a study of healthy male volunteers, co-administration of the endothelin antagonist, bosentan, (an inducer of CYP3A4 [moderate], CYP2C9 and possibly of CYP2C19) at steady state (125 mg twice a day) with sildenafil at steady state (80 mg three times a day) resulted in 62.6% and 55.4% decrease in sildenafil AUC and $C_{\text{max}}$, respectively. Therefore, concomitant administration of strong CYP3A4 inducers, such as rifampin, is expected to cause greater decreases in plasma concentrations of sildenafil.

Noricandil is a hybrid of potassium channel activator and nitrate. Due to the nitrate component it has the potential to result in a serious interaction with sildenafil.

Effects of sildenafil on other medicinal products

In vitro studies

Sildenafil is a weak inhibitor of the cytochrome P450 isoforms 1A2, 2C9, 2C19, 2D6, 2E1 and 3A4 (IC$_{50}$ >150 μM). Given sildenafil peak plasma concentrations of approximately 1 μM after recommended doses, it is unlikely that SILAFIL will alter the clearance of substrates of these isoenzymes.

There are no data on the interaction of sildenafil and non-specific phosphodiesterase inhibitors such as theophylline or dipyridamole.

In vivo studies

Consistent with its known effects on the nitric oxide/cGMP pathway (see section 5.1), sildenafil was shown to potentiate the hypotensive effects of nitrates, and its co-administration with nitric oxide donors or nitrates in any form is therefore contraindicated (see section 4.3).

Concomitant administration of sildenafil to patients taking alpha-blocker therapy may lead to symptomatic hypotension in a few susceptible individuals. This is most likely to occur within 4 hours post sildenafil dosing (see sections 4.2 and 4.4). In three specific drug-drug interaction studies, the alpha-blocker doxazosin (4 mg and 8 mg) and sildenafil (25 mg, 50 mg, or 100 mg) were administered simultaneously to patients with benign prostatic hyperplasia (BPH) stabilized on doxazosin therapy. In these study populations, mean additional reductions of supine blood pressure of 7/7 mmHg, 9/5 mmHg, and 8/4 mmHg, and mean additional reductions of standing blood pressure of 6/6 mmHg, 11/4 mmHg, and 4/5 mmHg, respectively, were observed. When sildenafil and doxazosin were administered simultaneously to patients stabilized on doxazosin therapy, there were infrequent reports of patients who experienced symptomatic postural hypotension. These reports included dizziness and lightheadedness, but not syncope.

No significant interactions were shown when sildenafil (50 mg) was co-administered with tolbutamide (250 mg) or warfarin (40 mg), both of which are metabolised by CYP2C9.
Sildenafil (50 mg) did not potentiate the increase in bleeding time caused by acetyl salicylic acid (150 mg).

Sildenafil (50 mg) did not potentiate the hypotensive effects of alcohol in healthy volunteers with mean maximum blood alcohol levels of 80 mg/dl.

Pooling of the following classes of antihypertensive medication; diuretics, beta-blockers, ACE inhibitors, angiotensin II antagonists, antihypertensive medicinal products (vasodilator and centrally-acting), adrenergic neurone blockers, calcium channel blockers and alpha-adrenoceptor blockers, showed no difference in the side effect profile in patients taking sildenafil compared to placebo treatment. In a specific interaction study, where sildenafil (100 mg) was co-administered with amlodipine in hypertensive patients, there was an additional reduction on supine systolic blood pressure of 8 mmHg. The corresponding additional reduction in supine diastolic blood pressure was 7 mmHg. These additional blood pressure reductions were of a similar magnitude to those seen when sildenafil was administered alone to healthy volunteers (see section 5.1).

4.6 Fertility, pregnancy and lactation
SILAFIL is not indicated for use by women.

There are no adequate and well-controlled studies in pregnant or breast-feeding women.

No relevant adverse effects were found in reproduction studies in rats and rabbits following oral administration of sildenafil.

There was no effect on sperm motility or morphology after single 100 mg oral doses of sildenafil in healthy volunteers (see section 5.1).

