

COMPOSITION

Plavix 75 mg film-coated tablet

Each film-coated tablet contains 97.875 mg of Clopidogrel hydrogen sulphate form II (molar equivalent of 75 mg of Clopidogrel base).

PHARMACEUTICAL FORM

Plavix 75 mg film-coated tablet

Film-coated tablet: pink, round, biconvex, engraved with <<75>> on one side and <<1171>> on the other side.

CLINICAL PARTICULARS

Therapeutic indications

Clopidogrel is indicated for the secondary prevention of atherothrombotic events in:

- Patients suffering from myocardial infarction (from a few days until less than 35 days), ischemic stroke (from 7 days until less than 6 months) or established peripheral arterial disease.
- Patients suffering from acute coronary syndrome:
 - Non-ST segment elevation acute coronary syndrome (unstable angina or non-Q-wave myocardial infarction), including patients undergoing a STENT placement following percutaneous coronary intervention, in combination with acetylsalicylic acid (ASA).
 - ST segment elevation acute myocardial infarction, in combination with ASA in patients undergoing percutaneous coronary intervention (including patients undergoing a stent placement) medically treated patients eligible for thrombolytic/fibrinolytic therapy.

In patients with moderate to high-risk Transient Ischemic Attack (TIA) or minor Ischemic Stroke (IS)

Clopidogrel in combination with ASA is indicated in:

- Adult patients with moderate to high-risk TIA (ABCD2 score ≥ 4) or minor IS (NIHSS ≤ 3) within 24 hours of either the TIA or IS event.

For further information please refer to “*Pharmacodynamic properties*”.

Posology and method of administration

• Adults and elderly

This 300 mg tablet of clopidogrel is intended for use as a loading dose in patients suffering from acute coronary syndrome:

- Non-ST segment elevation acute coronary syndrome (unstable angina or non-Q-wave myocardial infarction): clopidogrel treatment should be initiated with a single 300 mg or 600 mg loading dose. A 600 mg loading dose may be considered in patients <75 years of age when percutaneous coronary intervention is intended (see section 4.4). Clopidogrel treatment should be continued at 75 mg once a day (with acetylsalicylic acid (ASA) 75 mg-325 mg daily). Since higher doses of ASA were associated with higher bleeding risk it is recommended that the dose of ASA should not be higher than 100 mg. The optimal duration of treatment has not been formally established. Clinical trial data support use up to 12 months, and the maximum benefit was seen at 3 months (see “*Pharmacodynamic properties*”).
- ST segment elevation acute myocardial infarction: For medically treated patients eligible for thrombolytic/fibrinolytic therapy, clopidogrel should be given as a single daily dose of 75 mg initiated with a 300 mg loading dose in combination with ASA and with or without thrombolytics. For medically treated patients over 75 years of age clopidogrel, should be initiated without a loading dose. Combined therapy should be started as early as possible after symptoms start and

continued for at least four weeks. The benefit of the combination of clopidogrel with ASA beyond four weeks has not been studied in this setting (see "*Pharmacodynamic properties*").

- When percutaneous coronary intervention (PCI) is intended:

- Clopidogrel should be initiated at a loading dose of 600 mg in patients undergoing primary PCI and in patients undergoing PCI more than 24 hours of receiving fibrinolytic therapy. In patients ≥ 75 years old the 600 mg LD should be administered with caution (see section **Special warnings and precautions for use**).

- Clopidogrel 300 mg loading dose should be given in patients undergoing PCI within 24 hours of receiving fibrinolytic therapy.

- Clopidogrel treatment should be continued at 75 mg once a day with ASA 75 mg – 100 mg daily. Combined therapy should be started as early as possible after symptoms start and continued up to 12 months (see section **Pharmacodynamic properties**).

- Adult patients with moderate to high-risk TIA or minor IS

Adult patients with moderate to high-risk TIA (ABCD2 score ≥ 4) or minor IS (NIHSS ≤ 3) should be given a loading dose of clopidogrel 300 mg followed by clopidogrel 75 mg once daily and ASA (75 mg -100 mg once daily). Treatment with clopidogrel and ASA should be started within 24 hours of the event and be continued for 21 days followed by single antiplatelet therapy.

Special populations

- Elderly patients

Non-ST segment elevation acute coronary syndrome (unstable angina or non-Q-wave myocardial infarction):

- A 600 mg loading dose may be considered in patients <75 years of age when percutaneous coronary intervention is intended (see section **Special warnings and precautions for use**).

ST segment elevation acute myocardial infarction:

- For medically treated patients eligible for thrombolytic/fibrinolytic therapy: in patients over 75 years of age clopidogrel should be initiated without a loading dose.

For patients undergoing primary PCI and in patients undergoing PCI more than 24 hours of receiving fibrinolytic therapy:

- In patients ≥ 75 years old the 600 mg LD should be administered with caution (see section **Special warnings and precautions for use**).

- Paediatric population

The safety and efficacy of clopidogrel in children and adolescents under 18 years old have not yet been established.

- Renal impairment

Therapeutic experience is limited in patients with renal impairment (see "*Special warnings and precautions for use*").

- Hepatic impairment

Therapeutic experience is limited in patients with moderate hepatic disease who may have bleeding diatheses (see "*Special warnings and precautions for use*").

Method of administration.

For oral use.

It may be given with or without food.

Contraindications

- Hypersensitivity to the active substance or any of the excipients.
- Severe hepatic impairment.
- Active pathological bleeding such as peptic ulcer or intracranial haemorrhage.

Special warnings and precautions for use

Bleeding and haematological disorders

Due to the risk of bleeding and haematological adverse reactions, blood cell count determination and/or other appropriate testing should be promptly considered whenever clinical symptoms suggestive of bleeding arise during the course of treatment. As with other antiplatelet agents, clopidogrel should be used with caution in patients who may be at risk of increased bleeding from trauma, surgery or other pathological conditions and in patients receiving treatment with ASA, heparin, glycoprotein IIb/IIIa inhibitors or non-steroidal anti-inflammatory drugs (NSAIDs) including Cox-2 inhibitors, or selective serotonin reuptake inhibitors (SSRIs), or CYP2C19 strong inducers or other medicinal products associated with bleeding risk such as pentoxifylline (see Interaction with other medicinal products and other forms of interaction). Due to the increased risk of haemorrhage, triple antiplatelet therapy (clopidogrel + ASA + dipyridamole) for stroke secondary prevention is not recommended in patients with acute non-cardioembolic ischemic stroke or TIA (see section **Interaction with other medicinal products and other forms of interaction** and section **Undesirable effects**). Patients should be followed carefully for any signs of bleeding including occult bleeding, especially during the first weeks of treatment and/or after invasive cardiac procedures or surgery. The concomitant administration of clopidogrel with oral anticoagulants is not recommended since it may increase the intensity of bleedings.

If a patient is to undergo elective surgery and antiplatelet effect is temporarily not desirable, clopidogrel should be discontinued 7 days prior to surgery. Patients should inform physicians and dentists that they are taking clopidogrel before any surgery is scheduled and before any new medicinal product is taken. Clopidogrel prolongs bleeding time and should be used with caution in patients who have lesions with a propensity to bleed (particularly gastrointestinal and intraocular).

Patients should be told that it might take longer than usual to stop bleeding when they take clopidogrel (alone or in combination with ASA), and that they should report any unusual bleeding (site or duration) to their physician.

The use of clopidogrel 600 mg loading dose is not recommended in patients with non-ST segment elevation acute coronary syndrome and ≥ 75 years of age due to increased bleeding risk in this population.

Due to the limited clinical data in patients ≥ 75 years old with STEMI PCI, and increased risk of bleeding, the use of clopidogrel 600 mg loading dose should be considered only after an individual assessment of the bleeding risk of the patient by the physician.

Thrombotic Thrombocytopenic Purpura (TTP)

Thrombotic Thrombocytopenic Purpura (TTP) has been reported very rarely following the use of clopidogrel, sometimes after a short exposure. It is characterised by thrombocytopenia and microangiopathic haemolytic anaemia associated with either neurological findings, renal dysfunction or fever. TTP is a potentially fatal condition requiring prompt treatment including plasmapheresis.

Acquired haemophilia

Acquired haemophilia has been reported following use of clopidogrel. In cases of confirmed isolated activated Partial Thromboplastin Time (aPTT) prolongation with or without bleeding, acquired haemophilia should be considered. Patients with a confirmed diagnosis of acquired haemophilia should be managed and treated by specialists, and clopidogrel should be discontinued.

Recent ischemic stroke

- Initiation of therapy
 - o In acute minor IS or moderate to high-risk TIA patients, dual antiplatelet therapy (clopidogrel and ASA) should be started no later than 24 hours after the event onset.
 - o There is no data regarding the benefit-risk of short term dual antiplatelet therapy in acute minor IS or moderate to high-risk TIA patients, with a history of (non-traumatic) intracranial hemorrhage.
 - o In non-minor IS patients, clopidogrel monotherapy should be started only after the first 7 days of the event.
- Non-minor IS patients (NIHSS >4)
 - In view of the lack of data, use of dual antiplatelet therapy is not recommended (see section 4.1).
- Recent minor IS or moderate to high-risk TIA in patients for whom intervention is indicated or planned

There is no data to support the use of dual antiplatelet therapy in patients for whom treatment with carotid endarterectomy or intravascular thrombectomy is indicated, or in patients planned for thrombolysis or anticoagulant therapy. Dual antiplatelet therapy is not recommended in these situations.

Cytochrome P450 2C19 (CYP2C19)

Pharmacogenetics: In patients who are poor CYP2C19 metabolisers, clopidogrel at recommended doses forms less of the active metabolite of clopidogrel and has a smaller effect on platelet function. Tests are available to identify a patient's CYP2C19 genotype.

Since clopidogrel is metabolised to its active metabolite partly by CYP2C19, use of medicinal products that inhibit the activity of this enzyme would be expected to result in reduced drug levels of the active metabolite of clopidogrel. The clinical relevance of this interaction is uncertain. As a precaution concomitant use of strong or moderate CYP2C19 inhibitors should be discouraged.

Use of medicinal products that induce the activity of CYP2C19 would be expected to result in increased drug levels of the active metabolite of clopidogrel and might potentiate the bleeding risk. As a precaution concomitant use of strong CYP2C19 inducers should be discouraged.

CYP2C8 substrates

Caution is required in patients treated concomitantly with clopidogrel and CYP2C8 substrate medicinal products (see Interaction with other medicinal products and other forms of interaction).

Cross-reactions among thienopyridines

Patients should be evaluated for history of hypersensitivity to thienopyridines (such as clopidogrel, ticlopidine, prasugrel) since cross-reactivity among thienopyridines has been reported.

