## 1. NAME OF THE MEDICINAL PRODUCT

Xarelto 2.5 mg
Film-coated tablets

## 2. QUALITATIVE AND QUANTITATIVE COMPOSITION

Each film-coated tablet contains 2.5 mg rivaroxaban.

Excipient with known effect:
Each film-coated tablet contains 35.70 mg lactose monohydrate, see section 4.4.

For the full list of excipients, see section 6.1.

## 3. PHARMACEUTICAL FORM

Film-coated tablet (tablet).
Light yellow, round biconvex tablets (6 mm diameter, 9 mm radius of curvature) marked with the BAYER-cross on one side and "2.5" and a triangle on the other side.

**Prescriber guide**
**This product is marketed with** prescriber guide providing recommendations for the risk minimization in the use of Xarelto 2.5 mg. Please ensure you are familiar with this material as it contains important safety information.
**Patient safety information card**
The marketing of Xarelto 2.5 mg is subject to a risk management plan (RMP) including a 'Patient safety information card'. The 'Patient safety information card', emphasizes important safety information that the patient should be aware of before and during treatment. Please explain to the patient the need to review the card before starting treatment.

**WARNING: (A) PREMATURE DISCONTINUATION OF XARELTO INCREASES THE RISK OF THROMBOTIC EVENTS,**
**(B) SPINAL/EPIDURAL HEMATOMA**

**A. PREMATURE DISCONTINUATION OF XARELTO INCREASES THE RISK OF THROMBOTIC EVENTS**

**Premature discontinuation of any oral anticoagulant, including XARELTO, increases the risk of thrombotic events. If anticoagulation with XARELTO is discontinued for a reason other than pathological bleeding or completion of a course of therapy, consider coverage with another anticoagulant *[see posology and method of administration (4.2), and special warnings and precautions for use(4.4)]*.**

**B. SPINAL/EPIDURAL HEMATOMA**

**Epidural or spinal hematomas have occurred in patients treated with XARELTO who are receiving neuraxial anesthesia or undergoing spinal puncture. These hematomas may result in long-term or permanent paralysis. Consider these risks when scheduling patients for spinal procedures. Factors that can increase the risk of developing epidural or spinal hematomas in these patients include:**

- **use of indwelling epidural catheters**
- **concomitant use of other drugs that affect hemostasis, such as non-steroidal anti-inflammatory drugs (NSAIDs), platelet inhibitors, other anticoagulants**
- **a history of traumatic or repeated epidural or spinal punctures**
- **a history of spinal deformity or spinal surgery**

- **optimal timing between the administration of XARELTO and neuraxial procedures is not known**

***[see special warnings and precautions for use (4.4), and Undesirable effects (4.8)].***

**Monitor patients frequently for signs and symptoms of neurological impairment. If neurological compromise is noted, urgent treatment is necessary *[see special Warnings and Precautions for use (4.4)]*.**

**Consider the benefits and risks before neuraxial intervention in patients anticoagulated or to be anticoagulated for thromboprophylaxis *[see special Warnings and Precautions for use (4.4)]*.**

## 4. CLINICAL PARTICULARS

### 4.1 Therapeutic indications

Xarelto, co-administered with acetylsalicylic acid (ASA) alone or with ASA plus clopidogrel, is indicated for the prevention of atherothrombotic events in adult patients after an acute coronary syndrome (ACS) with elevated cardiac biomarkers (see sections 4.3, 4.4 and 5.1).

Xarelto, co-administered with acetylsalicylic acid (ASA), is indicated for the prevention of atherothrombotic events in adult patients with coronary artery disease (CAD) or symptomatic peripheral artery disease (PAD) at high risk of ischaemic events (see section 5.1).

### 4.2 Posology and method of administration

Posology
The recommended dose is 2.5 mg twice daily.

- *ACS*

Patients taking Xarelto 2.5 mg twice daily should also take a daily dose of 75 - 100 mg ASA or a daily dose of 75 - 100 mg ASA in addition to either a daily dose of 75 mg clopidogrel.

Treatment should be regularly evaluated in the individual patient weighing the risk for ischaemic events against the bleeding risks. Extension of treatment beyond 12 months should be done on an individual patient basis as experience up to 24 months is limited (see section 5.1).

Treatment with Xarelto should be started as soon as possible after stabilisation of the ACS event (including revascularisation procedures); at the earliest 24 hours after admission to hospital and at the time when parenteral anticoagulation therapy would normally be discontinued.

- *CAD/PAD*

Patients taking Xarelto 2.5 mg twice daily should also take a daily dose of 75 - 100 mg ASA.

Duration of treatment should be determined for each individual patient based on regular evaluations and should consider the risk for thrombotic events versus the bleeding risks.

In patients with an acute thrombotic event or vascular procedure and a need for dual antiplatelet therapy, the continuation of Xarelto 2.5 mg twice daily should be evaluated depending on the type of event or procedure and antiplatelet regimen.

Safety and efficacy of Xarelto 2.5 mg twice daily in combination with ASA plus clopidogrel has only been studied in patients with recent ACS (see section 4.1). Dual antiplatelet therapy has not been studied in combination with Xarelto 2.5 mg twice daily in patients with CAD/PAD (see sections 4.4 and 5.1).

If a dose is missed the patient should continue with the regular dose as recommended at the next scheduled time. The dose should not be doubled to make up for a missed dose.

*Converting from Vitamin K Antagonists (VKA) to Xarelto*
When converting patients from VKAs to Xarelto, International Normalised Ratio (INR) values could be falsely elevated after the intake of Xarelto. The INR is not valid to measure the anticoagulant activity of Xarelto, and therefore should not be used (see section 4.5).

*Converting from Xarelto to Vitamin K antagonists (VKA)*
There is a potential for inadequate anticoagulation during the transition from Xarelto to VKA. Continuous adequate anticoagulation should be ensured during any transition to an alternate anticoagulant. It should be noted that Xarelto can contribute to an elevated INR.
In patients converting from Xarelto to VKA, VKA should be given concurrently until the INR is ≥ 2.0. For the first two days of the conversion period, standard initial dosing of VKA should be used followed by VKA dosing, as guided by INR testing. While patients are on both Xarelto and VKA the INR should not be tested earlier than 24 hours after the previous dose but prior to the next dose of Xarelto. Once Xarelto is discontinued INR testing may be done reliably at least 24 hours after the last dose (see sections 4.5 and 5.2).

*Converting from parenteral anticoagulants to Xarelto*
For patients currently receiving a parenteral anticoagulant, discontinue the parenteral anticoagulant and start Xarelto 0 to 2 hours before the time that the next scheduled administration of the parenteral medicinal product (e.g. low molecular weight heparins) would be due or at the time of discontinuation of a continuously administered parenteral medicinal product (e.g. intravenous unfractionated heparin).

*Converting from Xarelto to parenteral anticoagulants*
Give the first dose of parenteral anticoagulant at the time the next Xarelto dose would be taken.

*Special populations*
*Renal impairment*
Limited clinical data for patients with severe renal impairment (creatinine clearance 15 - 29 ml/min) indicate that rivaroxaban plasma concentrations are significantly increased. Therefore, Xarelto is to be used with caution in these patients. Use is not recommended in patients with creatinine clearance < 15 ml/min (see sections 4.4 and 5.2).
No dose adjustment is necessary in patients with mild renal impairment (creatinine clearance 50 - 80 ml/min) or moderate renal impairment (creatinine clearance 30 - 49 ml/min) (see section 5.2).

*Hepatic impairment*
Xarelto is contraindicated in patients with hepatic disease associated with coagulopathy and clinically relevant bleeding risk including cirrhotic patients with Child Pugh B and C (see sections 4.3 and 5.2).

*Elderly population*
No dose adjustment (see sections 4.4 and 5.2).
The risk of bleeding increases with increasing age (see section 4.4).

*Body weight*
No dose adjustment (see sections 4.4 and 5.2).

*Gender*
No dose adjustment (see section 5.2).

*Paediatric population*
The safety and efficacy of Xarelto in children aged 0 to 18 years have not been established. No data are available. Therefore, Xarelto is not recommended for use in children below 18 years of age.

Method of administration
Xarelto is for oral use.

The tablets can be taken with or without food (see sections 4.5 and 5.2).

For patients who are unable to swallow whole tablets, Xarelto tablet may be crushed and mixed with water or apple puree immediately prior to use and administered orally.
The crushed Xarelto tablet may also be given through gastric tubes after confirmation of the correct gastric placement of the tube. The crushed tablet should be administered in a small amount of water via a gastric tube after which it should be flushed with water (see section 5.2).
There is no data regarding chewing or halving the tablets.

## 4.3 Contraindications

Hypersensitivity to the active substance or to any of the excipients listed in section 6.1.

Active clinically significant bleeding.

Lesion or condition, if considered to be a significant risk for major bleeding. This may include current or recent gastrointestinal ulceration, presence of malignant neoplasms at high risk of bleeding, recent brain or spinal injury, recent brain, spinal or ophthalmic surgery, recent intracranial haemorrhage, known or suspected oesophageal varices, arteriovenous malformations, vascular aneurysms or major intraspinal or intracerebral vascular abnormalities.