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

As dizziness and altered vision were reported in clinical trials with sildenafil, patients should be aware of how they react to SILAFIL, before driving or operating machinery.

4.8 Undesirable effects
Summary of the safety profile
The safety profile of SILAFIL is based on 8691 patients who received the recommended dosing regimen in 67 placebo-controlled clinical studies. The most commonly reported adverse reactions in clinical studies among sildenafil treated patients were headache, flushing, dyspepsia, visual disorders, nasal congestion, dizziness and visual colour distortion.

Adverse reactions from post-marketing surveillance has been gathered covering an estimated period >9 years. Because not all adverse reactions are reported to the Marketing Authorisation Holder and included in the safety database, the frequencies of these reactions cannot be reliably determined.

Tabulated list of adverse reactions

<table>
<thead>
<tr>
<th>System Organ Class</th>
<th>Adverse Reaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immune system disorders</td>
<td>Rare Hypersensitivity reactions</td>
</tr>
<tr>
<td>Nervous system disorders</td>
<td>Very common Headache</td>
</tr>
<tr>
<td></td>
<td>Common Dizziness</td>
</tr>
<tr>
<td></td>
<td>Uncommon Somnolence, Hypoaesthesia</td>
</tr>
<tr>
<td></td>
<td>Rare Cerebrovascular accident, Syncope</td>
</tr>
<tr>
<td></td>
<td>Not known Transient ischaemic attack, Seizure, Seizure recurrence</td>
</tr>
<tr>
<td>Eye disorders</td>
<td>Very common Visual disorders, Visual colour distortion</td>
</tr>
<tr>
<td></td>
<td>Uncommon Conjunctival disorders, Eye disorders, Lacrimation disorders, Other eye disorders</td>
</tr>
<tr>
<td></td>
<td>Not known Non-arteritic anterior ischaemic optic neuropathy (NAION), Retinal vascular occlusion, Visual field defect.</td>
</tr>
<tr>
<td>Ear and labyrinth disorders</td>
<td>Common Vertigo, Tinnitus</td>
</tr>
</tbody>
</table>
800 mg, adverse reactions were similar to those seen at lower doses, but the incidence rates and severities were increased. Doses of 200 mg did not result in increased efficacy but the incidence of adverse reactions (headache, flushing, dizziness, dyspepsia, nasal congestion, altered vision) was increased.

In cases of overdose, standard supportive measures should be adopted as required. Renal dialysis is not expected to accelerate clearance as sildenafil is highly bound to plasma proteins and not eliminated in the urine.

5. Pharmacological properties

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: Urologicals; Drugs used in erectile dysfunction. ATC Code: G04B E03.

Mechanism of action
Sildenafil is an oral therapy for erectile dysfunction. In the natural setting, i.e. with sexual stimulation, it restores impaired erectile function by increasing blood flow to the penis.

The physiological mechanism responsible for erection of the penis involves the release of nitric oxide (NO) in the corpus cavernosum during sexual stimulation. Nitric oxide then activates the enzyme guanylate cyclase, which results in increased levels of cyclic guanosine monophosphate (cGMP), producing smooth muscle relaxation in the corpus cavernosum and allowing inflow of blood.

Sildenafil is a potent and selective inhibitor of cGMP specific phosphodiesterase type 5 (PDE5) in the corpus cavernosum, where PDE5 is responsible for degradation of cGMP. Sildenafil has a peripheral site of action on erections. Sildenafil has no direct relaxant effect on isolated human corpus cavernosum but potently enhances the relaxant effect of NO on this tissue. When the NO/cGMP pathway is activated, as occurs with sexual stimulation, inhibition of PDE5 by sildenafil results in increased corpus cavernosum levels of cGMP. Therefore sexual stimulation is required in order for sildenafil to produce its intended beneficial pharmacological effects.

Pharmacodynamic effects
Studies in vitro have shown that sildenafil is selec-
A double-blind, placebo-controlled exercise stress trial evaluated 144 patients with erectile dysfunction and chronic stable angina who regularly received anti-anginal medicinal products (except nitrates). The results demonstrated no clinically relevant differences between sildenafil and placebo in time to limiting angina.