Thienopyridines may cause mild to severe allergic reactions such as rash, angioedema, or haematological cross-reactions such as thrombocytopenia and neutropenia. Patients who had developed a previous allergic reaction and/or haematological reaction to one thienopyridine may have an increased risk of developing the same or another reaction to another thienopyridine. Monitoring for signs of hypersensitivity in patients with a known allergy to thienopyridines is advised.

Renal impairment

Therapeutic experience with clopidogrel is limited in patients with renal impairment. Therefore clopidogrel should be used with caution in these patients.

Hepatic impairment

Experience is limited in patients with moderate hepatic disease who may have bleeding diatheses. Clopidogrel should therefore be used with caution in this population.

Excipients

Plavix contains lactose. Patients with rare hereditary problems of galactose intolerance, total lactase deficiency or glucose-galactose malabsorption should not take this medicinal product.

This medicinal product contains hydrogenated castor oil which may cause stomach upset and diarrhoea.

Interaction with other medicinal products and other forms of interaction

Medicinal products associated with bleeding risk: There is an increased risk of bleeding due to the potential additive effect. The concomitant administration of medicinal products associated with bleeding risk should be undertaken with caution.

Oral anticoagulants: the concomitant administration of clopidogrel with oral anticoagulants is not recommended since it may increase the intensity of bleedings. Although the administration of clopidogrel 75 mg/day did not modify the pharmacokinetics of S-warfarin or International Normalised Ratio (INR) in patients receiving long-term warfarin therapy, coadministration of clopidogrel with warfarin increases the risk of bleeding because of independent effects on hemostasis.

Glycoprotein IIb/IIIa inhibitors: clopidogrel should be used with caution in patients who receive concomitant glycoprotein IIb/IIIa inhibitors.

Acetylsalicylic acid (ASA): ASA did not modify the clopidogrel-mediated inhibition of ADP-induced platelet aggregation, but clopidogrel potentiated the effect of ASA on collagen-induced platelet aggregation. However, concomitant administration of 500 mg of ASA twice a day for one day did not significantly increase the prolongation of bleeding time induced by clopidogrel intake. A pharmacodynamic interaction between clopidogrel and acetylsalicylic acid is possible, leading to increased risk of bleeding. Therefore, concomitant use should be undertaken with caution. However, clopidogrel and ASA have been administered together for up to one year.

Heparin: in a clinical study conducted in healthy subjects, clopidogrel did not necessitate modification of the heparin dose or alter the effect of heparin on coagulation. Co-administration of heparin had no effect on the inhibition of platelet aggregation induced by clopidogrel. A pharmacodynamic interaction between clopidogrel and heparin is possible, leading to increased risk of bleeding. Therefore, concomitant use should be undertaken with caution.

Thrombolytics: the safety of the concomitant administration of clopidogrel, fibrin or non-fibrin specific thrombolytic agents and heparins was assessed in patients with acute myocardial infarction. The incidence of clinically significant bleeding was similar to that observed when thrombolytic agents and heparin are co-administered with ASA.

NSAIDs: in a clinical study conducted in healthy volunteers, the concomitant administration of clopidogrel and naproxen increased occult gastrointestinal blood loss. However, due to the lack of interaction studies with other NSAIDs it is presently unclear whether there is an increased risk of gastrointestinal bleeding with all NSAIDs. Consequently, NSAIDs including Cox-2 inhibitors and clopidogrel should be co-administered with caution.

SSRIs: since SSRIs affect platelet activation and increase the risk of bleeding, the concomitant administration of SSRIs with clopidogrel should be undertaken with caution.

Other concomitant therapy:

Inducers of CYP2C19

Since clopidogrel is metabolised to its active metabolite partly by CYP2C19, use of medicinal products that induce the activity of this enzyme would be expected to result in increased drug levels of the active metabolite of clopidogrel.

Rifampicin strongly induces CYP2C19, resulting in both an increased level of clopidogrel active metabolite and platelet inhibition, which in particular might potentiate the risk of bleeding. As a precaution, concomitant use of strong CYP2C19 inducers should be discouraged (see *Special warnings and precautions for use*).

Inhibitors of CYP2C19

Since clopidogrel is metabolised to its active metabolite partly by CYP2C19, use of medicinal products that inhibit the activity of this enzyme would be expected to result in reduced drug levels of the active metabolite of clopidogrel. The clinical relevance of this interaction is uncertain. As a precaution concomitant use of strong or moderate CYP2C19 inhibitors should be discouraged.

Medicinal products that are strong or moderate CYP2C19 inhibitors include, for example, omeprazole and esomeprazole, fluvoxamine, fluoxetine, moclobemide, voriconazole, fluconazole, ticlopidine, , , carbamazepine,

Proton Pump Inhibitors (PPI): Omeprazole 80 mg once daily administered either at the same time as clopidogrel or with 12 hours between the administrations of the two drugs decreased the exposure of the active metabolite by 45% (loading dose) and 40% (maintenance dose). The decrease was associated with a 39% (loading dose) and 21% (maintenance dose) reduction of inhibition of platelet aggregation. Esomeprazole is expected to give a similar interaction with clopidogrel.

Inconsistent data on the clinical implications of this pharmacokinetic (PK)/pharmacodynamic (PD) interaction in terms of major cardiovascular events have been reported from both observational and clinical studies. As a precaution, concomitant use of omeprazole or esomeprazole should be discouraged.

Less pronounced reductions of metabolite exposure has been observed with pantoprazole or lansoprazole.

The plasma concentrations of the active metabolite was 20% reduced (loading dose) and 14% reduced (maintenance dose) during concomitant treatment with pantoprazole 80 mg once daily. This was associated with a reduction of the mean inhibition of platelet aggregation by 15% and 11%, respectively. These results indicate that clopidogrel can be administered with pantoprazole.

There is no evidence that other medicinal products that reduce stomach acid such as H₂ blockers (except cimetidine which is a CYP2C19 inhibitor) or antacids interfere with antiplatelet activity of clopidogrel.

Other medicinal products: A number of other clinical studies have been conducted with clopidogrel and other concomitant medicinal products to investigate the potential for pharmacodynamic and pharmacokinetic interactions. No clinically significant pharmacodynamic interactions were observed when clopidogrel was co-administered with atenolol, nifedipine, or both atenolol and nifedipine.

Furthermore, the pharmacodynamic activity of clopidogrel was not significantly influenced by the coadministration of phenobarbital, cimetidine, or oestrogen.

The pharmacokinetics of digoxin or theophylline were not modified by the co-administration of clopidogrel. Antacids did not modify the extent of clopidogrel absorption.

Data from the CAPRIE study indicate that phenytoin and tolbutamide which are metabolised by CYP2C9 can be safely co-administered with clopidogrel.

CYP2C8 substrate medicinal products: Clopidogrel has been shown to increase repaglinide exposure in healthy volunteers. In vitro studies have shown the increase in repaglinide exposure is due to inhibition of CYP2C8 by the glucuronide metabolite of clopidogrel. Due to the risk of increased plasma concentrations, concomitant administration of clopidogrel and drugs primarily cleared by CYP2C8 metabolism (e.g., repaglinide, paclitaxel) should be undertaken with caution.

Apart from the specific medicinal product interaction information described above, interaction studies with clopidogrel and some medicinal products commonly administered in patients with atherothrombotic disease have not been performed. However, patients entered into clinical trials with clopidogrel received a variety of concomitant medicinal products including diuretics, beta blockers, ACEI, calcium antagonists, cholesterol lowering agents, coronary vasodilators, antidiabetic agents (including insulin), antiepileptic agents and GPIIb/IIIa antagonists without evidence of clinically significant adverse interactions.

As with other oral P2Y₁₂ inhibitors, co-administration of opioid agonists has the potential to delay and reduce the absorption of clopidogrel presumably because of slowed gastric emptying. The clinical relevance is unknown. Consider the use of a parenteral antiplatelet agent in acute coronary syndrome patients requiring co-administration of morphine or other opioid agonists.

Rosuvastatin: Clopidogrel has been shown to increase rosuvastatin exposure in patients by 2-fold (AUC) and 1.3-fold (C_{max}) after administration of a 300 mg clopidogrel dose, and by 1.4 fold (AUC) without effect on C_{max} after repeated administration of a 75 mg clopidogrel dose.

Fertility, pregnancy and lactation

Pregnancy

As no clinical data on exposure to clopidogrel during pregnancy are available, it is preferable not to use clopidogrel during pregnancy as a precautionary measure.

Animal studies do not indicate direct or indirect harmful effects with respect to pregnancy, embryonal/foetal development, parturition or postnatal development (see "*Preclinical safety data*").

Breastfeeding

It is unknown whether clopidogrel is excreted in human breast milk. Animal studies have shown excretion of clopidogrel in breast milk. As a precautionary measure, breast-feeding should not be continued during treatment with Plavix.

Fertility

Clopidogrel was not shown to alter fertility in animal studies.

Effects on ability to drive and use machines

Clopidogrel has no or negligible influence on the ability to drive and use machines.

Undesirable effects

Summary of the safety profile

Clopidogrel has been evaluated for safety in more than 44,000 patients who have participated in clinical studies, including over 12,000 patients treated for 1 year or more. Overall, clopidogrel 75 mg/day was comparable to ASA 325 mg/day in CAPRIE regardless of age, gender and race. The clinically relevant adverse reactions observed in the CAPRIE, CURE, CLARITY, COMMIT and ACTIVE-A

studies are discussed below. In addition to clinical studies experience, adverse reactions have been spontaneously reported.

Bleeding is the most common reaction reported both in clinical studies as well as in post-marketing experience where it was mostly reported during the first month of treatment.

In CAPRIE, in patients treated with either clopidogrel or ASA, the overall incidence of any bleeding was 9.3%. The incidence of severe cases was similar for clopidogrel and ASA.

In CURE, there was no excess in major bleeds with clopidogrel plus ASA within 7 days after coronary bypass graft surgery in patients who stopped therapy more than five days prior to surgery. In patients who remained on therapy within five days of bypass graft surgery, the event rate was 9.6% for clopidogrel plus ASA, and 6.3% for placebo plus ASA.

In CLARITY, there was an overall increase in bleeding in the clopidogrel plus ASA group vs. the placebo plus ASA group. The incidence of major bleeding was similar between groups. This was consistent across subgroups of patients defined by baseline characteristics, and type of fibrinolytic or heparin therapy.

In COMMIT, the overall rate of noncerebral major bleeding or cerebral bleeding was low and similar in both groups.

In ACTIVE-A, the rate of major bleeding was greater in the clopidogrel + ASA group than in the placebo + ASA group (6.7% versus 4.3%). Major bleeding was mostly of extracranial origin in both groups (5.3% in the clopidogrel + ASA group; 3.5% in the placebo +ASA group), mainly from the gastrointestinal tract (3.5% vs. 1.8%). There was an excess of intracranial bleeding in the clopidogrel + ASA treatment group compared to the placebo + ASA group (1.4% versus 0.8%, respectively). There was no statistically significant difference in the rates of fatal bleeding (1.1% in the clopidogrel + ASA group and 0.7% in the placebo +ASA group) and haemorrhagic stroke (0.8% and 0.6%, respectively) between groups.

