

SUMMARY OF PRODUCT CHARACTERISTICS

1 NAME OF THE MEDICINAL PRODUCT

Rivaroxaban 5 mg /ml Oral Suspension

2 QUALITATIVE AND QUANTITATIVE COMPOSITION

Each 1 ml of the oral suspension contains 5 mg rivaroxaban.

Excipients with known effect

Each 1 ml of the oral suspension contains 37 mg propylene glycol (E1520), 2.5 mg sodium benzoate (E211), 230 mg maltitol (E965) and 50 mg liquid sorbitol (E420).

For the full list of excipients, see section 6.1

3 PHARMACEUTICAL FORM

Oral suspension (suspension)

White to off-white aqueous suspension with a strawberry aroma.

4 CLINICAL PARTICULARS

4.1 Therapeutic indications

Adults

Rivaroxaban 5 mg/ml Oral Suspension is intended for:

- **Prevention of venous thromboembolism (VTE)** in adult patients undergoing elective hip or knee replacement surgery.
- **Prevention of stroke and systemic embolism** in adult patients with non-valvular atrial fibrillation with one or more risk factors, such as congestive heart

failure, hypertension, age ≥ 75 years, diabetes mellitus, prior stroke or transient ischaemic attack.

- **Treatment of deep vein thrombosis (DVT) and pulmonary embolism (PE), and prevention of recurrent DVT and PE in adults** (see section 4.4 for haemodynamically unstable PE patients).

Paediatric population

- **Treatment of venous thromboembolism (VTE) and prevention of VTE** recurrence in children and adolescents aged less than 18 years and weighing more than 30 kg after at least 5 days of initial parenteral anticoagulation treatment.

4.2 Posology and method of administration

Table 1: Summary of posology per indication

<i>Indication</i>	<i>Posology</i>	<i>Method of administration</i>
Prevention of venous thromboembolism (VTE) in adults undergoing elective hip or knee replacement surgery.	10 mg rivaroxaban (2 ml of suspension) once daily	with water (with or without food)
Treatment of VTE and prevention of VTE recurrence in children and adolescents aged less than 18 years and weighing from 30 to 50 kg after at least 5 days of initial parenteral anticoagulation treatment.	15 mg rivaroxaban (3 ml of suspension) once daily	with food
Treatment of VTE and prevention of VTE recurrence in children and adolescents aged less than 18 years and weighing more than 50 kg after at least 5 days of initial parenteral anticoagulation treatment.	20 mg rivaroxaban (4 ml of suspension) once daily	with food
Prevention of stroke and systemic embolism in adults with non-valvular atrial fibrillation with one or more risk factors, such as congestive heart failure, hypertension, age ≥ 75 years, diabetes mellitus, prior stroke or transient ischaemic attack.	20 mg rivaroxaban (4 ml of suspension) once daily	with food
Treatment of deep vein thrombosis (DVT) and pulmonary embolism (PE), and prevention of recurrent DVT and PE in adults.	15 mg rivaroxaban (3 ml of suspension) twice daily (day 1-21)	with food
	20 mg rivaroxaban (4 ml of suspension) once daily (day 22 onwards)	

Prevention of recurrent DVT and PE in adults (following completion of at least 6 months therapy for DVT or PE).	10 mg rivaroxaban (2 ml of suspension) once daily or 20 mg rivaroxaban (4 ml of suspension) once daily	with water (with or without food) with food
Prevention of stroke and systemic embolism in adults with moderate or severe renal impairment (creatinine clearance 15 – 49 ml/min).	15 mg rivaroxaban (3 ml of suspension) once daily	with food
Treatment of DVT and PE, and prevention of recurrent DVT and PE in adults with moderate or severe renal impairment (creatinine clearance 15 – 49 ml/min).	15 mg rivaroxaban (3 ml of suspension) twice daily (day 1-21)	with food
	15 mg rivaroxaban (3 ml of suspension) once daily (day 22 onwards)	

Posology

Prevention of VTE in adult patients undergoing elective hip or knee replacement surgery

The recommended dose is 10 mg of rivaroxaban (2 ml of suspension) taken orally once daily. The initial dose should be taken 6 to 10 hours after surgery, provided that haemostasis has been established.

The duration of treatment depends on the individual risk of the patient for venous thromboembolism which is determined by the type of orthopaedic surgery.