Concomitant treatment with any other anticoagulants e.g. unfractionated heparin (UFH), low molecular weight heparins (enoxaparin, dalteparin, etc.), heparin derivatives (fondaparinux, etc.), oral anticoagulants (warfarin, dabigatran etexilate, apixaban, etc.) except under specific circumstances of switching anticoagulant therapy (see section 4.2) or when UFH is given at doses necessary to maintain an open central venous or arterial catheter (see section 4.5).

Concomitant treatment of ACS with antiplatelet therapy in patients with a prior stroke or a transient ischaemic attack (TIA) (see section 4.4).

Concomitant treatment of CAD/PAD with ASA in patients with previous haemorrhagic or lacunar stroke, or any stroke within a month (see section 4.4).

Hepatic disease associated with coagulopathy and clinically relevant bleeding risk including cirrhotic patients with Child Pugh B and C (see section 5.2).

Pregnancy and breast feeding (see section 4.6).

## 4.4 Special warnings and precautions for use

In ACS patients, efficacy and safety of Xarelto 2.5 mg have been investigated in combination with the antiplatelet agents ASA alone or ASA plus clopidogrel. Treatment in combination with other antiplatelet agents, e.g. prasugrel or ticagrelor, has not been studied and is not recommended.
In patients at high risk of ischaemic events with CAD/PAD, efficacy and safety of Xarelto 2.5 mg have only been investigated in combination with ASA.

Clinical surveillance in line with anticoagulation practice is recommended throughout the treatment period.

<u>Haemorrhagic risk</u>
As with other anticoagulants, patients taking Xarelto are to be carefully observed for signs of bleeding. It is recommended to be used with caution in conditions with increased risk of haemorrhage. Xarelto administration should be discontinued if severe haemorrhage occurs (see section 4.9).

In the clinical studies mucosal bleedings (i.e. epistaxis, gingival, gastrointestinal, genito urinary including abnormal vaginal or increased menstrual bleeding) and anaemia were seen more frequently during long term rivaroxaban treatment on top of single or dual anti-platelet therapy. Thus, in addition to adequate clinical surveillance, laboratory testing of haemoglobin/haematocrit could be of value to

detect occult bleeding and quantify the clinical relevance of overt bleeding, as judged to be appropriate.

Several sub-groups of patients, as detailed below, are at increased risk of bleeding. Therefore, the use of Xarelto in combination with dual antiplatelet therapy in patients at known increased risk for bleeding should be balanced against the benefit in terms of prevention of atherothrombotic events. In addition these patients are to be carefully monitored for signs and symptoms of bleeding complications and anaemia after initiation of treatment (see section 4.8).
Any unexplained fall in haemoglobin or blood pressure should lead to a search for a bleeding site.

Although treatment with rivaroxaban does not require routine monitoring of exposure, rivaroxaban levels measured with a calibrated quantitative anti-factor Xa assay may be useful in exceptional situations where knowledge of rivaroxaban exposure may help to inform clinical decisions, e.g. overdose and emergency surgery (see sections 5.1 and 5.2).

Renal impairment
In patients with severe renal impairment (creatinine clearance < 30 ml/min) rivaroxaban plasma levels may be significantly increased (1.6 fold on average) which may lead to an increased bleeding risk. Xarelto is to be used with caution in patients with creatinine clearance 15 - 29 ml/min. Use is not recommended in patients with creatinine clearance < 15 ml/min (see sections 4.2 and 5.2).
In patients with moderate renal impairment (creatinine clearance 30 - 49 ml/min) concomitantly receiving other medicinal products which increase rivaroxaban plasma concentrations Xarelto is to be used with caution (see section 4.5).

Interaction with other medicinal products
The use of Xarelto is not recommended in patients receiving concomitant systemic treatment with azole-antimycotics (such as ketoconazole, itraconazole, voriconazole and posaconazole) or HIV protease inhibitors (e.g. ritonavir). These active substances are strong inhibitors of both CYP3A4 and P-gp and therefore may increase rivaroxaban plasma concentrations to a clinically relevant degree (2.6 fold on average) which may lead to an increased bleeding risk (see section 4.5).

Care is to be taken if patients are treated concomitantly with medicinal products affecting haemostasis such as non-steroidal anti-inflammatory medicinal products (NSAIDs), acetylsalicylic acid (ASA) and platelet aggregation inhibitors or selective serotonin reuptake inhibitors (SSRIs) and serotonin norepinephrine reuptake inhibitors (SNRIs). For patients at risk of ulcerative gastrointestinal disease an appropriate prophylactic treatment may be considered (see sections 4.5 and 5.1).
Patients on treatment with Xarelto and ASA or with Xarelto and ASA plus clopidogrel should only receive concomitant treatment with NSAIDs if the benefit outweighs the bleeding risk.

Other haemorrhagic risk factors
As with other antithrombotics, rivaroxaban is not recommended in patients with an increased bleeding risk such as:
- congenital or acquired bleeding disorders
- uncontrolled severe arterial hypertension
- other gastrointestinal disease without active ulceration that can potentially lead to bleeding complications (e.g. inflammatory bowel disease, oesophagitis, gastritis and gastroesophageal reflux disease)
- vascular retinopathy
- bronchiectasis or history of pulmonary bleeding

It should be used with caution in ACS and CAD/PAD patients:
- ≥ 75 years of age if co-administered with ASA alone or with ASA plus clopidogrel. The benefit-risk of the treatment should be individually assessed on a regular basis.
- with lower body weight (< 60 kg) if co-administered with ASA alone or with ASA plus clopidogrel.
- CAD patients with severe symptomatic heart failure. Study data indicate that such patients may benefit less from treatment with rivaroxaban (see section 5.1).

Patients with cancer
Patients with malignant disease may simultaneously be at higher risk of bleeding and thrombosis. The individual benefit of antithrombotic treatment should be weighed against risk for bleeding in patients with active cancer dependent on tumour location, antineoplastic therapy and stage of disease. Tumours located in the gastrointestinal or genitourinary tract have been associated with an increased risk of bleeding during rivaroxaban therapy.
In patients with malignant neoplasms at high risk of bleeding, the use of rivaroxaban is contraindicated (see section 4.3).

Patients with prosthetic valves
Rivaroxaban should not be used for thromboprophylaxis in patients having recently undergone transcatheter aortic valve replacement (TAVR). Safety and efficacy of Xarelto have not been studied in patients with prosthetic heart valves; therefore, there are no data to support that Xarelto provides adequate anticoagulation in this patient population. Treatment with Xarelto is not recommended for these patients.

Patients with antiphospholipid syndrome
Direct acting Oral Anticoagulants (DOACs) including rivaroxaban are not recommended for patients with a history of thrombosis who are diagnosed with antiphospholipid syndrome. In particular for patients that are triple positive (for lupus anticoagulant, anticardiolipin antibodies, and anti-beta 2-glycoprotein I antibodies), treatment with DOACs could be associated with increased rates of recurrent thrombotic events compared with vitamin K antagonist therapy.

Patients with prior stroke and/or TIA
*Patients with ACS*
Xarelto 2.5 mg is contraindicated for the treatment of ACS in patients with a prior stroke or TIA (see section 4.3). Few ACS patients with a prior stroke or TIA have been studied but the limited efficacy data available indicate that these patients do not benefit from treatment.

*Patients with CAD/PAD*
CAD/PAD patients with previous haemorrhagic or lacunar stroke, or an ischaemic, non-lacunar stroke with in the previous month were not studied (see section 4.3).

Spinal/epidural anaesthesia or puncture
When neuraxial anaesthesia (spinal/epidural anaesthesia) or spinal/epidural puncture is employed, patients treated with antithrombotic agents for prevention of thromboembolic complications are at risk of developing an epidural or spinal haematoma which can result in long-term or permanent paralysis [See boxed warning].
The risk of these events may be increased by the post-operative use of indwelling epidural catheters or the concomitant use of medicinal products affecting haemostasis. The risk may also be increased by traumatic or repeated epidural or spinal puncture. Patients are to be frequently monitored for signs and symptoms of neurological impairment (e.g. numbness or weakness of the legs, bowel or bladder dysfunction). If neurological compromise is noted, urgent diagnosis and treatment is necessary. Prior to neuraxial intervention the physician should consider the potential benefit versus the risk in anticoagulated patients or in patients to be anticoagulated for thromboprophylaxis. There is no clinical experience with the use of Xarelto 2.5 mg with ASA alone or with ASA plus clopidogrel in these situations.
To reduce the potential risk of bleeding associated with the concurrent use of rivaroxaban and neuraxial (epidural/spinal) anaesthesia or spinal puncture, consider the pharmacokinetic profile of rivaroxaban. Placement or removal of an epidural catheter or lumbar puncture is best performed when the anticoagulant effect of rivaroxaban is estimated to be low (see section 5.2). However, the exact timing to reach a sufficiently low anticoagulant effect in each patient is not known.
Platelet aggregation inhibitors should be discontinued as suggested by the manufacturer's prescribing information.

Dosing recommendations before and after invasive procedures and surgical intervention
If an invasive procedure or surgical intervention is required, Xarelto 2.5 mg should be stopped at least 12 hours before the intervention, if possible and based on the clinical judgement of the physician. If a patient is to undergo elective surgery and anti-platelet effect is not desired, platelet aggregation inhibitors should be discontinued as directed by the manufacturer's prescribing information.
If the procedure cannot be delayed the increased risk of bleeding should be assessed against the urgency of the intervention.
Xarelto should be restarted as soon as possible after the invasive procedure or surgical intervention provided the clinical situation allows and adequate haemostasis has been established as determined by the treating physician (see section 5.2).