In TARDIS, patients with recent ischemic stroke receiving intensive antiplatelet therapy with three medicinal products (ASA + clopidogrel + dipyridamole) had more bleeding and bleeding of greater severity when compared with either clopidogrel alone or combined ASA and dipyridamole (adjusted common OR 2.54, 95% CI 2.05-3.16, $p < 0.0001$).

Tabulated list of adverse reactions

Adverse reactions that occurred either during clinical studies or that were spontaneously reported are presented in the table below. Their frequency is defined using the following conventions: common ($\geq 1/100$ to $< 1/10$); uncommon ($\geq 1/1,000$ to $< 1/100$); rare ($\geq 1/10,000$ to $< 1/1,000$); very rare ($< 1/10,000$), not known (cannot be estimated from the available data). Within each system organ class, adverse reactions are presented in order of decreasing seriousness.

System Organ Class	Common	Uncommon	Rare	Very Rare, Not Known*
Blood and the lymphatic system disorders		Thrombocytopenia, leucopenia, eosinophilia	Neutropenia, including severe neutropenia	Thrombotic thrombocytopenic purpura (TTP), aplastic, anaemia, pancytopenia, agranulocytosis, severe thrombocytopenia, acquired haemophilia,

				Agranulocytopenia, anaemia
Cardiac Disorders				Kounis syndrome (vasospastic allergic angina / allergic myocardial infarction) in the context of a hypersensitivity reaction due to clopidogrel*
Immune system disorders				Serum sickness, anaphylactoid reactions, Cross-reactive drug hypersensitivity among thienopyridines (such as ticlopidine, prasugrel) Insulin autoimmune syndrome, which can lead to severe hypoglycemia, particularly in patients with HLA DRA4 subtype (more frequent in the Japanese population)
Psychiatric disorders				Hallucinations, confusion
Nervous system disorders		Intracranial bleeding (some cases were reported with fatal outcome), headache, paraesthesia, dizziness		Taste disturbances, ageusia
Eye disorders		Eye bleeding (conjunctival, ocular, retinal)		
Ear and labyrinth disorders			Vertigo	
Vascular disorders	Haematoma			Serious haemorrhage, haemorrhage of operative wound, vasculitis, hypotension
Respiratory, thoracic and mediastinal disorders	Epistaxis			Respiratory tract bleeding (haemoptysis, pulmonary haemorrhage), bronchospasm, interstitial pneumonitis, eosinophilic pneumonia

Gastrointestinal disorders	Gastrointestinal haemorrhage, diarrhoea, abdominal pain, dyspepsia	Gastric ulcer and duodenal ulcer, gastritis, vomiting, nausea, constipation, flatulence	Retroperitoneal haemorrhage	Gastrointestinal and retroperitoneal haemorrhage with fatal outcome, pancreatitis, colitis (including ulcerative or lymphocytic colitis), stomatitis
Hepato-biliary disorders				Acute liver failure, hepatitis, abnormal liver function test
Skin and subcutaneous tissue disorders	Bruising	Rash, pruritus, skin bleeding (purpura)		acute generalised exanthematous pustulosis (AGEP)), angioedema, drug-induced hypersensitivity syndrome, drug rash with eosinophilia and systemic symptoms (DRESS), rash erythematous or exfoliative, urticaria, eczema, lichen planus
Reproductive systems and breast disorders			Gynaecomastia	
Musculoskeletal, connective tissue and bone disorders				Musculo-skeletal bleeding (haemarthrosis), arthritis, arthralgia, myalgia
Renal and urinary disorders		Haematuria		Glomerulonephritis, blood creatinine increased
General disorders and administration site conditions	Bleeding at puncture site			Fever
Investigations		Bleeding time prolonged, neutrophil count decreased, platelet count decreased		

* Information related to clopidogrel with frequency “not known”.

Healthcare professionals are asked to report any suspected adverse reaction via farmakovigilans@kalventis.com and Pusat Farmakovigilans/MESO Nasional Direktorat Pengawasan Keamanan, Mutu, dan Ekspor Impor Obat, Narkotika, Psikotropika, Prekursor dan Zat Adiktif Badan Pengawas Obat dan Makanan.

Jl. Percetakan Negara No. 23, Jakarta Pusat, 10560

Email: pv-center@pom.go.id
Phone: +62-21-4244691 Ext. 1079
Website: <https://e-meso.pom.go.id/>.

Overdose

Overdose following clopidogrel administration may lead to prolonged bleeding time and subsequent bleeding complications. Appropriate therapy should be considered if bleedings are observed. No antidote to the pharmacological activity of clopidogrel has been found. If prompt correction of prolonged bleeding time is required, platelet transfusion may reverse the effects of clopidogrel.

PHARMACOLOGICAL PROPERTIES

Pharmacodynamic properties

Pharmacotherapeutic group: Platelet aggregation inhibitors excl. Heparin, ATC Code: B01AC-04.

Clopidogrel is a prodrug, one of whose metabolites is an inhibitor of platelet aggregation. Clopidogrel must be metabolized by CYP450 enzymes to produce the active metabolite that inhibits platelet aggregation. The active metabolite of clopidogrel selectively inhibits the binding of adenosine diphosphate (ADP) to its platelet P2Y₁₂ receptor, and the subsequent ADP-mediated activation of the glycoprotein GPIIb/IIIa complex, thereby inhibiting platelet aggregation. Due to the irreversible binding, platelets exposed are affected for the remainder of their lifespan (approximately 7-10 days) and recovery of normal platelet function occurs at a rate consistent with platelet turnover. Platelet aggregation induced by agonist other than ADP is also inhibited by blocking the amplification of platelet activation by released ADP.

Because the active metabolite is formed by CYP450 enzymes, some of which are polymorphic or subject to inhibition by other drugs, not all patients will have adequate platelet inhibition.

Repeated doses of 75 mg per day produced substantial inhibition of ADP-induced platelet aggregation from the first day; this increased progressively and reached steady state between Day 3 and Day 7. At steady state, the average inhibition level observed with a dose of 75 mg per day was between 40% and 60%. Platelet aggregation and bleeding time gradually returned to baseline values, generally within 5 days after treatment was discontinued.

The safety and efficacy of clopidogrel have been evaluated in 7 double-blind studies involving over 100,000 patients; the CAPRIE study, a comparison of clopidogrel to ASA, and the CURE, CLARITY, COMMIT, CHANCE, POINT and ACTIVE-A studies comparing clopidogrel to placebo, both medicinal products given in combination with ASA and other standard therapy.

Recent myocardial infarction (MI), recent stroke or established peripheral arterial disease

The CAPRIE study included 19,185 patients with atherothrombosis as manifested by recent MI (<35 days), recent ischaemic stroke (between 7 days and 6 months) or established peripheral arterial disease (PAD). Patients were randomised to clopidogrel 75 mg/day or ASA 325 mg/day, and were followed for 1 to 3 years. In the myocardial infarction subgroup, most of the patients received ASA for the first few days following the acute myocardial infarction.

Clopidogrel significantly reduced the incidence of new ischaemic events (combined end point of myocardial infarction, ischaemic stroke and vascular death) when compared to ASA. In the intention to treat analysis, 939 events were observed in the clopidogrel group and 1,020 events with ASA (relative risk reduction (RRR) 8.7%, [95% CI: 0.2 to 16.4]; p=0.045), which corresponds, for every 1000 patients treated for 2 years, to 10 [CI: 0 to 20] additional patients being prevented from

experiencing a new ischaemic event. Analysis of total mortality as a secondary endpoint did not show any significant difference between clopidogrel (5.8%) and ASA (6.0%).

In a subgroup analysis by qualifying condition (myocardial infarction, ischaemic stroke, and PAD) the benefit appeared to be strongest (achieving statistical significance at $p=0.003$) in patients enrolled due to PAD (especially those who also had a history of myocardial infarction) (RRR = 23.7%; CI: 8.9 to 36.2) and weaker (not significantly different from ASA) in stroke patients (RRR = 7.3%; CI: -5.7 to 18.7 [$p=0.258$]). In patients who were enrolled in the trial on the sole basis of a recent myocardial infarction, clopidogrel was numerically inferior, but not statistically different from ASA (RRR = -4.0%; CI: -22.5 to 11.7 [$p=0.639$]). In addition, a subgroup analysis by age suggested that the benefit of clopidogrel in patients over 75 years was less than that observed in patients ≤ 75 years.

Since the CAPRIE trial was not powered to evaluate efficacy of individual subgroups, it is not clear whether the differences in relative risk reduction across qualifying conditions are real, or a result of chance.

Acute coronary syndrome

The CURE study included 12,562 patients with non-ST segment elevation acute coronary syndrome (unstable angina or non-Q-wave myocardial infarction), and presenting within 24 hours of onset of the most recent episode of chest pain or symptoms consistent with ischaemia. Patients were required to have either ECG changes compatible with new ischaemia or elevated cardiac enzymes or troponin I or T to at least twice the upper limit of normal. Patients were randomised to clopidogrel (300 mg loading dose followed by 75 mg/day, N=6,259) or placebo (N=6,303), both given in combination with ASA (75-325 mg once daily) and other standard therapies. Patients were treated for up to one year. In CURE, 823 (6.6%) patients received concomitant GPIIb/IIIa receptor antagonist therapy. Heparins were administered in more than 90% of the patients and the relative rate of bleeding between clopidogrel and placebo was not significantly affected by the concomitant heparin therapy.

The number of patients experiencing the primary endpoint [cardiovascular (CV) death, myocardial infarction (MI), or stroke] was 582 (9.3%) in the clopidogrel-treated group and 719 (11.4%) in the placebo-treated group, a 20% relative risk reduction (95% CI of 10%-28%; $p=0.00009$) for the clopidogrel-treated group (17% relative risk reduction when patients were treated conservatively, 29% when they underwent PTCA with or without stent and 10% when they underwent CABG). New cardiovascular events (primary endpoint) were prevented, with relative risk reductions of 22% (CI: 8.6, 33.4), 32% (CI: 12.8, 46.4), 4% (CI: -26.9, 26.7), 6% (CI: -33.5, 34.3) and 14% (CI: -31.6, 44.2), during the 0-1, 1-3, 3-6, 6-9 and 9-12 month study intervals, respectively. Thus, beyond 3 months of treatment, the benefit observed in the clopidogrel + ASA group was not further increased, whereas the risk of haemorrhage persisted (see section 4.4).