- For patients undergoing major hip surgery, a treatment duration of 5 weeks is recommended.
- For patients undergoing major knee surgery, a treatment duration of 2 weeks is recommended

If a dose is missed the patient should take Rivaroxaban 5 mg/ml Oral Suspension immediately and then continue the following day with once daily intake as before.

Treatment of VTE and prevention of VTE recurrence in children and adolescents

Rivaroxaban 5 mg/ml Oral Suspension treatment in children and adolescents aged less than 18 years should be initiated following at least 5 days of initial parenteral anticoagulation treatment (see section 5.1).

The dose for children and adolescent is calculated based on body weight.

1. Body weight from 30 to 50 kg:
a once daily dose of 15 mg rivaroxaban (3 ml of suspension) is recommended.
This is the maximum daily dose.
2. For patients with body weight of 50 kg or more:
a once daily dose of 20 mg rivaroxaban (4 ml of suspension) is recommended.
This is the maximum daily dose.
3. For patients with body weight less 30 kg refer to the Summary of Product Characteristics of rivaroxaban formulation intended for paediatric population.

The weight of a child should be monitored and the dose reviewed regularly. This is to ensure a therapeutic dose is maintained. Dose adjustments should be made based on changes in body weight only.

Treatment should be continued for at least 3 months in children and adolescents. Treatment can be extended up to 12 months when clinically necessary. There are no data available in children to support a dose reduction after 6 months treatment. The benefit-risk of continued therapy after 3 months should be assessed on an individual basis taking into account the risk for recurrent thrombosis versus the potential bleeding risk.

If a dose is missed, the missed dose should be taken as soon as possible after it is noticed, but only on the same day. If this is not possible, the patient should skip the dose and continue with the next dose as prescribed. The patient should not take two doses to make up for a missed dose.

Prevention of stroke and systemic embolism in adults

The recommended dose is 20 mg of rivaroxaban (4 ml of suspension) once daily, which is also the recommended maximum dose.

Therapy with Rivaroxaban 5 mg/ml Oral Suspension should be continued long term provided the benefit of prevention of stroke and systemic embolism outweighs the risk of bleeding (see section 4.4).

If a dose is missed the patient should take Rivaroxaban 5 mg/ml Oral Suspension immediately and continue on the following day with the once daily intake as recommended. The dose should not be doubled within the same day to make up for a missed dose.

Treatment of DVT, treatment of PE and prevention of recurrent DVT and PE in adults

The recommended dose for the initial treatment of acute DVT or PE is 15 mg of rivaroxaban (3 ml of suspension) twice daily for the first three weeks followed by 20 mg of rivaroxaban (4 ml of suspension) once daily for the continued treatment and prevention of recurrent DVT and PE.

Short duration of therapy (at least 3 months) should be considered in patients with DVT or PE provoked by major transient risk factors (i.e. recent major surgery or trauma). Longer duration of therapy should be considered in patients with provoked DVT or PE not related to major transient risk factors, unprovoked DVT or PE, or a history of recurrent DVT or PE.

When extended prevention of recurrent DVT and PE is indicated (following completion of at least 6 months therapy for DVT or PE), the recommended dose is 10 mg of rivaroxaban (2 ml of suspension) once daily. In patients in whom the risk of recurrent DVT or PE is considered high, such as those with complicated comorbidities, or who have developed recurrent DVT or PE on extended prevention with 10 mg of rivaroxaban (2 ml of suspension) once daily, a dose of 20 mg of rivaroxaban (4 ml of suspension) once daily should be considered.

The duration of therapy and dose selection should be individualised after careful assessment of the treatment benefit against the risk for bleeding (see section 4.4).