Elderly population
Increasing age may increase haemorrhagic risk (see sections 5.1 and 5.2).

Dermatological reactions
Serious skin reactions, including Stevens-Johnson syndrome/toxic epidermal necrolysis and DRESS syndrome, have been reported during post-marketing surveillance in association with the use of rivaroxaban (see section 4.8). Patients appear to be at highest risk for these reactions early in the course of therapy: the onset of the reaction occurring in the majority of cases within the first weeks of treatment. Rivaroxaban should be discontinued at the first appearance of a severe skin rash (e.g. spreading, intense and/or blistering), or any other sign of hypersensitivity in conjunction with mucosal lesions.

Information about excipients
Xarelto 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 less than 1 mmol sodium (23 mg) per dosage unit, that is to say essentially "sodium-free".

Increased Risk of Thrombotic Events after Premature Discontinuation
Premature discontinuation of any oral anticoagulant, including Xarelto, in the absence of adequate alternative anticoagulation increases the risk of thrombotic events. An increased rate of stroke was observed during the transition from Xarelto to warfarin in clinical trials in atrial fibrillation patients. If Xarelto is discontinued for a reason other than pathological bleeding or completion of a course of therapy, consider coverage with another anticoagulant [for conversion instructions see Dosage and Administration (4.2)]

## 4.5 Interaction with other medicinal products and other forms of interaction

CYP3A4 and P-gp inhibitors
Co-administration of rivaroxaban with ketoconazole (400 mg once a day) or ritonavir (600 mg twice a day) led to a 2.6 fold / 2.5 fold increase in mean rivaroxaban AUC and a 1.7 fold / 1.6 fold increase in mean rivaroxaban $C_{max}$, with significant increases in pharmacodynamic effects which may lead to an increased bleeding risk. Therefore, the use of Xarelto is not recommended in patients receiving concomitant systemic treatment with azole-antimycotics such as ketoconazole, itraconazole, voriconazole and posaconazole or HIV protease inhibitors. These active substances are strong inhibitors of both CYP3A4 and P-gp (see section 4.4).

Active substances strongly inhibiting only one of the rivaroxaban elimination pathways, either CYP3A4 or P-gp, are expected to increase rivaroxaban plasma concentrations to a lesser extent. Clarithromycin (500 mg twice a day), for instance, considered as a strong CYP3A4 inhibitor and moderate P-gp inhibitor, led to a 1.5 fold increase in mean rivaroxaban AUC and a 1.4 fold increase in $C_{max}$. The interaction with clarithromycin is likely not clinically relevant in most patients but can be potentially significant in high-risk patients. (For patients with renal impairment: see section 4.4).

Erythromycin (500 mg three times a day), which inhibits CYP3A4 and P-gp moderately, led to a 1.3 fold increase in mean rivaroxaban AUC and $C_{max}$. The interaction with erythromycin is likely not clinically relevant in most patients but can be potentially significant in high-risk patients.
In subjects with mild renal impairment erythromycin (500 mg three times a day) led to a 1.8 fold increase in mean rivaroxaban AUC and 1.6 fold increase in $C_{max}$ when compared to subjects with normal renal function. In subjects with moderate renal impairment, erythromycin led to a 2.0 fold increase in mean rivaroxaban AUC and 1.6 fold increase in $C_{max}$ when compared to subjects with normal renal function. The effect of erythromycin is additive to that of renal impairment (see section 4.4).

Fluconazole (400 mg once daily), considered as a moderate CYP3A4 inhibitor, led to a 1.4 fold increase in mean rivaroxaban AUC and a 1.3 fold increase in mean $C_{max}$. The interaction with fluconazole is likely not clinically relevant in most patients but can be potentially significant in high-risk patients. (For patients with renal impairment: see section 4.4).

Given the limited clinical data available with dronedarone, co-administration with rivaroxaban should be avoided.

Anticoagulants
After combined administration of enoxaparin (40 mg single dose) with rivaroxaban (10 mg single dose) an additive effect on anti-factor Xa activity was observed without any additional effects on clotting tests (PT, aPTT). Enoxaparin did not affect the pharmacokinetics of rivaroxaban.
Due to the increased bleeding risk care is to be taken if patients are treated concomitantly with any other anticoagulants (see sections 4.3 and 4.4).

NSAIDs/platelet aggregation inhibitors
No clinically relevant prolongation of bleeding time was observed after concomitant administration of rivaroxaban (15 mg) and 500 mg naproxen. Nevertheless, there may be individuals with a more pronounced pharmacodynamic response.
No clinically significant pharmacokinetic or pharmacodynamic interactions were observed when rivaroxaban was co-administered with 500 mg acetylsalicylic acid.
Clopidogrel (300 mg loading dose followed by 75 mg maintenance dose) did not show a pharmacokinetic interaction with rivaroxaban (15 mg) but a relevant increase in bleeding time was observed in a subset of patients which was not correlated to platelet aggregation, P-selectin or GPIIb/IIIa receptor levels.
Care is to be taken if patients are treated concomitantly with NSAIDs (including acetylsalicylic acid) and platelet aggregation inhibitors because these medicinal products typically increase the bleeding risk (see section 4.4).

SSRIs/SNRIs
As with other anticoagulants the possibility may exist that patients are at increased risk of bleeding in case of concomitant use with SSRIs or SNRIs due to their reported effect on platelets. When concomitantly used in the rivaroxaban clinical programme, numerically higher rates of major or non-major clinically relevant bleeding were observed in all treatment groups.

Warfarin
Converting patients from the vitamin K antagonist warfarin (INR 2.0 to 3.0) to rivaroxaban (20 mg) or from rivaroxaban (20 mg) to warfarin (INR 2.0 to 3.0) increased prothrombin time/INR (Neoplastin) more than additively (individual INR values up to 12 may be observed), whereas effects on aPTT, inhibition of factor Xa activity and endogenous thrombin potential were additive.
If it is desired to test the pharmacodynamic effects of rivaroxaban during the conversion period, anti-factor Xa activity, PiCT, and Heptest can be used as these tests were not affected by warfarin. On the fourth day after the last dose of warfarin, all tests (including PT, aPTT, inhibition of factor Xa activity and ETP) reflected only the effect of rivaroxaban.
If it is desired to test the pharmacodynamic effects of warfarin during the conversion period, INR measurement can be used at the $C_{trough}$ of rivaroxaban (24 hours after the previous intake of rivaroxaban) as this test is minimally affected by rivaroxaban at this time point.
No pharmacokinetic interaction was observed between warfarin and rivaroxaban.

CYP3A4 inducers
Co-administration of rivaroxaban with the strong CYP3A4 inducer rifampicin led to an approximate 50% decrease in mean rivaroxaban AUC, with parallel decreases in its pharmacodynamic effects. The concomitant use of rivaroxaban with other strong CYP3A4 inducers (e.g. phenytoin, carbamazepine, phenobarbital or St. John's Wort (*Hypericum perforatum*)) may also lead to reduced rivaroxaban plasma concentrations. Therefore, concomitant administration of strong CYP3A4 inducers should be avoided unless the patient is closely observed for signs and symptoms of thrombosis.

Other concomitant therapies
No clinically significant pharmacokinetic or pharmacodynamic interactions were observed when rivaroxaban was co-administered with midazolam (substrate of CYP3A4), digoxin (substrate of P-gp), atorvastatin (substrate of CYP3A4 and P-gp) or omeprazole (proton pump inhibitor). Rivaroxaban neither inhibits nor induces any major CYP isoforms like CYP3A4.
No clinically relevant interaction with food was observed (see section 4.2).

Laboratory parameters
Clotting parameters (e.g. PT, aPTT, HepTest) are affected as expected by the mode of action of rivaroxaban (see section 5.1).

## 4.6 Fertility, pregnancy and lactation

Pregnancy
Safety and efficacy of Xarelto have not been established in pregnant women. Studies in animals have shown reproductive toxicity (see section 5.3). Due to the potential reproductive toxicity, the intrinsic risk of bleeding and the evidence that rivaroxaban passes the placenta, Xarelto is contraindicated during pregnancy (see section 4.3).
Women of child-bearing potential should avoid becoming pregnant during treatment with rivaroxaban.

Breast-feeding
Safety and efficacy of Xarelto have not been established in breast feeding women. Data from animals indicate that rivaroxaban is secreted into milk. Therefore Xarelto is contraindicated during breast feeding (see section 4.3). A decision must be made whether to discontinue breast feeding or to discontinue/abstain from therapy.

Fertility
No specific studies with rivaroxaban in humans have been conducted to evaluate effects on fertility. In a study on male and female fertility in rats no effects were seen (see section 5.3).

## 4.7 Effects on ability to drive and use machines

Xarelto has minor influence on the ability to drive and use machines. Adverse reactions like syncope (frequency: uncommon) and dizziness (frequency: common) have been reported (see section 4.8). Patients experiencing these adverse reactions should not drive or use machines.

## 4.8 Undesirable effects

Summary of the safety profile
The safety of rivaroxaban has been evaluated in thirteen phase III studies including 53,103 patients exposed to rivaroxaban (see Table 1).