The use of clopidogrel in CURE was associated with a decrease in the need of thrombolytic therapy (RRR = 43.3%; CI: 24.3%, 57.5%) and GPIIb/IIIa inhibitors (RRR = 18.2%; CI: 6.5%, 28.3%).

The number of patients experiencing the co-primary endpoint (CV death, MI, stroke or refractory ischaemia) was 1035 (16.5%) in the clopidogrel-treated group and 1187 (18.8%) in the placebo-treated group, a 14% relative risk reduction (95% CI of 6%-21%, $p=0.0005$) for the clopidogrel-treated group. This benefit was mostly driven by the statistically significant reduction in the incidence of MI [287 (4.6%) in the clopidogrel treated group and 363 (5.8%) in the placebo treated group]. There was no observed effect on the rate of rehospitalisation for unstable angina.

The results obtained in populations with different characteristics (e.g. unstable angina or non-Q-wave MI, low to high risk levels, diabetes, need for revascularisation, age, gender, etc.) were consistent with the results of the primary analysis. In particular, in a post-hoc analysis in 2172 patients (17% of the

total CURE population) who underwent stent placement (Stent-CURE), the data showed that clopidogrel compared to placebo, demonstrated a significant RRR of 26.2% favouring clopidogrel for the co-primary endpoint (CV death, MI, stroke) and also a significant RRR of 23.9% for the second co-primary endpoint (CV death, MI, stroke or refractory ischaemia). Moreover, the safety profile of clopidogrel in this subgroup of patients did not raise any particular concern. Thus, the results from this subset are in line with the overall trial results.

The benefits observed with clopidogrel were independent of other acute and long-term cardiovascular therapies (such as heparin/LMWH, GPIIb/IIIa antagonists, lipid lowering medicinal products, beta blockers, and ACE-inhibitors). The efficacy of clopidogrel was observed independently of the dose of ASA (75-325 mg once daily).

ST-segment Elevation Myocardial Infarction

In patients with acute ST-segment elevation MI (STEMI), safety and efficacy of clopidogrel have been evaluated in 2 randomised, placebo-controlled, double-blind studies, CLARITY, a prospective subgroup analysis of CLARITY (CLARITY PCI) and COMMIT.

The CLARITY trial included 3,491 patients presenting within 12 hours of the onset of a ST elevation MI and planned for thrombolytic therapy. Patients received clopidogrel (300 mg loading dose, followed by 75 mg/day, n=1752) or placebo (n=1739), both in combination with ASA (150 to 325 mg as a loading dose, followed by 75 to 162 mg/day), a fibrinolytic agent and, when appropriate, heparin. The patients were followed for 30 days. The primary endpoint was the occurrence of the composite of an occluded infarct-related artery on the predischARGE angiogram, or death or recurrent MI before coronary angiography. For patients who did not undergo angiography, the primary endpoint was death or recurrent myocardial infarction by Day 8 or by hospital discharge. The patient population included 19.7% women and 29.2% patients \geq 65 years. A total of 99.7% of patients received fibrinolytics (fibrin specific: 68.7%, non-fibrin specific: 31.1%), 89.5% heparin, 78.7% beta blockers, 54.7% ACE inhibitors and 63% statins.

Fifteen percent (15.0%) of patients in the clopidogrel group and 21.7% in the placebo group reached the primary endpoint, representing an absolute reduction of 6.7% and a 36% odds reduction in favor of clopidogrel (95% CI: 24, 47%; $p < 0.001$), mainly related to a reduction in occluded infarct-related arteries. This benefit was consistent across all prespecified subgroups including patients' age and gender, infarct location, and type of fibrinolytic or heparin used.

CLARITY PCI sub-group analysis involved 1,863 STEMI patients undergoing PCI. Patients receiving 300 mg loading dose (LD) of clopidogrel (n=933) had a significant reduction in incidence of cardiovascular death, MI or stroke following PCI compared to those receiving placebo (n=930) (3.6% with clopidogrel pre-treatment versus 6.2% with placebo, OR: 0.54; 95% CI: 0.35-0.85; $p = 0.008$). The patients receiving 300 mg LD of clopidogrel had a significant reduction in incidence of cardiovascular death, MI or stroke through 30 days following PCI compared to those receiving placebo (7.5% with clopidogrel pre-treatment versus 12.0% with placebo, OR: 0.59; 95% CI: 0.43-0.81; $p = 0.001$). However, this composite endpoint when assessed in the overall population of the CLARITY study was not statistically significant as a secondary endpoint. No significant difference was observed in the rates of major or minor bleeding between both the treatments (2.0% with clopidogrel pre-treatment versus 1.9% with placebo, $p > 0.99$). The findings of this analysis support the early use of clopidogrel loading dose in STEMI and the strategy of routine clopidogrel pretreatment in patients undergoing PCI.

The 2x2 factorial design COMMIT trial included 45,852 patients presenting within 24 hours of the onset of the symptoms of suspected MI with supporting ECG abnormalities (i.e. ST elevation, ST depression or left bundle-branch block). Patients received clopidogrel (75 mg/day, n=22,961) or

placebo (n=22,891), in combination with ASA (162 mg/day), for 28 days or until hospital discharge. The co-primary endpoints were death from any cause and the first occurrence of re-infarction, stroke or death. The population included 27.8% women, 58.4% patients ≥ 60 years (26% ≥ 70 years) and 54.5% patients who received fibrinolytics.

Clopidogrel significantly reduced the relative risk of death from any cause by 7% ($p=0.029$), and the relative risk of the combination of re-infarction, stroke or death by 9% ($p=0.002$), representing an absolute reduction of 0.5% and 0.9%, respectively. This benefit was consistent across age, gender and with or without fibrinolytics, and was observed as early as 24 hours.

Clopidogrel 600 mg Loading Dose in Acute Coronary Syndrome Patients Undergoing PCI

CURRENT-OASIS-7 (Clopidogrel and Aspirin Optimal Dose Usage to Reduce Recurrent Events Seventh Organization to Assess Strategies in Ischemic Syndromes)

This randomized factorial trial included 25,086 individuals with acute coronary syndrome (ACS) intended for early PCI. Patients were randomly assigned to either double-dose (600 mg on Day 1, then 150 mg on Days 2–7, then 75 mg daily) versus standard-dose (300 mg on day 1 then 75 mg daily) clopidogrel, and high-dose (300–325 mg daily) versus low-dose (75–100 mg daily) ASA. The 24,835 enrolled ACS patients underwent coronary angiography and 17,263 received PCI. Among the 17,263 patients receiving PCI treatment, when compared with the standard dose, double-dose clopidogrel reduced the rate of the primary endpoint (3.9% vs 4.5% adjusted HR= 0.86, 95% CI 0.74-0.99, $p=0.039$) and significantly reduced stent thrombosis (1.6% vs 2.3%, HR: 0.68; 95% CI: 0.55-0.85; $p=0.001$). Major bleeding was more common with double-dose than with standard-dose clopidogrel (1.6% vs 1.1%, HR=1.41, 95% CI 1.09-1.83, $p=0.009$). In this trial, clopidogrel 600 mg loading dose has shown consistent efficacy in patients age ≥ 75 years of age and patients <75 years of age.

ARMYDA-6 MI (The Antiplatelet therapy for Reduction of MYocardial Damage during Angioplasty - Myocardial Infarction)

This randomized, prospective, international, multicenter trial evaluated pre-treatment with a 600 mg versus 300 mg clopidogrel LD in the setting of urgent PCI for STEMI. Patients received a clopidogrel 600 mg LD (n=103) or clopidogrel 300 mg LD (n=98) prior to PCI, then were prescribed 75 mg/day from the day after PCI up to 1 year. Patients receiving a 600 mg LD of clopidogrel had a significantly reduced infarct size compared to those receiving a 300 mg LD. There was less frequent thrombolysis in MI flow Grade <3 after PCI in 600 mg LD (5.8% versus 16.3%, $p=0.031$), improved LVEF at discharge ($52.1 \pm 9.5\%$ versus $48.8 \pm 11.3\%$, $p=0.026$), and 30-day major adverse cardiovascular events were fewer (5.8% versus 15%, $p=0.049$). No increase in bleeding or entry-site complications were observed (secondary endpoints at Day 30).

HORIZONS-AMI (Harmonizing Outcomes with Revascularization and Stents in Acute Myocardial Infarction)

This post-hoc analysis trial was conducted to evaluate whether a 600 mg clopidogrel LD provides faster and greater inhibition of platelet activation. The analysis examined the impact of a LD of 600 mg compared with 300 mg on 30-day clinical outcomes in 3,311 patients from the main trial (n=1,153; 300 mg LD group; n=2,158; 600 mg LD group) before cardiac catheterization followed by 75 mg/day dose for ≥ 6 months post-discharge. The results showed significantly lower 30-day unadjusted rates of mortality (1.9% versus 3.1%, $p=0.03$), reinfarction (1.3% versus 2.3%, $p=0.02$), and definite or probable stent thrombosis (1.7% versus 2.8%, $p=0.04$) with the 600 mg LD without higher bleeding rates. By multivariable analysis, a 600 mg LD was an independent predictor of lower rates of 30-day major adverse cardiac events (HR: 0.72 [95% CI: 0.53–0.98], $p=0.04$). Major bleeding rate (non-CABG related) was 6.1% in 600 mg LD group and 9.4% in 300 mg LD group ($p=0.0005$). Minor bleeding rate was 11.3% in 600 mg LD group and 13.8% in 300 mg LD group ($p=0.03$).

Long Term (12 Months) Treatment with Clopidogrel in STEMI Patients after PCI

CREDO (Clopidogrel for the Reduction of Adverse Events During Observation)

This randomized, double-blind, placebo-controlled trial was conducted in the United States and Canada to evaluate the benefit of long-term (12 month) treatment with clopidogrel after PCI. There were 2,116 patients randomized to receive a 300 mg clopidogrel LD (n=1,053) or placebo (n=1,063) 3 to 24 hours before PCI. All patients also received 325 mg of aspirin. Thereafter, all patients received clopidogrel 75 mg/day through Day 28 in both groups. From Day 29 through 12 months, patients in clopidogrel group received 75 mg/day clopidogrel and in control group received placebo. Both groups received ASA throughout the study (81 to 325 mg/day). At 1-year, significant reduction in the combined risk of death, MI or stroke was observed with clopidogrel (26.9% relative reduction, 95% CI: 3.9%-44.4%; p=0.02; absolute reduction 3%) compared to placebo. No significant increase in the rate of major bleeding (8.8% with clopidogrel versus 6.7% with placebo, p=0.07) or minor bleeding (5.3% with clopidogrel versus 5.6% with placebo, p=0.84) at 1-year was observed. The major finding of this study is that continuation of clopidogrel and ASA for at least 1-year leads to a statistically and clinically significant reduction in major thrombotic events.