Mild and transient differences in colour discrimination (blue/green) were detected in some subjects using the Farnsworth-Munsell 100 hue test at 1 hour following a 100 mg dose, with no effects evident after 2 hours post-dose. The postulated mechanism for this change in colour discrimination is related to inhibition of PDE6, which is involved in the phototransduction cascade of the retina. Sildenafil has no effect on visual acuity or contrast sensitivity. In a small size placebo-controlled study of patients with documented early age-related macular degeneration (n=9), sildenafil (single dose, 100 mg) demonstrated no significant changes in the visual tests conducted (visual acuity, Amsler grid, colour discrimination simulated traffic light, Humphrey perimeter and photostress).

There was no effect on sperm motility or morphology after single 100 mg oral doses of sildenafil in healthy volunteers (see section 4.6).

Further information on clinical trials
In clinical trials sildenafil was administered to more than 8000 patients aged 19-87. The following patient groups were represented: elderly (19.9%), patients with hypertension (30.9%), diabetes mellitus (20.3%), ischaemic heart disease (5.8%), hyperlipidaemia (19.8%), spinal cord injury (0.6%), depression (5.2%), transurethral resection of the prostate (3.7%), radical prostatectomy (3.3%). The following groups were not well represented or excluded from clinical trials: patients with pelvic surgery, patients post-radiotherapy, patients with severe renal or hepatic impairment and patients with certain cardiovascular conditions (see section 4.3).

In fixed dose studies, the proportions of patients reporting that treatment improved their erections were 62% (25 mg), 74% (50 mg) and 82% (100 mg) compared to 25% on placebo. In controlled clinical trials, the discontinuation rate due to sildenafil was low and similar to placebo.

tive for PDE5, which is involved in the erection process. Its effect is more potent on PDE5 than on other known phosphodiesterases. There is a 10-fold selectivity over PDE6 which is involved in the phototransduction pathway in the retina. At maximum recommended doses, there is an 80-fold selectivity over PDE1, and over 700-fold over PDE 2, 3, 4, 7, 8, 9, 10 and 11. In particular, sildenafil has greater than 4,000-fold selectivity for PDE5 over PDE3, the cAMP-specific phosphodiesterase isof orm involved in the control of cardiac contractility.

Clinical efficacy and safety
Two clinical studies were specifically designed to assess the time window after dosing during which sildenafil could produce an erection in response to sexual stimulation. In a penile plethysmography (RigiScan) study of fasted patients, the median time to onset for those who obtained erections of 60% rigidity (sufficient for sexual intercourse) was 25 minutes (range 12-37 minutes) on sildenafil. In a separate RigiScan study, sildenafil was still able to produce an erection in response to sexual stimulation 4-5 hours post-dose.

Sildenafil causes mild and transient decreases in blood pressure which, in the majority of cases, do not translate into clinical effects. The mean maximum decreases in supine systolic blood pressure following 100 mg oral dosing of sildenafil was 8.4 mmHg. The corresponding change in supine diastolic blood pressure was 5.5 mmHg. These decreases in blood pressure are consistent with the vasodilatory effects of sildenafil, probably due to increased cGMP levels in vascular smooth muscle. Single oral doses of sildenafil up to 100 mg in healthy volunteers produced no clinically relevant effects on ECG.

In a study of the hemodynamic effects of a single oral 100 mg dose of sildenafil in 14 patients with severe coronary artery disease (CAD) (>70% stenosis of at least one coronary artery), the mean resting systolic and diastolic blood pressures decreased by 7% and 6% respectively compared to baseline. Mean pulmonary systolic blood pressure decreased by 9%. Sildenafil showed no effect on cardiac output, and did not impair blood flow through the stenosed coronary arteries.
Biotransformation

Sildenafil is cleared predominantly by the CYP3A4 (major route) and CYP2C9 (minor route) hepatic microsomal isoenzymes. The major circulating metabolite results from N-demethylation of sildenafil. This metabolite has a phosphodiesterase selectivity profile similar to sildenafil and an in vitro potency for PDE5 approximately 50% that of the parent drug. Plasma concentrations of this metabolite are approximately 40% of those seen for sildenafil. The N-desmethyl metabolite is further metabolised, with a terminal half life of approximately 4 h.