**Table 1: Number of patients studied, total daily dose and maximum treatment duration in phase III studies**

| Indication | Number of patients* | Total daily dose | Maximum treatment duration |
|---|---|---|---|
| Prevention of venous thromboembolism (VTE) in adult patients undergoing elective hip or knee replacement surgery | 6,097 | 10 mg | 39 days |
| Prevention of VTE in medically ill patients | 3,997 | 10 mg | 39 days |
| Treatment of deep vein thrombosis (DVT), pulmonary embolism (PE) and prevention of recurrence | 6,790 | Day 1 - 21: 30 mg<br>Day 22 and onwards: 20 mg<br>After at least 6 months: 10 mg or 20 mg | 21 months |
| Prevention of stroke and systemic embolism in patients with non-valvular atrial fibrillation | 7,750 | 20 mg | 41 months |
| Prevention of atherothrombotic events in patients after an ACS | 10,225 | 5 mg or 10 mg respectively, co-administered with either ASA or ASA plus clopidogrel or ticlopidine | 31 months |
| Prevention of atherothrombotic events in patients with CAD/PAD | 18,244 | 5 mg co-administered with ASA or 10 mg alone | 47 months |
| | 3,256** | 5 mg co-administered with ASA | 42 months |

*Patients exposed to at least one dose of rivaroxaban
** From the VOYAGER PAD study

The most commonly reported adverse reactions in patients receiving rivaroxaban were bleedings (see section 4.4. and 'Description of selected adverse reactions' below) (Table 2). The most commonly reported bleedings were epistaxis (4.5 %) and gastrointestinal tract haemorrhage (3.8 %).

**Table 2: Bleeding* and anaemia events rates in patients exposed to rivaroxaban across the completed phase III studies**

| Indication | Any bleeding | Anaemia |
|---|---|---|
| Prevention of venous thromboembolism (VTE) in adult patients undergoing elective hip or knee replacement surgery | 6.8% of patients | 5.9% of patients |
| Prevention of venous thromboembolism in medically ill patients | 12.6% of patients | 2.1% of patients |
| Treatment of DVT, PE and prevention of recurrence | 23% of patients | 1.6% of patients |
| Prevention of stroke and systemic embolism in patients with non-valvular atrial fibrillation | 28 per 100 patient years | 2.5 per 100 patient years |
| Prevention of atherothrombotic events in patients after an ACS | 22 per 100 patient years | 1.4 per 100 patient years |
| Prevention of atherothrombotic events in patients with CAD/PAD | 6.7 per 100 patient years | 0.15 per 100 patient years** |
| | 8.38 per 100 patient years # | 0.74 per 100 patient years*** # |

* For all rivaroxaban studies all bleeding events are collected, reported and adjudicated.
** In the COMPASS study, there is a low anaemia incidence as a selective approach to adverse event collection was applied
*** A selective approach to adverse event collection was applied
# From the VOYAGER PAD study

Tabulated list of adverse reactions
The frequencies of adverse reactions reported with Xarelto are summarised in Table 3 below by system organ class (in MedDRA) and by frequency.

Frequencies are defined as:
very common (≥ 1/10)
common (≥ 1/100 to < 1/10)
uncommon (≥ 1/1,000 to < 1/100)
rare (≥ 1/10,000 to < 1/1,000)
very rare (< 1/10,000)
not known (cannot be estimated from the available data)

**Table 3: All adverse reactions reported in patients in phase III clinical studies or through post-marketing use***

| Common | Uncommon | Rare | Very rare | Not known |
|---|---|---|---|---|
| **Blood and lymphatic system disorders** | | | | |
| Anaemia (incl. respective laboratory parameters) | Thrombocytosis (incl. platelet count increased)[A], Thrombocytopenia | | | |
| **Immune system disorders** | | | | |
| | Allergic reaction, dermatitis allergic, Angioedema and allergic oedema | | Anaphylactic reactions including anaphylactic shock | |
| **Nervous system disorders** | | | | |
| Dizziness, headache | Cerebral and intracranial haemorrhage, syncope | | | |
| **Eye disorders** | | | | |
| Eye haemorrhage (incl. conjunctival haemorrhage) | | | | |
| **Cardiac disorders** | | | | |
| | Tachycardia | | | |
| **Vascular disorders** | | | | |
| Hypotension, haematoma | | | | |
| **Respiratory, thoracic and mediastinal disorders** | | | | |
| Epistaxis, haemoptysis | | | Eosinophilic pneumonia | |
| **Gastrointestinal disorders** | | | | |
| Gingival bleeding, gastrointestinal tract haemorrhage (incl. rectal haemorrhage), gastrointestinal and abdominal pains, dyspepsia, nausea, constipation[A], diarrhoea, vomiting[A] | Dry mouth | | | |
| **Hepatobiliary disorders** | | | | |
| Increase in transaminases | Hepatic impairment, Increased bilirubin, increased blood alkaline phosphatase[A], increased GGT[A] | Jaundice, Bilirubin conjugated increased (with or without concomitant increase of ALT), Cholestasis, Hepatitis (incl. hepatocellular injury) | | |

| Common | Uncommon | Rare | Very rare | Not known |
|---|---|---|---|---|
| **Skin and subcutaneous tissue disorders** | | | | |
| Pruritus (incl. uncommon cases of generalised pruritus), rash, ecchymosis, cutaneous and subcutaneous haemorrhage | Urticaria | | Stevens-Johnson syndrome/ Toxic Epidermal Necrolysis, DRESS syndrome | |
| **Musculoskeletal and connective tissue disorders** | | | | |
| Pain in extremity[A] | Haemarthrosis | Muscle haemorrhage | | Compartment syndrome secondary to a bleeding |
| **Renal and urinary disorders** | | | | |
| Urogenital tract haemorrhage (incl. haematuria and menorrhagia[B]), renal impairment (incl. blood creatinine increased, blood urea increased) | | | | Renal failure/acute renal failure secondary to a bleeding sufficient to cause hypoperfusion |
| **General disorders and administration site conditions** | | | | |
| Fever[A], peripheral oedema, decreased general strength and energy (incl. fatigue and asthenia) | Feeling unwell (incl. malaise) | Localised oedema[A] | | |
| **Investigations** | | | | |
| | Increased LDH[A], increased lipase[A], increased amylase[A] | | | |
| **Injury, poisoning and procedural complications** | | | | |
| Postprocedural haemorrhage (incl. postoperative anaemia, and wound haemorrhage), contusion, wound secretion[A] | | Vascular pseudoaneurysm[C] | | |

A: observed in prevention of VTE in adult patients undergoing elective hip or knee replacement surgery

B: observed in treatment of DVT, PE and prevention of recurrence as very common in women < 55 years

C: observed as uncommon in prevention of atherothrombotic events in patients after an ACS (following percutaneous coronary intervention)

* A pre-specified selective approach to adverse event collection was applied. As incidence of adverse reactions did not increase and no new adverse reaction was identified, COMPASS study data were not included for frequency calculation in this table.

Description of selected adverse reactions
Due to the pharmacological mode of action, the use of Xarelto may be associated with an increased risk of occult or overt bleeding from any tissue or organ which may result in post haemorrhagic anaemia. The signs, symptoms and severity (including fatal outcome) will vary according to the location and degree or extent of the bleeding and/or anaemia (see section 4.9 "Management of bleeding"). In the clinical studies mucosal bleedings (i.e. epistaxis, gingival, gastrointestinal, genito urinary including abnormal vaginal or increased menstrual bleeding) and anaemia were seen more frequently during long term rivaroxaban treatment compared with VKA treatment. Thus, in addition to adequate clinical surveillance, laboratory testing of haemoglobin/haematocrit could be of value to detect occult bleeding and quantify the clinical relevance of overt bleeding, as judged to be appropriate. The risk of bleedings may be increased in certain patient groups e.g. those patients with uncontrolled severe arterial hypertension and/or on concomitant treatment affecting haemostasis (see section 4.4 "Haemorrhagic risk"). Menstrual bleeding may be intensified and/or prolonged.
Haemorrhagic complications may present as weakness, paleness, dizziness, headache or unexplained swelling, dyspnoea and unexplained shock. In some cases as a consequence of anaemia, symptoms of cardiac ischaemia like chest pain or angina pectoris have been observed.
Known complications secondary to severe bleeding such as compartment syndrome and renal failure due to hypoperfusion have been reported for Xarelto. Therefore, the possibility of haemorrhage is to be considered in evaluating the condition in any anticoagulated patient.

Reporting of suspected adverse reactions
Reporting suspected adverse reactions after authorisation of the medicinal product is important. It allows continued monitoring of the benefit/risk balance of the medicinal product.
Any suspected adverse events should be reported to the Ministry of Health according to the National Regulation by using an online form
https://sideeffects.health.gov.il

## 4.9 Overdose

Rare cases of overdose up to 1,960 mg have been reported. In case of overdose, the patient should be observed carefully for bleeding complications or other adverse reactions (see section "Management of bleeding"). Due to limited absorption a ceiling effect with no further increase in average plasma exposure is expected at supratherapeutic doses of 50 mg rivaroxaban or above.
A specific reversal agent (andexanet alfa)antagonising the pharmacodynamic effect of rivaroxaban is available (refer to the physician prescribing information of andexanet alfa).
The use of activated charcoal to reduce absorption in case of rivaroxaban overdose may be considered.