EXCELLENT (Efficacy of Xience/Promus Versus Cypher to Reduce Late Loss After Stenting)

This prospective, open-label, randomized trial was conducted in Korea to evaluate whether 6-month dual antiplatelet therapy (DAPT) would be noninferior to 12-month DAPT after implantation of drug-eluting stents. The study included 1,443 patients undergoing implantation who were randomized to receive 6-month DAPT (ASA 100–200 mg/day plus clopidogrel 75 mg/day for 6 months and thereafter ASA alone up to 12 months) or 12-month DAPT (ASA 100–200 mg/day plus clopidogrel 75 mg/day for 12 months). No significant difference was observed in the incidence of target vessel failure (composite of cardiac death, MI or target vessel revascularization) which was primary end point between 6-month and 12-month DAPT groups (HR: 1.14; 95% CI: 0.70-1.86; p=0.60). Also, the study showed no significant difference in the safety end point (composite of death, MI, stroke, stent thrombosis or TIMI major bleeding) between 6-month and 12-month DAPT groups (HR: 1.15; 95% CI: 0.64-2.06; p=0.64). The major finding of this study was that 6-month DAPT was non-inferior to 12-month DAPT in the risk of target vessel failure.

De-escalation of P2Y₁₂ Inhibitor Agents in ACS

Switching from a more potent P2Y₁₂ receptor inhibitor to clopidogrel in association with aspirin after acute phase in ACS has been evaluated in two randomized investigator-sponsored studies (ISS) – TOPIC and TROPICAL-ACS – with clinical outcome data.

The clinical benefit provided by the more potent P2Y₁₂ inhibitors, ticagrelor and prasugrel, in their pivotal studies is related to a significant reduction in recurrent ischaemic events (including acute and subacute stent thrombosis (ST), myocardial infarction (MI), and urgent revascularization). Although the ischaemic benefit was consistent throughout the first year, greater reduction in ischaemic recurrence after ACS was observed during the initial days following the treatment initiation. In contrast, *post-hoc* analyses demonstrated statistically significant increases in the bleeding risk with the more potent P2Y₁₂ inhibitors, occurring predominantly during the maintenance phase, after the first month post-ACS. TOPIC and TROPICAL-ACS were designed to study how to mitigate the bleeding events while maintaining efficacy.

TOPIC (Timing Of Platelet Inhibition after acute Coronary syndrome)

This randomized, open-label trial included ACS patients requiring PCI. Patients on aspirin and a more potent P2Y₁₂ blocker and without adverse event at one month were assigned to switch to fixed-dose aspirin plus clopidogrel (de-escalated dual antiplatelet therapy (DAPT)) or continuation of their drug regimen (unchanged DAPT).

Overall, 645 of 646 patients with STEMI or NSTEMI or unstable angina were analyzed (de-escalated DAPT (n=322); unchanged DAPT (n=323)). Follow-up at one year was performed for 316 patients (98.1%) in the de-escalated DAPT group and 318 patients (98.5%) in the unchanged DAPT group. The median follow-up for both groups was 359 days. The characteristics of the studied cohort were similar in the 2 groups.

The primary outcome, a composite of cardiovascular death, stroke, urgent revascularization, and BARC (Bleeding Academic Research Consortium) bleeding ≥ 2 at 1 year post ACS, occurred in 43 patients (13.4%) in the de-escalated DAPT group and in 85 patients (26.3%) in the unchanged DAPT group ($p < 0.01$). This statistically significant difference was mainly driven by fewer bleeding events, with no difference reported in ischaemic endpoints ($p = 0.36$), while BARC ≥ 2 bleeding occurred less frequently in the de-escalated DAPT group (4.0%) versus 14.9% in the unchanged DAPT group ($p < 0.01$). Bleeding events defined as all BARC occurred in 30 patients (9.3%) in the de-escalated DAPT group and in 76 patients (23.5%) in the unchanged DAPT group ($p < 0.01$).

TROPICAL-ACS (*Testing Responsiveness to Platelet Inhibition on Chronic Antiplatelet Treatment for Acute Coronary Syndromes*)

This randomized, open-label trial included 2,610 biomarker-positive ACS patients after successful PCI. Patients were randomized to receive either prasugrel 5 or 10 mg/d (Days 0-14) (n=1306), or prasugrel 5 or 10 mg/d (Days 0-7) then de-escalated to clopidogrel 75 mg/d (Days 8-14) (n=1304), in combination with ASA (< 100 mg/day). At Day 14, platelet function testing (PFT) was performed. The prasugrel-only patients were continued on prasugrel for 11.5 months.

The de-escalated patients underwent high platelet reactivity (HPR) testing. If $HPR \geq 46$ units, the patients were escalated back to prasugrel 5 or 10 mg/d for 11.5 months; if $HPR < 46$ units, the patients continued on clopidogrel 75 mg/d for 11.5 months. Therefore, the guided de-escalation arm had patients on either prasugrel (40%) or clopidogrel (60%). All patients were continued on aspirin and were followed for one year.

The primary endpoint (the combined incidence of CV death, MI, stroke and BARC bleeding grade ≥ 2 at 12 months) was met showing non-inferiority. Ninety five patients (7%) in the guided de-escalation group and 118 patients (9%) in the control group (p non-inferiority=0.0004) had an event. The guided de-escalation did not result in an increased combined risk of ischemic events (2.5% in the de-escalation group vs 3.2% in the control group; p non-inferiority=0.0115), nor in the key secondary endpoint of BARC bleeding ≥ 2 (5%) in the de-escalation group versus 6% in the control group ($p = 0.23$). The cumulative incidence of all bleeding events (BARC class 1 to 5) was 9% (114 events) in the guided de-escalation group versus 11% (137 events) in the control group ($p = 0.14$).

Dual Antiplatelet Therapy (DAPT) in Acute Minor IS or Moderate to High-risk TIA

DAPT with combination clopidogrel and ASA as a treatment to prevent stroke after an acute minor IS or moderate to high-risk TIA has been evaluated in two randomized investigator-sponsored studies (ISS) – CHANCE and POINT – with clinical safety and efficacy outcome data.

CHANCE (*Clopidogrel in High-risk patients with Acute Non-disabling Cerebrovascular Events*)

This randomized, double-blinded, multicenter, placebo-controlled clinical trial included 5,170 Chinese patients with acute TIA (ABCD2 score ≥ 4) or acute minor stroke (NIHSS ≤ 3). Patients in both groups received open-label ASA on day 1 (with the dose ranging from 75 to 300 mg, at the discretion of the treating physician). Patients randomly assigned to the clopidogrel-ASA group received a loading dose of 300 mg of clopidogrel on day 1, followed by a dose of 75 mg of clopidogrel per day on days 2 through 90, and ASA at a dose of 75 mg per day on days 2 through 21. Patients randomly assigned to the ASA group received a placebo version of clopidogrel on days 1 through 90 and ASA at a dose of 75 mg per day on days 2 through 90.

The primary efficacy outcome was any new stroke event (ischemic and hemorrhagic) in the first 90 days after acute minor IS or high-risk TIA. This occurred in 212 patients (8.2%) in the clopidogrel-ASA group compared with 303 patients (11.7%) in the ASA group (hazard ratio [HR], 0.68; 95% confidence interval [CI], 0.57 to 0.81; $P < 0.001$). IS occurred in 204 patients (7.9%) in the clopidogrel-ASA group compared with 295 (11.4%) in the ASA group (HR, 0.67; 95% CI, 0.56 to 0.81; $P < 0.001$). Hemorrhagic stroke occurred in 8 patients in each of the two study groups (0.3% of each group). Moderate or severe hemorrhage occurred in seven patients (0.3%) in the clopidogrel-ASA group and in eight (0.3%) in the ASA group ($P = 0.73$). The rate of any bleeding event was 2.3% in the clopidogrel-ASA group as compared with 1.6% in the ASA group (HR, 1.41; 95% CI, 0.95 to 2.10; $P = 0.09$).

POINT (Platelet-Oriented Inhibition in New TIA and Minor Ischemic Stroke)

This randomized, double-blinded, multicenter, placebo-controlled clinical trial included 4,881 international patients with acute TIA (ABCD2 score ≥ 4) or minor stroke (NIHSS ≤ 3). All patients in both groups received open-label ASA on day 1 to 90 (50-325 mg depending upon the discretion of the treating physician). Patients randomly assigned to the clopidogrel group received a loading dose of 600 mg of clopidogrel on day 1, followed by 75 mg of clopidogrel per day on days 2 through 90. Patients randomly assigned to the placebo group received clopidogrel placebo on days 1 through 90.

The primary efficacy outcome was a composite of major ischemic events (IS, MI or death from an ischemic vascular event) at day 90. This occurred in 121 patients (5.0%) receiving clopidogrel plus ASA compared with 160 patients (6.5%) receiving ASA alone (HR, 0.75; 95% CI, 0.59 to 0.95; $P = 0.02$). The secondary outcome of IS occurred in 112 patients (4.6%) receiving clopidogrel plus ASA compared with 155 patients (6.3%) receiving ASA alone (HR, 0.72; 95% CI, 0.56 to 0.92; $P = 0.01$). The primary safety outcome of major hemorrhage occurred in 23 of 2,432 patients (0.9%) receiving clopidogrel plus ASA and in 10 of 2,449 patients (0.4%) receiving ASA alone (HR, 2.32; 95% CI, 1.10 to 4.87; $P = 0.02$). Minor hemorrhage occurred in 40 patients (1.6%) receiving clopidogrel plus ASA and in 13 (0.5%) receiving ASA alone (HR, 3.12; 95% CI, 1.67 to 5.83; $P < 0.001$).

CHANCE and POINT Time Course Analysis

There was no efficacy benefit of continuing DAPT beyond 21 days. A time-course distribution of major ischemic events and major hemorrhages by treatment assignment was done to analyze the impact of the short-term time-course of DAPT.

Table 1- Time course distribution of major ischemic events and major hemorrhages by treatment assignment in CHANCE and POINT

Outcomes in CHANCE and POINT	Treatment assignment	No. of events			
		Total	1 st week	2 nd week	3 rd week
Major ischemic events	ASA (n=5,035)	458	330	36	21
	CLP+ASA(n=5,016)	328	217	30	14
	Difference	130	113	6	7
Major Hemorrhage	ASA (n=5,035)	18	4	2	1
	CLP+ASA(n=5,016)	30	10	4	2
	Difference	-12	-6	-2	-1

Paediatric population

The European Medicines Agency has deferred the obligation to submit the results of studies with Plavix in one or more subsets of the paediatric population for the prevention of thromboembolic events.