Elimination

The total body clearance of sildenafil is 41 L/h with a resultant terminal phase half life of 3-5 h. After either oral or intravenous administration, sildenafil is excreted as metabolites predominantly in the faeces (approximately 80% of administered oral dose) and to a lesser extent in the urine (approximately 13% of administered oral dose).

Pharmacokinetic properties

Absorption

Sildenafil is rapidly absorbed. Maximum observed plasma concentrations are reached within 30 to 120 minutes (median 60 minutes) of oral dosing in the fasted state. The mean absolute oral bioavailability is 41% (range 25-63%). After oral dosing of sildenafil AUC and C_max increase in proportion with dose over the recommended dose range (25-100 mg). When sildenafil is taken with food, the rate of absorption is reduced with a mean delay in t_max of 60 minutes and a mean reduction in C_max of 29%.

Distribution

The mean steady state volume of distribution (V_d) for sildenafil is 105 l, indicating distribution into the tissues. After a single oral dose of 100 mg, the mean maximum total plasma concentration of sildenafil is approximately 440 ng/mL (CV 40%). Since sildenafil (and its major circulating N-desmethyl metabolite) is 96% bound to plasma proteins, this results in the mean maximum free plasma concentration for sildenafil of 18 ng/mL (38 nM). Protein binding is independent of total drug concentrations.

In healthy volunteers receiving sildenafil (100 mg single dose), less than 0.0002% (average 188 ng) of the administered dose was present in ejaculate 90 minutes after dosing.

Across all trials, the proportion of patients reporting improvement on sildenafil were as follows: psychogenic erectile dysfunction (84%), mixed erectile dysfunction (77%), organic erectile dysfunction (68%), elderly (67%), diabetes mellitus (59%), ischaemic heart disease (69%), hypertension (68%), TURP (61%), radical prostatectomy (43%), spinal cord injury (83%), depression (75%). The safety and efficacy of sildenafil was maintained in long term studies.

Paediatric population

The European Medicines Agency has waived the obligation to submit the results of studies with SILAFIL in all subsets of the paediatric population for the treatment of erectile dysfunction. See section 4.2 for information on paediatric use.

5.2 Pharmacokinetic properties

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In healthy volunteers receiving sildenafil (100 mg single dose), less than 0.0002% (average 188 ng) of the administered dose was present in ejaculate 90 minutes after dosing.
C\textsubscript{max} of 100\% and 88\% respectively compared to age-matched volunteers with no renal impairment. In addition, N-desmethyl metabolite AUC and C\textsubscript{max} values were significantly increased 79\% and 200\% respectively.

**Hepatic insufficiency**

In volunteers with mild to moderate hepatic cirrhosis (Child-Pugh A and B) sildenafil clearance was reduced, resulting in increases in AUC (84\%) and C\textsubscript{max} (47\%) compared to age-matched volunteers with no hepatic impairment. The pharmacokinetics of sildenafil in patients with severely impaired hepatic function has not been studied.

5.3 Preclinical safety data

Non-clinical data revealed no special hazard for humans based on conventional studies of safety pharmacology, repeated dose toxicity, genotoxicity, carcinogenic potential, and toxicity to reproduction and development.

6. Pharmaceutical particulars

6.1 List of excipients

- Microcrystalline cellulose
- Calcium hydrogen phosphate (anhydrous)
- Croscarmellose sodium
- Magnesium stearate
- Colloidal anhydrous silica
- Opadry Blue

6.2 Incompatibilities

Not applicable.

6.3 Shelf life

2 years.

6.4 Special precautions for storage

Store below 30°C.

Store in the original package in order to protect from moisture.

6.5 Nature and contents of container

PVC/Aluminum blisters in cartons of 4 tablets.

6.6 Special precautions for disposal and other handling

No special requirements.

7. Marketing authorization holder

SAJA Pharmaceuticals