Management of bleeding
Should a bleeding complication arise in a patient receiving rivaroxaban, the next rivaroxaban administration should be delayed or treatment should be discontinued as appropriate. Rivaroxaban has a half-life of approximately 5 to 13 hours (see section 5.2). Management should be individualised according to the severity and location of the haemorrhage. Appropriate symptomatic treatment could be used as needed, such as mechanical compression (e.g. for severe epistaxis), surgical haemostasis with bleeding control procedures, fluid replacement and haemodynamic support, blood products (packed red cells or fresh frozen plasma, depending on associated anaemia or coagulopathy) or platelets.
If bleeding cannot be controlled by the above measures, either the administration of a specific factor Xa inhibitor reversal agent (andexanet alfa), which antagonises the pharmacodynamic effect of rivaroxaban, or a specific procoagulant agent, such as prothrombin complex concentrate (PCC), activated prothrombin complex concentrate (APCC) or recombinant factor VIIa (r-FVIIa), should be considered. However, there is currently very limited clinical experience with the use of these medicinal products in individuals receiving rivaroxaban. The recommendation is also based on limited non-clinical data. Re-dosing of recombinant factor VIIa shall be considered and titrated depending on improvement of bleeding. Depending on local availability, a consultation with a coagulation expert should be considered in case of major bleedings (see section 5.1).

Protamine sulphate and vitamin K are not expected to affect the anticoagulant activity of rivaroxaban. There is limited experience with tranexamic acid and no experience with aminocaproic acid and

aprotinin in individuals receiving rivaroxaban. There is neither scientific rationale for benefit nor experience with the use of the systemic haemostatic desmopressin in individuals receiving rivaroxaban. Due to the high plasma protein binding rivaroxaban is not expected to be dialysable.

## 5. PHARMACOLOGICAL PROPERTIES

### 5.1 Pharmacodynamic properties

Pharmacotherapeutic group: Antithrombotic agents, direct factor Xa inhibitors, ATC code: B01AF01

Mechanism of action
Rivaroxaban is a highly selective direct factor Xa inhibitor with oral bioavailability. Inhibition of factor Xa interrupts the intrinsic and extrinsic pathway of the blood coagulation cascade, inhibiting both thrombin formation and development of thrombi. Rivaroxaban does not inhibit thrombin (activated factor II) and no effects on platelets have been demonstrated.

Pharmacodynamic effects
Dose-dependent inhibition of factor Xa activity was observed in humans. Prothrombin time (PT) is influenced by rivaroxaban in a dose dependent way with a close correlation to plasma concentrations (r value equals 0.98) if Neoplastin is used for the assay. Other reagents would provide different results. The readout for PT is to be done in seconds, because the INR is only calibrated and validated for coumarins and cannot be used for any other anticoagulant.
In a clinical pharmacology study on the reversal of rivaroxaban pharmacodynamics in healthy adult subjects (n=22), the effects of single doses (50 IU/kg) of two different types of PCCs, a 3-factor PCC (Factors II, IX and X) and a 4-factor PCC (Factors II, VII, IX and X) were assessed. The 3-factor PCC reduced mean Neoplastin PT values by approximately 1.0 second within 30 minutes, compared to reductions of approximately 3.5 seconds observed with the 4-factor PCC. In contrast, the 3-factor PCC had a greater and more rapid overall effect on reversing changes in endogenous thrombin generation than the 4-factor PCC (see section 4.9).
The activated partial thomboplastin time (aPTT) and HepTest are also prolonged dose-dependently; however, they are not recommended to assess the pharmacodynamic effect of rivaroxaban. There is no need for monitoring of coagulation parameters during treatment with rivaroxaban in clinical routine. However, if clinically indicated, rivaroxaban levels can be measured by calibrated quantitative anti-factor-Xa tests (see section 5.2).

Clinical efficacy and safety

*ACS*

The rivaroxaban clinical programme was designed to demonstrate the efficacy of Xarelto for the prevention of cardiovascular (CV) death, myocardial infarction (MI) or stroke in subjects with a recent ACS (ST-elevation myocardial infarction [STEMI], non- ST-elevation myocardial infarction [NSTEMI] or unstable angina [UA]). In the pivotal double-blind ATLAS ACS 2 TIMI 51 study, 15,526 patients were randomly assigned in a 1:1:1 fashion to one of three treatment groups: Xarelto 2.5 mg orally twice daily, 5 mg orally twice daily or to placebo twice daily co-administered with ASA alone or with ASA plus a thienopyridine (clopidogrel or ticlopidine). Patients with an ACS under the age of 55 had to have either diabetes mellitus or a previous MI. The median time on treatment was 13 months and overall treatment duration was up to almost 3 years. 93.2 % of patients received ASA concomitantly plus thienopyridine treatment and 6.8 % ASA only. Among patients receiving dual anti-platelets therapy 98.8% received clopidogrel, 0.9 % received ticlopidine and 0.3 % received prasugrel. Patients received the first dose of Xarelto at a minimum of 24 hours and up to 7 days (mean 4.7 days) after admission to the hospital, but as soon as possible after stabilisation of the ACS event, including revascularisation procedures and when parenteral anticoagulation therapy would normally be discontinued.

Both the 2.5 mg twice daily and the 5 mg twice daily regimens of rivaroxaban were effective in further reducing the incidence of CV events on a background of standard antiplatelet care. The 2.5 mg twice daily regimen reduced mortality, and there is evidence that the lower dose had lower bleeding

risks, therefore rivaroxaban 2.5 mg twice daily co-administered with acetylsalicylic acid (ASA) alone or with ASA plus clopidogrel or ticlopidine is recommended for the prevention of atherothrombotic events in adult patients after an ACS with elevated cardiac biomarkers.

Relative to placebo, Xarelto significantly reduced the primary composite endpoint of CV death, MI or stroke. The benefit was driven by a reduction in CV death and MI and appeared early with a constant treatment effect over the entire treatment period (see Table 4 and Figure 1). Also the first secondary endpoint (all cause death, MI or stroke) was reduced significantly. An additional retrospective analysis showed a nominally significant reduction in the incidence rates of stent thrombosis compared with placebo (see Table 4). The incidence rates for the principal safety outcome (non- coronary artery bypass graft (CABG) TIMI major bleeding events) were higher in patients treated with Xarelto than in patients who received placebo (see Table 6). However the incidence rates were balanced between Xarelto and placebo for the components of fatal bleeding events, hypotension requiring treatment with intravenous inotropic agents and surgical intervention for ongoing bleeding.

In Table 5 the efficacy results of patients undergoing percutaneous coronary intervention (PCI) are presented. The safety results in this subgroup of patients undergoing PCI were comparable to the overall safety results.

Patients with elevated biomarkers (troponin or CK-MB) and without a prior stroke/TIA constituted 80 % of the study population. The results of this patient population were also consistent with the overall efficacy and safety results.

**Table 4: Efficacy results from phase III ATLAS ACS 2 TIMI 51**

| **Study population** | **Patients with a recent acute coronary syndrome** [a)] | |
|---|---|---|
| **Treatment dose** | **Xarelto 2.5 mg, twice daily, N=5,114 n (%) Hazard Ratio (HR) (95% CI) p-value** [b)] | **Placebo N=5,113 n (%)** |
| Cardiovascular death, MI or stroke | 313 (6.1%)<br>0.84 (0.72, 0.97) p = 0.020* | 376 (7.4%) |
| All-cause death, MI or stroke | 320 (6.3%)<br>0.83 (0.72, 0.97) p = 0.016* | 386 (7.5%) |
| Cardiovascular death | 94 (1.8%)<br>0.66 (0.51, 0.86) p = 0.002** | 143 (2.8%) |
| All-cause death | 103 (2.0%)<br>0.68 (0.53, 0.87) p = 0.002** | 153 (3.0%) |
| MI | 205 (4.0%)<br>0.90 (0.75, 1.09) p = 0.270 | 229 (4.5%) |
| Stroke | 46 (0.9%)<br>1.13 (0.74, 1.73) p = 0.562 | 41 (0.8%) |
| Stent thrombosis | 61 (1.2%)<br>0.70 (0.51, 0.97) p = 0.033** | 87 (1.7%) |

a) modified intent to treat analysis set (intent to treat total analysis set for stent thrombosis)
b) vs. placebo; Log-Rank p-value
* statistically superior
** nominally significant

**Table 5: Efficacy results from phase III ATLAS ACS 2 TIMI 51 in patients undergoing PCI**

| **Study population** | **Patients with recent acute coronary syndrome undergoing PCI** [a)] | |
|---|---|---|
| **Treatment dose** | **Xarelto 2.5 mg, twice daily, N=3114<br>n (%)<br>HR (95% CI) p-value** [b)] | **Placebo<br>N=3096<br>n (%)** |
| Cardiovascular death, MI or stroke | 153 (4.9%)<br>0.94 (0.75, 1.17) p = 0.572 | 165 (5.3%) |
| Cardiovascular death | 24 (0.8%)<br>0.54 (0.33, 0.89) p = 0.013** | 45 (1.5%) |
| All-cause death | 31 (1.0%)<br>0.64 (0.41, 1.01) p = 0.053 | 49 (1.6%) |
| MI | 115 (3.7%)<br>1.03 (0.79, 1.33) p = 0.829 | 113 (3.6%) |
| Stroke | 27 (0.9%)<br>1.30 (0.74, 2.31) p = 0.360 | 21 (0.7%) |
| Stent thrombosis | 47 (1.5%)<br>0.66 (0.46, 0.95) p = 0.026** | 71 (2.3%) |