Table 2: Treatment and prevention of recurrent DVT and PE

	Time period	Dosing schedule	Total daily dose
Treatment and prevention of recurrent DVT and PE	Day 1 - 21	15 mg of rivaroxaban (3 ml of suspension) twice daily	30 mg of rivaroxaban (6 ml of suspension)
	Day 22 onwards	20 mg of rivaroxaban (4 ml of suspension) once daily	20 mg of rivaroxaban (4 ml of suspension)
Prevention of recurrent DVT and PE	Following completion of at least 6 months therapy for DVT or PE	10 mg of rivaroxaban (2 ml of suspension) once daily or 20 mg of rivaroxaban (4 ml of suspension) once daily	10 mg or 20 mg of rivaroxaban (2 or 4 ml of suspension)

If a dose is missed during the 15 mg of rivaroxaban (3 ml of suspension) twice daily treatment phase (day 1 - 21), the patient should take Rivaroxaban 5 mg/ml Oral Suspension immediately to ensure intake of 30 mg of rivaroxaban (6 ml of suspension) per day. In this case 30 mg of rivaroxaban (6 ml of suspension) may be taken at once. The patient should continue with the regular 15 mg of rivaroxaban (3 ml of suspension) twice daily intake as recommended on the following day.

If a dose is missed during the once daily treatment phase, the patient should take Rivaroxaban 5 mg/ml Oral Suspension immediately, and continue on the following day with the once daily intake as recommended. The dose should not be doubled within the same day to make up for a missed dose.

Converting from Vitamin K Antagonists (VKA) to Rivaroxaban 5 mg/ml Oral Suspension

- Prevention of stroke and systemic embolism:

- VKA treatment should be stopped and Rivaroxaban 5 mg/ml Oral Suspension therapy should be initiated when the International Normalized Ratio (INR) is ≤ 3.0 .
- Treatment of DVT, PE and prevention of recurrence in adults and treatment of VTE and prevention of recurrence in paediatric patients:

VKA treatment should be stopped and Rivaroxaban 5 mg/ml Oral Suspension therapy should be initiated once the INR is ≤ 2.5 .

When converting patients from VKAs to Rivaroxaban 5 mg/ml Oral Suspension, INR values will be falsely elevated after the intake of Rivaroxaban 5 mg/ml Oral Suspension. The INR is not valid to measure the anticoagulant activity of, and therefore should not be used (see section 4.5).

Converting from Rivaroxaban 5 mg/ml Oral Suspension to Vitamin K antagonists (VKA)

There is a potential for inadequate anticoagulation during the transition from Rivaroxaban 5 mg/ml Oral Suspension to VKA. Continuous adequate anticoagulation should be ensured during any transition to an alternate anticoagulant. It should be noted that Rivaroxaban 5 mg/ml Oral Suspension can contribute to an elevated INR.

In patients converting from Rivaroxaban 5 mg/ml Oral Suspension 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 Rivaroxaban 5 mg/ml Oral Suspension and VKA the INR should not be tested earlier than 24 hours after the previous dose but prior to the next dose of Rivaroxaban 5 mg/ml Oral Suspension. Once Rivaroxaban 5mg/ml Oral Suspension is discontinued INR testing may be done reliably at least 24 hours after the last dose (see sections 4.5 and 5.2).

Paediatric patients

Children who convert from Rivaroxaban 5 mg/ml Oral Suspension to VKA need to continue Rivaroxaban 5 mg/ml Oral Suspension for 48 hours after the first dose of VKA. After 2 days of co-administration an INR should be obtained prior to the next scheduled dose of Rivaroxaban 5 mg/ml Oral Suspension. Co-administration of Rivaroxaban 5 mg/ml Oral Suspension and VKA is advised to continue until the INR is ≥ 2.0 . Once Rivaroxaban 5 mg/ml Oral Suspension is discontinued INR testing may be done reliably 24 hours after the last dose (see above and section 4.5).

Converting from parenteral anticoagulants to Rivaroxaban 5 mg/ml Oral Suspension

For adult and paediatric patients currently receiving a parenteral anticoagulant, discontinue the parenteral anticoagulant and start Rivaroxaban 5 mg/ml Oral Suspension 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 Rivaroxaban 5 mg/ml Oral Suspension to parenteral anticoagulants

Discontinue Rivaroxaban 5 mg/ml Oral Suspension and give the first dose of parenteral anticoagulant at the time the next Rivaroxaban 5 mg/ml Oral Suspension dose would be taken.

Special populations

Renal impairment in adults

Limited clinical data for patients with severe renal impairment (creatinine clearance 15 – 29 ml/min) indicate that rivaroxaban plasma concentrations are significantly increased. Therefore, Rivaroxaban 5 mg/ml Oral Suspension 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).