Pharmacokinetic properties

Absorption

After single and repeated oral doses of 75 mg per day, clopidogrel is rapidly absorbed. Mean peak plasma levels of unchanged clopidogrel (approximately 2.2-2.5 ng/ml after a single 75 mg oral dose) occurred approximately 45 minutes after dosing. Absorption is at least 50%, based on urinary excretion of clopidogrel metabolites.

Distribution

Clopidogrel and the main circulating (inactive) metabolite bind reversibly *in vitro* to human plasma proteins (98% and 94% respectively). The binding is non-saturable *in vitro* over a wide concentration range.

Metabolism

Clopidogrel is extensively metabolized by the liver. *In vitro* and *in vivo*, clopidogrel is metabolized according to two main metabolic pathways: one mediated by esterases and leading to hydrolysis into its inactive carboxylic acid derivative (85% of circulating metabolites), and one mediated by multiple cytochromes P450. Clopidogrel is first metabolised to a 2-oxo-clopidogrel intermediate metabolite. Subsequent metabolism of the 2-oxo-clopidogrel intermediate metabolite results in formation of the active metabolite, a thiol derivative of clopidogrel. The active metabolite is formed mostly by CYP2C19 with contributions from several other CYP enzymes, including CYP1A2, CYP2B6 and CYP3A4. The active thiol metabolite which has been isolated *in vitro*, binds rapidly and irreversibly to platelet receptors, thus inhibiting platelet aggregation.

The C_{max} of the active metabolite is twice as high following a single 300 mg clopidogrel loading dose as it is after four days of 75 mg maintenance dose. C_{max} occurs approximately 30 to 60 minutes after dosing.

Elimination

Following an oral dose of ¹⁴C-labelled clopidogrel in man, approximately 50% was excreted in the urine and approximately 46% in the faeces in the 120-hour interval after dosing. After a single oral dose of 75 mg, clopidogrel has a half-life of approximately 6 hours. The elimination half-life of the main circulating (inactive) metabolite was 8 hours after single and repeated administration.

Pharmacogenetics

CYP2C19 is involved in the formation of both the active metabolite and the 2-oxo-clopidogrel intermediate metabolite. Clopidogrel active metabolite pharmacokinetics and antiplatelet effects, as measured by ex vivo platelet aggregation assays, differ according to CYP2C19 genotype.

The CYP2C19*1 allele corresponds to fully functional metabolism while the CYP2C19*2 and CYP2C19*3 alleles are non functional. The CYP2C19*2 and CYP2C19*3 alleles account for the majority of reduced function alleles in Caucasian (85%) and Asian (99%) poor metabolisers. Other alleles associated with absent or reduced metabolism are less frequent and include CYP2C19*4, *5, *6, *7, and *8. A patient with poor metaboliser status will possess two loss-of-function alleles as defined above. Published frequencies for the poor CYP2C19 metaboliser genotypes are approximately 2% for Caucasians, 4% for Blacks and 14% for Chinese. Tests are available to determine a patient's CYP2C19 genotype.

A crossover study in 40 healthy subjects, 10 each in the four CYP2C19 metaboliser groups (ultrarapid, extensive, intermediate and poor), evaluated pharmacokinetic and antiplatelet responses using 300 mg followed by 75 mg/day and 600 mg followed by 150 mg/day, each for a total of 5 days (steady

state). No substantial differences in active metabolite exposure and mean inhibition of platelet aggregation (IPA) were observed between ultrarapid, extensive and intermediate metabolisers. In poor metabolisers, active metabolite exposure was decreased by 63-71% compared to extensive metabolisers. After the 300 mg/75 mg dose regimen, antiplatelet responses were decreased in the poor metabolisers with mean IPA (5 μ M ADP) of 24% (24 hours) and 37% (Day 5) as compared to IPA of 39% (24 hours) and 58% (Day 5) in the extensive metabolisers and 37% (24 hours) and 60% (Day 5) in the intermediate metabolisers. When poor metabolisers received the 600 mg/150 mg regimen, active metabolite exposure was greater than with the 300 mg/75 mg regimen. In addition, IPA was 32% (24 hours) and 61% (Day 5), which were greater than in the poor metabolisers receiving the 300 mg/75 mg regimen, and were similar to the other CYP2C19 metaboliser groups receiving the 300 mg/75 mg regimen. An appropriate dose regimen for this patient population has not been established in clinical outcome trials.

Consistent with the above results, in a meta-analysis including 6 studies of 335 clopidogrel-treated subjects at steady state, it was shown that active metabolite exposure was decreased by 28% for intermediate metabolisers, and 72% for poor metabolisers while platelet aggregation inhibition (5 μ M ADP) was decreased with differences in IPA of 5.9% and 21.4%, respectively, when compared to extensive metabolisers.

The influence of CYP2C19 genotype on clinical outcomes in patients treated with clopidogrel has not been evaluated in prospective, randomised, controlled trials. There have been a number of retrospective analysis, however, to evaluate this effect in patient treated with clopidogrel for whom there are genotyping results: CURE (n=2721), CHARISMA (n=2428), CLARITY-TIMI 28 (n=227), TRITON-TIMI 38 (n=1447), and ACTIVE-A (n=601), as well as a number of published cohort studies.

In TRITON-TIMI 38 and 3 of the cohort studies (Collet, Sibbing, Giusti) the combined group of patients with either intermediate or poor metaboliser status had a higher rate of cardiovascular events (death, myocardial infarction, and stroke) or stent thrombosis compared to extensive metabolisers.

In CHARISMA and one cohort study (SIMON), an increased event rate was observed only in poor metabolisers when compared to extensive metabolisers.

In CURE, CLARITY, ACTIVE-A and one of the cohort studies (Trenk), no increased event rate was observed based on metaboliser status.

None of these analyses were adequately sized to detect differences in outcome in poor metabolisers.

Special populations

The pharmacokinetics of the active metabolite of clopidogrel is not known in these special populations.

Renal impairment

After repeated doses of 75 mg clopidogrel per day in subjects with severe renal disease (creatinine clearance from 5 to 15 ml/min), inhibition of ADP-induced platelet aggregation was lower (25%) than that observed in healthy subjects, however, the prolongation of bleeding time was similar to that seen in healthy subjects receiving 75 mg of clopidogrel per day. In addition, clinical tolerance was good in all patients.

Hepatic impairment

After repeated doses of 75 mg clopidogrel per day for 10 days in patients with severe hepatic impairment, inhibition of ADP-induced platelet aggregation was similar to that observed in healthy subjects. The mean bleeding time prolongation was also similar in the two groups.

Race

The prevalence of CYP2C19 alleles that result in intermediate and poor CYP2C19 metabolism differs according to race/ethnicity (see Pharmacogenetics). From literature, limited data in Asian populations are available to assess the clinical implication of genotyping of this CYP on clinical outcome events.

Preclinical safety data

During non clinical studies in rat and baboon, the most frequently observed effects were liver changes. These occurred at doses representing at least 25 times the exposure seen in humans receiving the clinical dose of 75 mg/day and were a consequence of an effect on hepatic metabolising enzymes. No effect on hepatic metabolising enzymes was observed in humans receiving clopidogrel at the therapeutic dose.

At very high doses, a poor gastric tolerability (gastritis, gastric erosions and/or vomiting) of clopidogrel was also reported in rat and baboon.

There was no evidence of carcinogenic effect when clopidogrel was administered for 78 weeks to mice and 104 weeks to rats when given at doses up to 77 mg/kg per day (representing at least 25 times the exposure seen in humans receiving the clinical dose of 75 mg/day).

Clopidogrel has been tested in a range of *in vitro* and *in vivo* genotoxicity studies, and showed no genotoxic activity.

Clopidogrel was found to have no effect on the fertility of male and female rats and was not teratogenic in either rats or rabbits. When given to lactating rats, clopidogrel caused a slight delay in the development of the offspring. Specific pharmacokinetic studies performed with radiolabelled clopidogrel have shown that the parent compound or its metabolites are excreted in the milk. Consequently, a direct effect (slight toxicity), or an indirect effect (low palatability) cannot be excluded.

PHARMACEUTICAL PARTICULARS

List of Excipients

Core: Mannitol (E421), Macrogol 6000, Microcrystalline cellulose, Hydrogenated castor oil, Low substituted hydroxypropylcellulose.

Coating: Hypromellose (E464), Lactose monohydrate, Triacetin (E1518), Titanium dioxide (E171), Red iron oxide (E172).

Polishing agent: Carnauba wax

Incompatibilities

Not applicable.

Shelf-Life

Do not use later than the date of Expiry.

Special precautions for storage

Do not store above 30°C.

Nature and content of container

Plavix 75 mg film-coated tablet

28, tablets packed in PVC/PVDC/Aluminium blisters or all aluminium blisters in cardboard cartons.

Instructions for use and handling, and disposal (If Appropriate)

Not applicable.

AVAILABILITY

Plavix 75 mg Box of 2 blisters of 14 film coated tablets in packs.

HARUS DENGAN RESEP DOKTER

Plavix 75 mg Reg. No. DKL1321205717A1

Manufactured and Registered by:

PT Kalventis Sinergi Farma,
Jakarta – Indonesia

Under license from:

Sanofi Winthrop Industrie, France

Date of text revision:

As on approval date

LEAFLET KEMASAN: INFORMASI UNTUK PASIEN

PLAVIX 75 MG TABLET SALUT SELAPUT

Clopidogrel

sanofi

Bacalah seluruh isi leaflet ini dengan seksama sebelum Anda mulai mengonsumsi obat ini.

- Simpan leaflet ini. Anda mungkin perlu membacanya lagi.
- Jika ada pertanyaan lebih lanjut, hubungi dokter atau apoteker Anda.
- Obat ini telah diresepkan untuk Anda. Jangan diberikan kepada orang lain. Produk ini dapat berdampak negatif bagi mereka, sekalipun gejala yang Anda dan mereka alami serupa.
- Jika efek sampingnya menjadi serius, atau jika mengalami efek samping yang tidak tercantum dalam leaflet ini, segera konsultasikan kepada dokter atau apoteker Anda.

Informasi dalam lembaran ini:

1. Apa itu Plavix dan tujuan penggunaannya
2. Sebelum Anda mengonsumsi Plavix
3. Cara mengonsumsi Plavix
4. Kemungkinan efek samping
5. Cara menyimpan Plavix
6. Informasi lebih lanjut

1. APA ITU PLAVIX DAN TUJUAN PENGGUNAANNYA

Plavix 75 mg tablet salut selaput mengandung 75 mg clopidogrel (sebagai sulfat hidrogen). Plavix tergolong kelompok obat yang disebut obat antiplatelet (anti pembekuan darah). Platelet atau trombosit adalah keping darah yang merupakan bagian sangat kecil dalam darah yang membentuk gumpalan saat terjadinya pembekuan darah. Dengan mencegah terjadinya gumpalan, obat antiplatelet (anti pembekuan darah) ini mengurangi resiko pembekuan darah (proses yang disebut trombus).