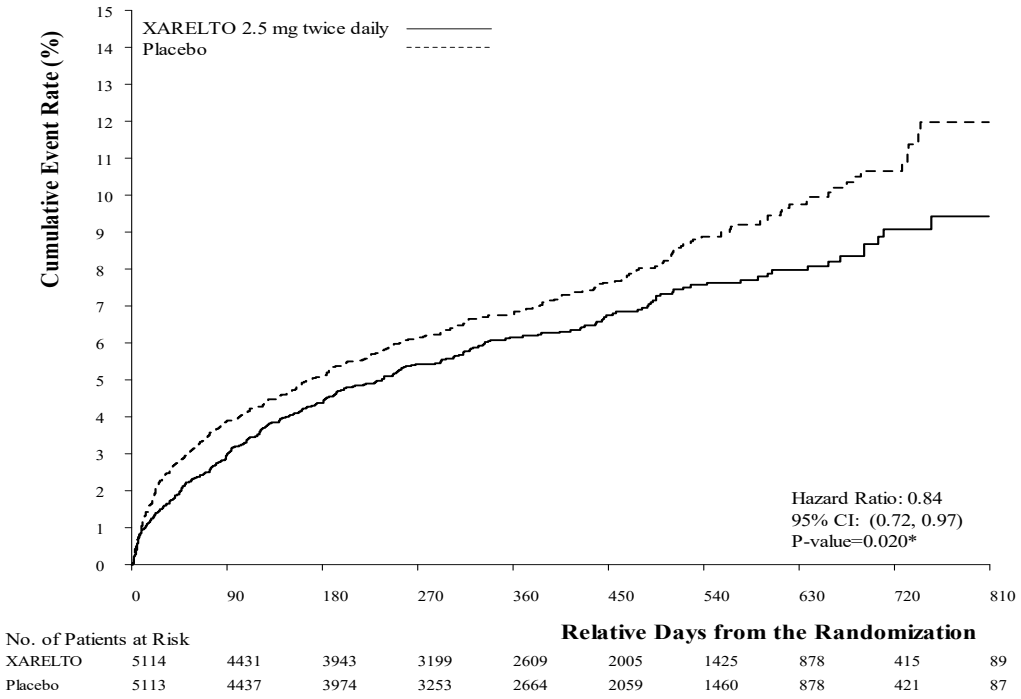
a) modified intent to treat analysis set (intent to treat total analysis set for stent thrombosis)
b) vs. placebo; Log-Rank p-value
** nominally significant

**Table 6: Safety results from phase III ATLAS ACS 2 TIMI 51**

| **Study population** | **Patients with recent acute coronary syndrome** [a)] | |
|---|---|---|
| **Treatment Dose** | **Xarelto 2.5 mg, twice daily,<br>N=5,115<br>n (%)<br>HR (95% CI) p-value** [b)] | **Placebo<br>N=5,125<br>n(%)** |
| Non-CABG TIMI major bleeding event | 65 (1.3%)<br>3.46 (2.08, 5.77) p = < 0.001* | 19 (0.4%) |
| Fatal bleeding event | 6 (0.1%)<br>0.67 (0.24, 1.89) p = 0.450 | 9 (0.2%) |
| Symptomatic intracranial haemorrhage | 14 (0.3%)<br>2.83 (1.02, 7.86) p = 0.037 | 5 (0.1%) |
| Hypotension requiring treatment with intravenous inotropic agents | 3 (0.1%) | 3 (0.1%) |
| Surgical intervention for ongoing bleeding | 7 (0.1%) | 9 (0.2%) |
| Transfusion of 4 or more units of blood over a 48 hour period | 19 (0.4%) | 6 (0.1%) |

a) safety population, on treatment
b) vs. placebo; Log-Rank p-value
* statistically significant

**Figure 1: Time to first occurrence of primary efficacy endpoint (CV death, MI or stroke)**




| No. of Patients at Risk | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| XARELTO | 5114 | 4431 | 3943 | 3199 | 2609 | 2005 | 1425 | 878 | 415 | 89 |
| Placebo | 5113 | 4437 | 3974 | 3253 | 2664 | 2059 | 1460 | 878 | 421 | 87 |

*CAD/PAD*

The phase III COMPASS study (27,395 patients, 78.0% male, 22.0% female) demonstrated the efficacy and safety of Xarelto for the prevention of a composite of CV death, MI, stroke in patients with CAD or symptomatic PAD at high risk of ischaemic events. Patients were followed for a median of 23 months and maximum of 3.9 years.

Subjects without a continuous need for treatment with a proton pump inhibitor were randomized to pantoprazole or placebo. All patients were then randomized 1:1:1 to rivaroxaban 2.5 mg twice daily/ASA 100 mg once daily, to rivaroxaban 5 mg twice daily, or ASA 100 mg once daily alone, and their matching placebos.

High risk patients are defined by COMPASS inclusion criteria

CAD patients had multivessel CAD and/or prior MI. Patients included in COMPASS were ≥65 years of age, or if < 65 years of age atherosclerosis or revascularization involving at least two vascular beds or at least two additional cardiovascular risk factors (smoking, diabetes mellitus, renal dysfunction with estimated glomerular filtration rate <60 ml/min, heart failure, non-lacunar ischemic stroke ≥1 month ago) were required.

PAD patients had previous interventions such as bypass surgery or percutaneous transluminal angioplasty or limb or foot amputation for arterial vascular disease or intermittent claudication with ankle/arm blood pressure ratio < 0.90 and/ or significant peripheral artery stenosis or previous carotid revascularization or asymptomatic carotid artery stenosis ≥ 50%.

Exclusion criteria included the need for dual antiplatelet or other non-ASA antiplatelet or oral anticoagulant therapy and patients with high bleeding risk, or heart failure with ejection fraction

< 30% or New York Heart Association class III or IV, or any ischaemic, non-lacunar stroke within 1 month or any history of haemorrhagic or lacunar stroke.

Xarelto 2.5 mg twice daily in combination with ASA 100 mg once daily was superior to ASA 100 mg, in the reduction of the primary composite outcome of CV death, MI, stroke (see Table 7 and Figure 2).

There was a significant increase of the primary safety outcome (modified ISTH major bleeding events) in patients treated with Xarelto 2.5 mg twice daily in combination with ASA 100 mg once daily compared to patients who received ASA 100 mg (see Table 8).

For the primary efficacy outcome, the observed benefit of Xarelto 2.5 mg twice daily plus ASA 100 mg once daily compared with ASA 100 mg once daily was HR=0.89 (95% CI 0.7-1.1) in patients ≥75 years (incidence: 6.3% vs 7.0%) and HR=0.70 (95% CI 0.6-0.8) in patients <75 years (3.6% vs 5.0%). For modified ISTH major bleeding, the observed risk increase was HR=2.12 (95% CI 1.5-3.0) in patients ≥75 years (5.2% vs 2.5%) and HR=1.53 (95% CI 1.2-1.9) in patients <75 years (2.6% vs 1.7%).

The use of pantoprazole 40 mg once daily in addition to antithrombotic study medication in patients with no clinical need for a proton pump inhibitor showed no benefit in the prevention of upper gastrointestinal events (i.e. composite of upper gastrointestinal bleeding, upper gastrointestinal ulceration, or upper gastrointestinal obstruction or perforation); the incidence rate of upper gastrointestinal events was 0.39/100 patient-years in the pantoprazole 40 mg once daily group and 0.44/100 patient-years in the placebo once daily group.

**Table 7: Efficacy results from phase III COMPASS**

| **Study Population** | **Patients with CAD/PAD** [a)] | | | | | |
|---|---|---|---|---|---|---|
| **Treatment Dosage** | **Xarelto 2.5 mg bid in combination with ASA 100 mg od N=9152** | | **ASA 100 mg od N=9126** | | | |
| | **Patients with events** | **KM %** | **Patients with events** | **KM %** | **HR (95% CI)** | **p-value** [b)] |
| | | | | | | |
| Stroke, MI or CV death | 379 (4.1%) | 5.20% | 496 (5.4%) | 7.17% | 0.76 (0.66;0.86) | p = 0.00004* |
| - Stroke | 83 (0.9%) | 1.17% | 142 (1.6%) | 2.23% | 0.58 (0.44;0.76) | p = 0.00006 |
| - MI | 178 (1.9%) | 2.46% | 205 (2.2%) | 2.94% | 0.86 (0.70;1.05) | p = 0.14458 |
| - CV death | 160 (1.7%) | 2.19% | 203 (2.2%) | 2.88% | 0.78 (0.64;0.96) | p = 0.02053 |
| | | | | | | |
| All-cause mortality | 313 (3.4%) | 4.50% | 378 (4.1%) | 5.57% | 0.82 (0.71;0.96) | |
| Acute limb ischaemia | 22 (0.2%) | 0.27% | 40 (0.4%) | 0.60% | 0.55 (0.32;0.92) | |

a) intention to treat analysis set, primary analyses
b) vs. ASA 100 mg; Log-Rank p-value
* The reduction in the primary efficacy outcome was statistically superior.
bid: twice daily; CI: confidence interval; KM %: Kaplan-Meier estimates of cumulative incidence risk calculated at 900 days; CV: cardiovascular; MI: myocardial infarction; od: once daily