- *For the prevention of VTE in adult patients undergoing elective hip or knee replacement surgery, 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).*

- *For the prevention of stroke and systemic embolism in patients with non-valvular atrial fibrillation,*
 - no dose adjustment from the recommended dose is necessary in patients with mild renal impairment (creatinine clearance 50 – 80 ml/min) (see section 5.2).
 - in patients with moderate (creatinine clearance 30 – 49 ml/min) or severe (creatinine clearance 15 – 29 ml/min) renal impairment: the recommended dose is 15 mg of rivaroxaban (3 ml of suspension) once daily (see section 5.2).

- *For the treatment of DVT, treatment of PE and prevention of recurrent DVT and PE,*
 - no dose adjustment from the recommended dose is necessary in patients with mild renal impairment (creatinine clearance 50 – 80 ml/min) (see section 5.2).
 - in patients with moderate (creatinine clearance 30 – 49 ml/min) or severe (creatinine clearance 15 – 29 ml/min) renal impairment: patients should be treated with 15 mg of rivaroxaban (3 ml of suspension) twice daily for the first 3 weeks. Thereafter, when the recommended dose is 20 mg of rivaroxaban (4 ml of suspension) once daily, a reduction of the dose from 20 mg of rivaroxaban (4 ml of suspension) once daily to 15 mg of rivaroxaban (3 ml of suspension) once daily should be considered if the patient's assessed risk for bleeding outweighs the risk for recurrent DVT and PE. The recommendation for the use of 15 mg of rivaroxaban (3 ml of suspension) is based on PK modelling and has not been studied in this clinical setting (see sections 4.4, 5.1 and 5.2).

When the recommended dose is 10 mg of rivaroxaban (2 ml of suspension) once daily, no dose adjustment from the recommended dose is necessary.

Renal impairment in paediatric population

- Children and adolescents with mild renal impairment (glomerular filtration rate 50 – 80 ml/min/1.73 m²): no dose adjustment is required, based on data in adults and limited data in paediatric patients (see section 5.2).
- Children and adolescents with moderate or severe renal impairment (glomerular filtration rate < 50 ml/min/1.73 m²): Rivaroxaban is not recommended as no clinical data are available (see section 4.4).

Hepatic impairment

Rivaroxaban 5 mg/ml Oral Suspension 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). No clinical data are available in children with hepatic impairment.

Elderly

No dose adjustment (see section 5.2).

The risk of bleeding increases with increasing age (see section 4.4).

Body weight

No dose adjustment for adults (see section 5.2).

For paediatric patients the dose is determined based on body weight.

Gender

No dose adjustment (see section 5.2).

Patients undergoing cardioversion

Rivaroxaban 5 mg/ml Oral Suspension can be initiated or continued in patients who may require cardioversion.

For transoesophageal echocardiogram (TEE) guided cardioversion in patients not previously treated with anticoagulants, Rivaroxaban 5 mg/ml Oral Suspension treatment should be started at least 4 hours before cardioversion to ensure adequate anticoagulation (see sections 5.1 and 5.2). For all patients, confirmation should be sought prior to cardioversion that the patient has taken Rivaroxaban 5 mg/ml Oral Suspension as prescribed. Decisions on initiation and duration of treatment should take established guideline recommendations for anticoagulant treatment in patients undergoing cardioversion into account.

Patients with non-valvular atrial fibrillation who undergo PCI (percutaneous coronary intervention) with stent placement

There is limited experience of a reduced dose of 15 mg of rivaroxaban (3 ml of suspension) once daily or 10 mg of rivaroxaban (2 ml of suspension) once daily for patients with moderate renal impairment (creatinine clearance 30 – 49 ml/min) in addition to a P2Y12 inhibitor for a maximum of 12 months in patients with non-valvular atrial fibrillation who require oral anticoagulation and undergo PCI with stent placement (see sections 4.4 and 5.1).

Paediatric population

The safety and efficacy of rivaroxaban in children aged 0 to < 18 years have not been established in other indications than the treatment of VTE and prevention of VTE recurrence. No data are available. Therefore, it is not recommended for use in children below 18 years of age in indications other than the treatment of VTE and prevention of VTE recurrence.

Method of administration

Rivaroxaban 5 mg/ml Oral Suspension is for oral use.

The doses of 15 and 20 mg of rivaroxaban (3 and 4 ml of suspension) must be taken with food (see section 5.2).