Plavix dikonsumsi untuk mencegah pembekuan darah (trombus) yang terbentuk dalam pembuluh darah (arteri) yang mengeras, sebuah proses yang disebut sebagai aterotrombusis, yang dapat menyebabkan sejumlah penyakit aterotrombusis (seperti stroke, serangan jantung, atau kematian).

Anda telah diresepkan Plavix untuk membantu mencegah pembekuan darah dan mengurangi risiko berbahaya seperti itu yang dapat disebabkan karena:

- Pembuluh darah arteri Anda mengalami pengerasan (juga dikenal sebagai aterosklerosis), dan
- Anda pernah mengalami serangan jantung, stroke atau mengalami kondisi yang dikenal sebagai penyakit arteri perifer, atau
- Anda menderita nyeri dada parah yang disebut 'angina tak stabil' atau infark miokard (serangan jantung). Untuk pengobatannya, dokter Anda mungkin telah menempatkan stent dalam arteri yang tersumbat atau menyempit untuk melancarkan aliran darah. Anda mungkin juga mendapatkan asam asetilsalisilat (zat yang terkandung dalam obat pereda rasa sakit dan penurun demam serta untuk mencegah pembekuan darah) oleh dokter Anda.
- Anda pernah mengalami gejala stroke yang hilang dalam waktu singkat (juga dikenal sebagai serangan iskemik transien) atau stroke iskemik dengan tingkat keparahan ringan. Anda mungkin juga diberikan asam asetilsalisilat oleh dokter Anda dimulai dalam 24 jam pertama.

2. SEBELUM ANDA MENGGONSUMSI PLAVIX

Jangan mengonsumsi Plavix:

- Jika Anda alergi (hipersensitif) terhadap clopidogrel atau bahan lain yang terkandung dalam Plavix;
- Jika Anda mengalami kondisi medis yang saat ini menyebabkan perdarahan seperti tukak lambung (luka pada lapisan lambung) atau pendarahan dalam otak;
- Jika Anda menderita penyakit hati yang berat.

Jika Anda mengalami kondisi tersebut di atas, atau jika Anda ingin memastikan, konsultasikan dengan dokter Anda sebelum mengonsumsi Plavix.

Hal-hal yang perlu diperhatikan tentang Plavix:

Jika Anda mengalami salah satu kondisi di bawah ini, Anda harus terlebih dahulu memberitahu dokter Anda sebelum mengonsumsi Plavix:

- jika Anda memiliki resiko pendarahan seperti
 - Kondisi medis yang berisiko pendarahan internal (misalnya tukak lambung).
 - Kelainan darah yang membuat Anda rentan terhadap pendarahan internal (pendarahan di dalam jaringan, organ atau persendian dalam tubuh Anda).
 - Cedera serius yang belum lama terjadi.
 - Operasi (termasuk gigi) yang belum lama dilakukan.
 - Operasi (termasuk gigi) yang rencananya dilakukan dalam tujuh hari mendatang.
- jika Anda mengalami penyumbatan dalam arteri otak (stroke iskemik) yang terjadi dalam tujuh hari terakhir.
- jika Anda menderita penyakit ginjal atau hati.
- jika Anda memiliki riwayat medis pendarahan otak non-traumatis sebelumnya.

Ketika Anda mengonsumsi Plavix:

- Anda harus memberitahu dokter Anda jika dalam waktu dekat akan menjalani operasi (termasuk gigi).
- Anda juga harus segera memberitahu dokter Anda jika Anda menderita demam dan memar di bawah kulit yang dapat berupa bintik merah, yang dinamakan Thrombotic Thrombocytopenic Purpura atau TTP, dengan ataupun tanpa mengalami kelelahan luar biasa tanpa sebab yang jelas, kebingungan, menguningnya kulit atau mata (sakit kuning) (lihat 'KEMUNGKINAN EFEK SAMPING' bagian 4).
- Jika Anda mengalami cedera atau luka terbuka, pendarahannya dapat berlangsung lebih lama daripada biasanya. Ini terkait dengan cara obat Anda bekerja karena obat tersebut mencegah pembekuan darah. Untuk cedera dan luka ringan seperti tersayat, luka kecil saat mencukur, tidak ada yang perlu dikhawatirkan. Namun, jika Anda cemas dengan pendarahan yang terjadi, segera hubungi dokter Anda (lihat 'KEMUNGKINAN EFEK SAMPING' bagian 4).
- Dokter mungkin merasa Anda perlu menjalani tes darah.

Plavix tidak diperuntukkan untuk anak-anak atau remaja.

Mengonsumsi obat-obatan lain:

Konsultasikan kepada dokter atau apoteker Anda jika Anda sedang mengonsumsi atau baru saja minum obat-obatan lain, termasuk obat-obatan yang tidak menggunakan resep dokter. Beberapa obat tertentu dapat berpengaruh terhadap penggunaan Plavix ataupun sebaliknya.

Secara khusus, Anda harus memberitahu dokter jika Anda sedang mengonsumsi:

- antikoagulan oral, obat yang mengurangi pembekuan darah,

- obat anti-inflamasi non-steroid, yang lazim digunakan untuk mengobati otot atau persendian yang sakit atau mengalami peradangan,
- Heparin atau obat injeksi lainnya yang digunakan untuk mengurangi pembekuan darah,
- Rifampicin (digunakan untuk mengobati infeksi berat).
- Omeprazol, esomeprazol obat-obatan untuk mengobati sakit perut,
- Flukonazol, vorikonazol, obat-obatan untuk mengobati infeksi akibat bakteri dan jamur,
- Fluoxetine, fluvoxamine, atau moclobemide, obat-obatan untuk mengobati depresi,
- Carbamazepine, atau obat-obatan untuk mengobati epilepsi,
- Ticlopidine, atau zat antiplatelet lainnya.
- Repaglinide, obat untuk mengobati diabetes,
- Paclitaxel, obat untuk mengobati kanker,
- Opioid: apabila Anda sedang diobati dengan clopidogrel, Anda harus memberitahu dokter Anda sebelum diresepkan opioid (digunakan untuk mengobati nyeri berat).
- Rosuvastatin (digunakan untuk menurunkan kadar kolesterol Anda)

Jika Anda menderita nyeri dada yang parah (angina tak stabil atau serangan jantung), serangan iskemik transien atau stroke iskemik dengan tingkat keparahan ringan, dokter Anda mungkin akan meresepkan Plavix dikombinasikan dengan asam asetilsalisilat, zat yang terkandung dalam obat-obatan untuk menghilangkan rasa sakit dan menurunkan demam. Sesekali mengkonsumsi asam asetilsalisilat (tidak lebih dari 1.000 mg dalam kurun waktu 24 jam) pada umumnya tidak menimbulkan masalah, namun jika dikonsumsi untuk waktu yang lama dalam situasi yang berbeda harus terlebih dahulu dikonsultasikan dengan dokter.

Mengonsumsi Plavix dengan makanan dan minuman

Plavix dapat dikonsumsi dengan ataupun tanpa makanan.

Selama kehamilan atau menyusui

Dianjurkan agar tidak mengonsumsi produk ini selama kehamilan.

Jika Anda hamil atau mulai merasakan gejala kehamilan, Anda harus terlebih dahulu berkonsultasi dengan dokter atau apoteker Anda sebelum mengonsumsi Plavix. Jika Anda mulai hamil ketika menjalani pengobatan Plavix, segeralah berkonsultasi ke dokter Anda karena clopidogrel tidak dianjurkan untuk dikonsumsi selama kehamilan.

Jangan menyusui selama mengonsumsi obat ini.

Jika Anda sedang atau akan menyusui, konsultasikan dengan dokter sebelum mengonsumsi obat ini.

Mintalah saran dokter atau apoteker Anda sebelum mengonsumsi obat apapun.

Mengemudi dan mengoperasikan mesin:

Plavix tidak mempengaruhi kemampuan Anda mengemudi atau mengoperasikan suatu mesin.

Informasi penting tentang beberapa bahan Plavix:

Plavix mengandung laktosa. Jika Anda pernah diberitahu oleh dokter Anda bahwa Anda alergi terhadap jenis gula tertentu (misalnya laktosa), konsultasikan terlebih dahulu dengan dokter Anda sebelum mengonsumsi obat ini.

Plavix juga mengandung castor oil yang terhidrogenasi yang dapat menimbulkan gangguan perut atau diare.

3. CARA MENGONSUMSI PLAVIX

Saat mengonsumsi Plavix, lakukanlah tepat seperti anjuran dokter. Tanyakan kepada dokter atau apoteker jika ada hal yang perlu Anda pastikan.

Jika Anda menderita nyeri dada yang parah (angina tidak stabil atau serangan jantung), dokter mungkin memberikan Anda Plavix dengan dosis 300 mg atau 600 mg (4 atau 8 tablet @75 mg) sekali pada awal pengobatan, kecuali untuk pasien usia lanjut lebih dari 75 tahun. Kemudian, dosis normalnya adalah satu tablet Plavix @75 mg per hari untuk diminum dengan atau tanpa makanan, dan pada jam yang sama setiap hari.

Jika dokter Anda merencanakan untuk pemasangan stent dalam arteri yang tersumbat atau menyempit untuk melancarkan aliran darah, dokter mungkin memberikan Anda Plavix dengan dosis 300 mg atau 600 mg (4 atau 8 tablet @75 mg) sekali pada awal pengobatan, kecuali untuk pasien usia lanjut lebih dari 75 tahun. Kemudian, dosis normalnya adalah satu tablet Plavix 75 mg per hari seperti dijelaskan di atas dengan asam asetilsalisilat.

Pada pasien berusia ≥ 75 tahun yang akan menjalani prosedur pemasangan stent dalam waktu lebih dari 24 jam, setelah melakukan penilaian terhadap faktor risiko pendarahan, dokter mungkin memberikan Anda Plavix dengan dosis 600 mg (8 tablet @75 mg) dapat diberikan sekali pada awal pengobatan dengan perhatian.

Jika Anda mengalami gejala stroke yang hilang dalam waktu singkat (juga dikenal sebagai serangan iskemik transien) atau stroke iskemik dengan tingkat keparahan ringan, dokter mungkin memberikan Anda Plavix dengan dosis 300 mg (4 tablet @75 mg) sekali pada awal pengobatan. Kemudian, dosis normalnya adalah satu tablet Plavix 75 mg per hari seperti dijelaskan di atas dengan asam asetilsalisilat selama 3 minggu. Kemudian dokter akan meresepkan Plavix saja atau asam asetilsalisilat saja.

Anda harus mengonsumsi Plavix selama dokter terus meresepkannya untuk Anda.