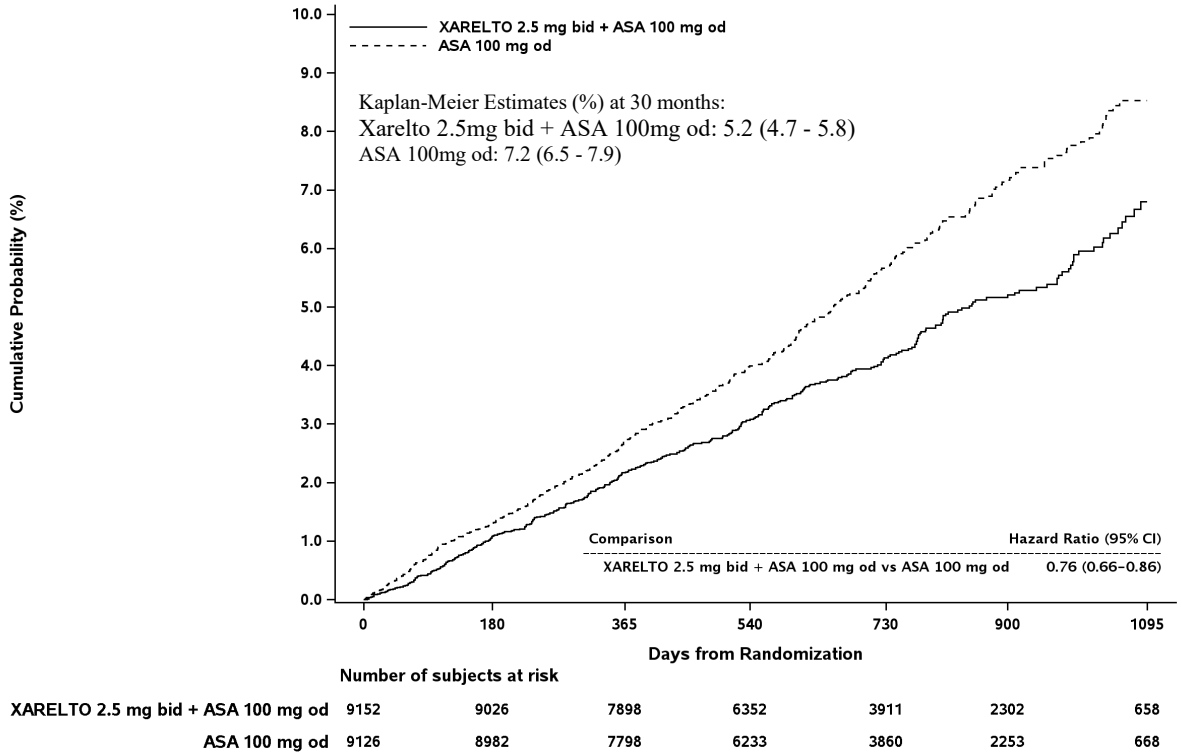
**Table 8: Safety results from phase III COMPASS**

| **Study population** | **Patients with CAD/PAD** [a)] | | |
|---|---|---|---|
| **Treatment Dose** | **Xarelto 2.5 mg bid in combination with ASA 100 mg od, N=9152 n (Cum. risk %)** | **ASA 100 mg od N=9126 n (Cum.risk %)** | **Hazard Ratio (95 % CI) p-value** [b)] |
| Modified ISTH major bleeding | 288 (3.9%) | 170 (2.5%) | 1.70 (1.40;2.05) p < 0.00001 |
| - Fatal bleeding event | 15 (0.2%) | 10 (0.2%) | 1.49 (0.67;3.33) p = 0.32164 |
| - Symptomatic bleeding in critical organ (non-fatal) | 63 (0.9%) | 49 (0.7%) | 1.28 (0.88;1.86) p = 0.19679 |
| - Bleeding into the surgical site requiring reoperation (non-fatal, not in critical organ) | 10 (0.1%) | 8 (0.1%) | 1.24 (0.49;3.14) p = 0.65119 |
| - Bleeding leading to hospitalisation (non-fatal, not in critical organ, not requiring reoperation) | 208 (2.9%) | 109 (1.6%) | 1.91 (1.51;2.41) p < 0.00001 |
| - With overnight stay | 172 (2.3%) | 90 (1.3%) | 1.91 (1.48;2.46) p < 0.00001 |
| - Without overnight stay | 36 (0.5%) | 21 (0.3%) | 1.70 (0.99;2.92) p = 0.04983 |
| Major gastrointestinal bleeding | 140 (2.0%) | 65 (1.1%) | 2.15 (1.60;2.89) p < 0.00001 |

| Study population | Patients with CAD/PAD [a] | | |
|---|---|---|---|
| **Treatment Dose** | **Xarelto 2.5 mg bid in combination with ASA 100 mg od, N=9152 n (Cum. risk %)** | **ASA 100 mg od N=9126 n (Cum.risk %)** | **Hazard Ratio (95 % CI) p-value [b]** |
| Major intracranial bleeding | 28 (0.4%) | 24 (0.3%) | 1.16 (0.67;2.00) p = 0.59858 |

a) intention-to-treat analysis set, primary analyses
b) vs. ASA 100 mg; Log-Rank p-value
bid: twice daily; CI: confidence interval; Cum. Risk: Cumulative incidence risk (Kaplan-Meier estimates) at 30 months; ISTH: International Society on Thrombosis and Haemostasis; od: once daily

**Figure 2: Time to first occurrence of primary efficacy outcome (stroke, myocardial infarction, cardiovascular death) in COMPASS**




bid: twice daily; od: once daily; CI: confidence interval

CAD with heart failure

The **COMMANDER HF** study included 5,022 patients with heart failure and significant coronary artery disease (CAD) following a hospitalization of decompensated heart failure (HF) which were randomly assigned into one of the two treatment groups: rivaroxaban 2.5 mg twice daily (N=2,507) or matching placebo (N=2,515), respectively. The overall median study treatment duration was 504 days. Patients must have had symptomatic HF for at least 3 months and left ventricular ejection fraction (LVEF) of ≤40% within one year of enrollment. At baseline, the median ejection fraction was 34% (IQR: 28%-38%) and 53% of subjects were NYHA Class III or IV.
The primary efficacy analysis (i.e. composite of all-cause mortality, MI, or stroke) showed no statistically significant difference between the rivaroxaban 2.5 mg twice daily group and the placebo group with a HR=0.94 (95% CI 0.84 - 1.05), p=0.270. For all-cause mortality, there was no difference between rivaroxaban and placebo in the number of events (event rate per 100 patient-years; 11.41 vs. 11.63, HR: 0.98; 95% CI: 0.87 to 1.10; p=0.743). The event rates for MI per 100 patient-years (rivaroxaban vs placebo) were 2.08 vs 2.52 (HR 0.83; 95% CI: 0.63 to 1.08; p=0.165) and for stroke the event rates per 100 patient-years were 1.08 vs 1.62 (HR: 0.66; 95% CI: 0.47 to 0.95; p=0.023). The principal safety outcome (i.e. composite of fatal bleeding or bleeding into a critical space with a

potential for permanent disability), occurred in 18 (0.7%) patients in the rivaroxaban 2.5 mg twice daily treatment group and in 23 (0.9%) patients in the placebo group, respectively (HR=0.80; 95% CI 0.43 - 1.49; p=0.484). There was a statistically significant increase in ISTH major bleeding in the rivaroxaban group compared with placebo (event rate per 100 patient-years: 2.04 vs 1.21, HR 1.68; 95% CI: 1.18 to 2.39; p=0.003).

In patients with mild and moderate heart failure the treatment effects for the COMPASS study subgroup were similar to those of the entire study population (see section CAD/PAD).

Patients with high risk triple positive antiphospholipid syndrome

In an investigator sponsored, randomized open-label multicenter study with blinded endpoint adjudication, rivaroxaban was compared to warfarin in patients with a history of thrombosis, diagnosed with antiphospholipid syndrome and at high risk for thromboembolic events (positive for all 3 antiphospholipid tests: lupus anticoagulant, anticardiolipin antibodies, and anti-beta 2-glycoprotein I antibodies). The study was terminated prematurely after the enrolment of 120 patients due to an excess of events among patients in the rivaroxaban arm. Mean follow-up was 569 days. 59 patients were randomized to rivaroxaban 20 mg (15 mg for patients with creatinine clearance (CrCl) <50 mL/min) and 61 to warfarin (INR 2.0-3.0). Thromboembolic events occurred in 12% of patients randomized to rivaroxaban (4 ischaemic strokes and 3 myocardial infarctions). No events were reported in patients randomized to warfarin. Major bleeding occurred in 4 patients (7%) of the rivaroxaban group and 2 patients (3%) of the warfarin group.

## 5.2 Pharmacokinetic properties

Absorption

Rivaroxaban is rapidly absorbed with maximum concentrations ($C_{max}$) appearing 2 - 4 hours after tablet intake.