The dose of 10 mg of rivaroxaban (2 ml of suspension) must be taken with water (with or without food ; see section 5.2).

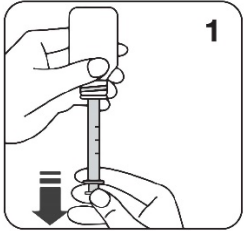
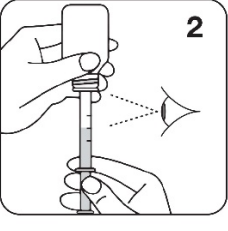
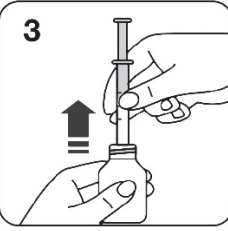
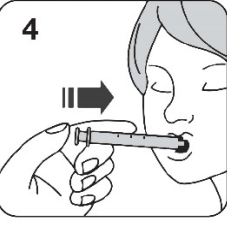
This medicinal product is administered orally as a “ready for-use” oral suspension using a graduated oral syringe. It may be administered directly into the mouth and followed by liquid, preferably with water.

The suspension may also be given through gastric tubes after confirmation of the correct gastric placement of the tube. The suspension should be administered in a small amount of water via a gastric tube after which it should be flushed with water (see sections 5.2 and 6.6).

In case the patient immediately spits up the dose or vomits within 30 minutes after receiving the dose, a new dose should be given. However, if the patient vomits more than 30 minutes after the dose, the dose should not be re-administered and the next dose should be taken as scheduled.

Instruction for use of the oral syringe

Shake the bottle before each use for five seconds. **Check the prescribed dose.**

			
<p>1. Place the syringe in the opening of the bottle adaptor and turn the bottle upside down. Then pull the plunger slowly down to the volume you need for your dose.</p>	<p>2. Check the syringe for any bubbles. If there are any, empty the syringe back into the bottle and repeat the step 1. Double check the dose.</p>	<p>3. Turn the bottle back again and remove the syringe.</p>	<p>4. You can give the liquid directly into the patient's mouth or apply the liquid to a kitchen spoon.</p>
<p>5. Cleaning: It is recommended to use only cold tap water for cleaning the syringe.</p>			

4.3 Contraindications

- Hypersensitivity to the active substance or to any of the excipients listed in section 6.1.
- Active clinically significant bleeding.
- Lesions or conditions, 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).
- 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

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

Haemorrhagic risk

As with other anticoagulants, patients taking Rivaroxaban 5 mg/ml Oral Suspension are to be carefully observed for signs of bleeding. It is recommended to be used with caution in conditions with increased risk of haemorrhage. Rivaroxaban 5 mg/ml Oral Suspension 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 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.

Several sub-groups of patients, as detailed below, are at increased risk of bleeding. These patients are to be carefully monitored for signs and symptoms of bleeding complications and anaemia after initiation of treatment (see section 4.8).

In patients receiving Rivaroxaban 5 mg/ml Oral Suspension for VTE prevention following elective hip or knee replacement surgery, this may be done by regular physical examination of the patients, close observation of the surgical wound drainage and periodic measurements of haemoglobin. 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).

Paediatric population

There are limited data in children with cerebral vein and sinus thrombosis who have a CNS infection (see section 5.1). The risk of bleeding should be carefully evaluated before and during therapy with rivaroxaban.

Renal impairment

In adult 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. Rivaroxaban 5 mg/ml Oral Suspension 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 Rivaroxaban 5 mg/ml Oral Suspension is to be used with caution (see section 4.5).

Rivaroxaban 5 mg/ml Oral Suspension is not recommended in children and adolescents with moderate or severe renal impairment (glomerular filtration rate < 50 ml/min/1.73 m²), as no clinical data are available.

Interaction with other medicinal products

The use of Rivaroxaban 5 mg/ml Oral Suspension 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. No clinical data are available in children receiving concomitant systemic treatment with strong inhibitors of both CYP 3A4 and P-gp (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 section 4.5 and 5.1).

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

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 rivaroxaban have not been studied in patients with prosthetic heart valves; therefore, there are no data to support that rivaroxaban provides adequate anticoagulation in this patient population. Treatment with Rivaroxaban 5 mg/ml Oral Suspension 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.