Jika Anda mengonsumsi Plavix secara berlebihan:

Jika Anda mengonsumsi Plavix dalam jumlah yang berlebihan, hubungi dokter Anda atau rumah sakit terdekat karena risiko pendarahan yang meningkat. Saat ini, belum ada obat penawar khusus untuk menghilangkan efek clopidogrel. Namun, jika diperlukan perbaikan segera dari efek clopidogrel, dokter mungkin akan menyarankan transfusi trombosit untuk membantu memulihkan proses pembekuan darah.

Jika Anda lupa mengonsumsi Plavix:

Jika Anda lupa mengonsumsi Plavix sesuai jadwal, tetapi menyadarinya dalam kurun waktu 12 jam, segeralah minum obat tersebut. Jadwal berikutnya tetap jatuh pada waktu seperti biasa.

Jika Anda menyadarinya lebih dari 12 jam, minumlah obat berikutnya sesuai jadwal biasanya. Jangan mengonsumsi dosis ganda untuk menebus dosis yang terlupakan.

Untuk paket berisi 28 tablet, Anda dapat memeriksa hari dimana Anda terakhir mengonsumsi tablet Plavix dengan melihat kalender yang tertera pada blister.

Jika Anda berhenti mengonsumsi Plavix:

Jangan menghentikan pengobatan kecuali atas anjuran dokter. Konsultasikan dengan dokter atau apoteker Anda sebelum berhenti.

Untuk pertanyaan lebih lanjut mengenai produk ini, konsultasikan kepada dokter atau apoteker.

4. KEMUNGKINAN EFEK SAMPING

Sebagaimana halnya dengan semua obat-obatan, Plavix dapat menimbulkan efek samping, walaupun tidak semua orang mengalaminya.

Segera hubungi dokter jika Anda mengalami:

- demam, gejala infeksi atau kelelahan ekstrem. Ini dapat disebabkan oleh penurunan beberapa sel darah yang sangat jarang terjadi.
- gejala penyakit hati seperti menguningnya kulit dan/atau mata (penyakit kuning), terlepas dari apakah itu berhubungan dengan perdarahan yang muncul di bawah kulit berupa bintik-bintik merah, dan/atau kebingungan (lihat bagian 2 dari 'Hal-hal yang perlu diperhatikan tentang Plavix').
- pembengkakan di dalam mulut atau gangguan kulit seperti ruam dan gatal-gatal, lecet pada kulit. Hal tersebut dapat merupakan pertanda reaksi alergi.

Efek samping yang paling umum dilaporkan tentang Plavix adalah pendarahan. Perdarahan dapat terjadi misalnya di dalam lambung atau usus, memar, hematoma (memar atau pendarahan yang tidak lazim di bawah kulit), hidung berdarah, darah dalam urin. Dalam beberapa kasus pernah terjadi pendarahan di mata, di dalam kepala, paru-paru atau persendian.

Jika Anda mengalami perdarahan yang berkepanjangan saat mengonsumsi Plavix

Jika Anda terluka atau cedera, mungkin pendarahan berlangsung lebih lama dari biasanya. Hal ini terkait dengan cara obat bekerja karena ia mencegah terjadinya pembekuan darah. Untuk cedera atau luka ringan seperti tersayat sedikit, luka ringan saat mencukur, biasanya tidak ada yang perlu dikhawatirkan. Namun, jika Anda cemas dengan pendarahan yang terjadi, segera hubungi dokter (lihat bagian 2 'Hal-hal yang perlu diperhatikan tentang Plavix').

Efek samping lain yang pernah dilaporkan tentang Plavix adalah:

- Efek samping yang umum (mungkin terjadi pada 1 sampai 10 orang)
- Efek samping yang tidak umum (mungkin terjadi pada 1 sampai 100 orang)
- Efek samping yang jarang (mungkin terjadi pada 1 sampai 1.000 orang)
- Efek samping yang sangat jarang (mungkin terjadi pada 1 sampai 10.000 orang)
- Efek samping yang tidak diketahui

Gangguan sistem darah dan limfatik

Tidak umum: Trombositopenia (jumlah trombosit yang rendah), leukopenia (jumlah sel darah putih yang rendah), eosinofilia (jumlah sel darah putih eosinofil meningkat)

Jarang: Neutropenia (jumlah sel darah putih netrofil yang rendah), termasuk neutropenia berat

Sangat jarang, tidak diketahui: Kelainan darah yang membuat darah lebih cepat menggumpal, anemia aplastik, pansitopenia (jumlah sel darah merah, sel darah putih, dan trombosit yang rendah), produksi granulosit terlalu sedikit, trombositopenia berat, hemofilia (gangguan pembekuan darah), anemia (jumlah sel darah merah yang rendah)

Gangguan jantung

Sangat jarang, tidak diketahui: Gejala pada sistem jantung dan pembuluh darah sekunder akibat alergi atau reaksi hipersensitivitas akibat clopidogrel*

Gangguan sistem kekebalan tubuh

Sangat jarang, tidak diketahui: Reaksi hipersensitivitas, alergi berat, reaksi alergi terhadap obat golongan tienopiridin (seperti tiklopidin, prasugrel), kelainan sistem kekebalan tubuh terhadap insulin yang dapat menyebabkan penurunan yang besar pada kadar gula dalam darah

Gangguan psikiatri

Sangat jarang, tidak diketahui: Halusinasi, kebingungan

Gangguan sistem saraf

Tidak umum: Perdarahan di dalam rongga kepala, sakit kepala, kesemutan, pusing
Sangat jarang, tidak diketahui: Gangguan rasa, kehilangan rasa

Gangguan mata

Tidak umum: Perdarahan mata

Gangguan telinga dan labirin

Jarang: Pusing hingga merasa diri atau sekeliling berputar

Gangguan vaskular (pembuluh darah)

Umum: Pengumpulan darah di luar pembuluh darah

Sangat jarang, tidak diketahui: Perdarahan serius, perdarahan pada luka operasi, peradangan pembuluh darah, tekanan darah rendah

Gangguan pernapasan, dada dan rongga di bagian tengah dada

Umum: Mimisan

Sangat jarang, tidak diketahui: Batuk darah, perdarahan paru, penyempitan saluran napas, peradangan paru, pneumonia akibat peningkatan eosinofil di paru-paru

Gangguan saluran pencernaan

Umum: Perdarahan saluran cerna, diare, nyeri perut, rasa tidak nyaman di area perut bagian atas

Tidak umum: Tukak (luka) lambung dan tukak duodenum, radang lambung, muntah, mual, sembelit, perut kembung

Jarang: Perdarahan di area belakang rongga perut

Sangat jarang, tidak diketahui: Perdarahan saluran cerna dan area belakang rongga perut dengan akibat fatal, radang pankreas, usus besar, dan area mulut

Gangguan hati dan saluran empedu

Sangat jarang, tidak diketahui: Gagal hati akut, peradangan pada hati, hasil tes fungsi hati abnormal

Gangguan kulit dan jaringan di bawah kulit

Umum: Memar

Tidak umum: Ruam, gatal, perdarahan kulit

Sangat jarang, tidak diketahui: Reaksi alergi langka pada kulit karena obat-obatan, pembengkakan di bawah kulit, reaksi hipersensitivitas obat yang berat dan mengancam jiwa, iritasi kulit atau peradangan pada kulit yang juga dapat disebabkan karena kelainan pada sistem kekebalan tubuh

Gangguan sistem reproduksi dan payudara

Jarang: Pembesaran kelenjar payudara pada pria

Gangguan otot-tulang dan jaringan penghubung

Sangat jarang, tidak diketahui: Perdarahan pada otot dan sendi, radang sendi, nyeri sendi, nyeri otot

Gangguan ginjal dan saluran kemih

Umum: Terdapat darah dalam urin

Sangat jarang, tidak diketahui: Peradangan pada ginjal, peningkatan kadar kreatinin dalam darah

Gangguan umum dan kondisi tempat pemberian

Umum: Perdarahan di tempat suntikan

Sangat jarang, tidak diketahui: Demam

Pemeriksaan

Tidak umum: Waktu perdarahan memanjang, jumlah neutrofil menurun, jumlah trombosit menurun

*Informasi terkait clopidogrel dengan frekuensi “tidak diketahui”.

Jika mengalami efek samping yang serius atau mengalami efek samping apapun yang tidak tercantum dalam leaflet ini, hubungi dokter atau apoteker Anda.

Anda juga dapat melaporkan efek samping secara langsung ke Industri Farmasi dengan kontak berikut farmakovigilans@kalventis.com. Dengan melaporkan efek samping Anda dapat membantu memberikan informasi tentang keamanan obat ini.

5. CARA MENYIMPAN PLAVIX

Jauhkan dari jangkauan dan penglihatan anak-anak.

Jangan mengonsumsi Plavix setelah tanggal kadaluwarsa yang tertera pada karton dan blister, setelah masa kadaluwarsa.

Ikuti petunjuk pada kemasan tentang aturan penyimpanan.

Simpan pada suhu di bawah 30°C.

Jangan mengonsumsi Plavix jika ada tanda-tanda kerusakan.

Obat tidak boleh dibuang melalui limbah air atau limbah rumah tangga. Tanyakan apoteker bagaimana membuang obat-obatan yang tidak diperlukan lagi. Langkah-langkah ini bermanfaat dalam menjaga kelestarian lingkungan.

6. INFORMASI LEBIH LANJUT

Apa yang terkandung dalam Plavix

Zat aktif di dalamnya adalah clopidogrel.

Plavix 75 mg Tablet Salut Selaput

Tiap tablet bersalut selaput ini mengandung 75 mg clopidogrel (sebagai sulfat hidrogen).

Bahan lainnya adalah:

- Inti Tablet: manitol (E421), castor oil yang telah dihidrogenasi, mikrokristalin selulosa, macrogol 6000 dan hidroksipropilselulosa substitusi rendah.
- Lapisan tablet: laktosa monohidrat (gula susu), hypromellose (E464), triasetin (E1518), oksida merah besi (E172) dan titanium dioksida (E171),
- Agen Poles: carnauba wax.

Bagaimana mengenali Plavix dan kemasan yang digunakan Plavix?

Plavix berbentuk bulat, cembung di kedua sisinya, berwarna merah muda, di satu sisi terukir nomor '75' dan di sisi lain dengan nomor '1171'. Plavix tersedia dalam kemasan karton berisi 28 tablet, dalam blister yang berbahan PVC/PVDC/Aluminium atau yang seluruhnya berbahan aluminium.

HARUS DENGAN RESEP DOKTER

Plavix 75 mg Reg. No. DKL1321205717A1

Diproduksi dan didaftarkan oleh:

PT Kalventis Sinergi Farma,

Jakarta – Indonesia

Atas dasar lisensi dari:

Sanofi Winthrop Industrie, France

Tanggal revisi teks:
Sesuai persetujuan