Oral absorption of rivaroxaban is almost complete and oral bioavailability is high (80 - 100 %) for the 2.5 mg and 10 mg tablet dose, irrespective of fasting/fed conditions. Intake with food does not affect rivaroxaban AUC or $C_{max}$ at the 2.5 mg and 10 mg dose. Rivaroxaban 2.5 mg and 10 mg tablets can be taken with or without food.

Rivaroxaban pharmacokinetics are approximately linear up to about 15 mg once daily. At higher doses rivaroxaban displays dissolution limited absorption with decreased bioavailability and decreased absorption rate with increased dose. This is more marked in fasting state than in fed state. Variability in rivaroxaban pharmacokinetics is moderate with inter-individual variability (CV %) ranging from 30 % to 40 %.

Absorption of rivaroxaban is dependent on the site of its release in the gastrointestinal tract. A 29% and 56% decrease in AUC and $C_{max}$ compared to tablet was reported when rivaroxaban granulate is released in the proximal small intestine. Exposure is further reduced when rivaroxaban is released in the distal small intestine, or ascending colon. Therefore, administration of rivaroxaban distal to the stomach should be avoided since this can result in reduced absorption and related rivaroxaban exposure.

Bioavailability (AUC and $C_{max}$) was comparable for 20 mg rivaroxaban administered orally as a crushed tablet mixed in apple puree, or suspended in water and administered via a gastric tube followed by a liquid meal, compared to a whole tablet. Given the predictable, dose-proportional pharmacokinetic profile of rivaroxaban, the bioavailability results from this study are likely applicable to lower rivaroxaban doses.

Distribution

Plasma protein binding in humans is high at approximately 92 % to 95 %, with serum albumin being the main binding component. The volume of distribution is moderate with $V_{ss}$ being approximately 50 litres.

Biotransformation and elimination

Of the administered rivaroxaban dose, approximately 2/3 undergoes metabolic degradation, with half then being eliminated renally and the other half eliminated by the faecal route. The final 1/3 of the administered dose undergoes direct renal excretion as unchanged active substance in the urine, mainly via active renal secretion.

Rivaroxaban is metabolised via CYP3A4, CYP2J2 and CYP-independent mechanisms. Oxidative degradation of the morpholinone moiety and hydrolysis of the amide bonds are the major sites of biotransformation. Based on *in vitro* investigations rivaroxaban is a substrate of the transporter proteins P-gp (P-glycoprotein) and Bcrp (breast cancer resistance protein).
Unchanged rivaroxaban is the most important compound in human plasma, with no major or active circulating metabolites being present. With a systemic clearance of about 10 l/h, rivaroxaban can be classified as a low-clearance substance. After intravenous administration of a 1 mg dose the elimination half-life is about 4.5 hours. After oral administration the elimination becomes absorption rate limited. Elimination of rivaroxaban from plasma occurs with terminal half-lives of 5 to 9 hours in young individuals, and with terminal half-lives of 11 to 13 hours in the elderly.

Special populations

*Gender*

There were no clinically relevant differences in pharmacokinetics and pharmacodynamics between male and female patients.

*Elderly population*

Elderly patients exhibited higher plasma concentrations than younger patients, with mean AUC values being approximately 1.5 fold higher, mainly due to reduced (apparent) total and renal clearance. No dose adjustment is necessary.

*Different weight categories*

Extremes in body weight (< 50 kg or > 120 kg) had only a small influence on rivaroxaban plasma concentrations (less than 25 %). No dose adjustment is necessary.

*Inter-ethnic differences*

No clinically relevant inter-ethnic differences among Caucasian, African-American, Hispanic, Japanese or Chinese patients were observed regarding rivaroxaban pharmacokinetics and pharmacodynamics.

*Hepatic impairment*

Cirrhotic patients with mild hepatic impairment (classified as Child Pugh A) exhibited only minor changes in rivaroxaban pharmacokinetics (1.2 fold increase in rivaroxaban AUC on average), nearly comparable to their matched healthy control group. In cirrhotic patients with moderate hepatic impairment (classified as Child Pugh B), rivaroxaban mean AUC was significantly increased by 2.3 fold compared to healthy volunteers. Unbound AUC was increased 2.6 fold. These patients also had reduced renal elimination of rivaroxaban, similar to patients with moderate renal impairment. There are no data in patients with severe hepatic impairment.
The inhibition of factor Xa activity was increased by a factor of 2.6 in patients with moderate hepatic impairment as compared to healthy volunteers; prolongation of PT was similarly increased by a factor of 2.1. Patients with moderate hepatic impairment were more sensitive to rivaroxaban resulting in a steeper PK/PD relationship between concentration and PT.
Xarelto is contraindicated in patients with hepatic disease associated with coagulopathy and clinically relevant bleeding risk, including cirrhotic patients with Child Pugh B and C (see section 4.3).

*Renal impairment*

There was an increase in rivaroxaban exposure correlated to decrease in renal function, as assessed via creatinine clearance measurements. In individuals with mild (creatinine clearance 50 - 80 ml/min), moderate (creatinine clearance 30 - 49 ml/min) and severe (creatinine clearance 15 - 29 ml/min) renal impairment, rivaroxaban plasma concentrations (AUC) were increased 1.4, 1.5 and 1.6 fold respectively. Corresponding increases in pharmacodynamic effects were more pronounced. In individuals with mild, moderate and severe renal impairment the overall inhibition of factor Xa activity was increased by a factor of 1.5, 1.9 and 2.0 respectively as compared to healthy volunteers; prolongation of PT was similarly increased by a factor of 1.3, 2.2 and 2.4 respectively. There are no data in patients with creatinine clearance < 15 ml/min.
Due to the high plasma protein binding rivaroxaban is not expected to be dialysable.
Use is not recommended in patients with creatinine clearance < 15 ml/min. Xarelto is to be used with caution in patients with creatinine clearance 15 - 29 ml/min (see section 4.4).

Pharmacokinetic data in patients
In patients receiving rivaroxaban 2.5 mg twice daily for the prevention of atherothrombotic events in patients with ACS the geometric mean concentration (90 % prediction interval) 2 - 4 h and about 12 h after dose (roughly representing maximum and minimum concentrations during the dose interval) was 47 (13 - 123) and 9.2 (4.4 - 18) mcg/l, respectively.

Pharmacokinetic/pharmacodynamic relationship
The pharmacokinetic/pharmacodynamic (PK/PD) relationship between rivaroxaban plasma concentration and several PD endpoints (factor-Xa inhibition, PT, aPTT, Heptest) has been evaluated after administration of a wide range of doses (5 - 30 mg twice a day). The relationship between rivaroxaban concentration and factor-Xa activity was best described by an $E_{max}$ model. For PT, the linear intercept model generally described the data better. Depending on the different PT reagents used, the slope differed considerably. When Neoplastin PT was used, baseline PT was about 13 s and the slope was around 3 to 4 s/(100 mcg/l). The results of the PK/PD analyses in Phase II and III were consistent with the data established in healthy subjects.

Paediatric population
Safety and efficacy have not been established for children and adolescents up to 18 years.

### 5.3 Preclinical safety data

Non-clinical data reveal no special hazard for humans based on conventional studies of safety pharmacology, single dose toxicity, phototoxicity, genotoxicity, carcinogenic potential and juvenile toxicity.
Effects observed in repeat-dose toxicity studies were mainly due to the exaggerated pharmacodynamic activity of rivaroxaban. In rats, increased IgG and IgA plasma levels were seen at clinically relevant exposure levels.
In rats, no effects on male or female fertility were seen. Animal studies have shown reproductive toxicity related to the pharmacological mode of action of rivaroxaban (e.g. haemorrhagic complications). Embryo-foetal toxicity (post-implantation loss, retarded/progressed ossification, hepatic multiple light coloured spots) and an increased incidence of common malformations as well as placental changes were observed at clinically relevant plasma concentrations. In the pre- and post-natal study in rats, reduced viability of the offspring was observed at doses that were toxic to the dams.

## 6. PHARMACEUTICAL PARTICULARS

### 6.1 List of excipients

Excipients
Cellulose microcrystalline
Lactose monohydrate
Croscarmellose sodium
Hypromellose 5 cP (syn.: Hydroxypropylmethylcellulose 2910)
Magnesium stearate
Sodium laurilsulfate

Film-coat:
Hypromellose 15 cP (syn.: Hydroxypropylmethylcellulose 2910)
Macrogol 3350 (syn.: Polyethelene glycol (3350))
Titanium dioxide
Ferric oxide yellow

### 6.2 Incompatibilities

Not applicable.

### 6.3 Shelf life

The expiry date of the product is indicated on the packaging materials.

### 6.4 Special precautions for storage

Do not store above 25°C

### 6.5 Nature and contents of container

PP/Aluminium foil blisters in cartons of 14, 56, 60, 168 film-coated tablets.

Not all pack sizes may be marketed.

### 6.6 Special precautions for disposal

No special requirements for disposal.

## 7. MANUFACTURER

Bayer AG, Leverkusen, Germany or Bayer healthcare manufacturing s.r.l, Garbagnate Milanese, italy.

## 8. REGISTRATION HOLDER

Bayer Israel Ltd., 36 Hacharash St., Hod Hasharon 4527702.

**Revised in March 2023 according to MoHs guidelines**