Hip fracture surgery

Rivaroxaban has not been studied in interventional clinical studies in patients undergoing hip fracture surgery to evaluate efficacy and safety.

Haemodynamically unstable PE patients or patients who require thrombolysis or pulmonary embolectomy

Rivaroxaban 5 mg/ml Oral Suspension is not recommended as an alternative to unfractionated heparin in patients with pulmonary embolism who are haemodynamically unstable or may receive thrombolysis or pulmonary embolectomy since the safety and efficacy of rivaroxaban have not been established in these clinical situations.

Patients with non-valvular atrial fibrillation who undergo PCI with stent placement

Clinical data are available from an interventional study with the primary objective to assess safety in patients with non-valvular atrial fibrillation who undergo PCI with stent placement. Data on efficacy in this population are limited (see sections 4.2 and 5.1). No data are available for such patients with a history of stroke/ transient ischaemic attack (TIA).

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. 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 15 mg or 20 mg of rivaroxaban 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 and should be weighed against the urgency of a diagnostic procedure.

For the removal of an epidural catheter and based on the general PK characteristics at least 2x half- life, i.e. at least 18 hours in young adult patients and 26 hours in elderly patients should elapse after the last administration of rivaroxaban (see section 5.2). Following removal of the catheter, at least 6 hours should elapse before the next rivaroxaban dose is administered.

If traumatic puncture occurs the administration of rivaroxaban is to be delayed for 24 hours.

No data are available on the timing of the placement or removal of neuraxial catheter in children while on rivaroxaban. In such cases, discontinue rivaroxaban and consider a short acting parenteral anticoagulant.

Dosing recommendations before and after invasive procedures and surgical intervention other than elective hip or knee replacement surgery

If an invasive procedure or surgical intervention is required, Rivaroxaban 5 mg/ml Oral Suspension should be stopped at least 24 hours before the intervention, if possible and based on the clinical judgement of the physician.

If the procedure cannot be delayed the increased risk of bleeding should be assessed against the urgency of the intervention.

Rivaroxaban 5 mg/ml Oral Suspension 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 section 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.

Excipients

Propylene glycol

This medicinal product contains 37 mg propylene glycol per 1 ml of oral suspension.

Sodium

This medicinal product contains less than 1 mmol sodium (23 mg) per the highest individual dose (6ml), that is to say essentially “sodium-free”.

Sodium benzoate

This medicinal product contains 2.5 mg sodium benzoate per 1 ml.

Maltitol

Patients with rare hereditary problems of fructose intolerance should not take this medicinal product.

Sorbitol

This medicinal product contains 50 mg liquid sorbitol per 1 ml of oral suspension. Patients with hereditary fructose intolerance (HFI) should not take/be given this medicinal product.

4.5 Interaction with other medicinal products and other forms of interaction

The extent of interactions in the paediatric population is not known. The below mentioned interaction data were obtained in adults and the warnings in section 4.4 should be taken into account for the paediatric population.

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 Rivaroxaban 5 mg/ml Oral Suspension 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 for the dose of 10 mg of rivaroxaban (2 ml of suspension) (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 rivaroxaban 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, this medicinal product 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 rivaroxaban have not been established in breast-feeding women. Data from animals indicate that rivaroxaban is secreted into milk. Therefore this medicinal product 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

Rivaroxaban 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 pivotal phase III studies (see Table 3).

Overall, 69 608 adult patients in nineteen phase III studies and 488 paediatric patients in two phase II and two phase III studies were exposed to rivaroxaban.

Table 3: Number of patients studied, total daily dose and maximum treatment duration in adult and paediatric 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 Day 22 and onwards: 20 mg After at least 6 months: 10 mg or 20 mg	21 months

Treatment of VTE and prevention of VTE recurrence in term neonates and children aged less than 18 years following initiation of standard anticoagulation treatment	329	Body weight-adjusted dose to achieve a similar exposure as that observed in adults treated for DVT with 20 mg rivaroxaban once daily	12 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 4). The most commonly reported bleedings were epistaxis (4.5%) and gastrointestinal tract haemorrhage (3.8%).

Table 4: Bleeding* and anaemia events rates in patients exposed to rivaroxaban across the completed adult and paediatric phase III studies

Indication	Any bleeding	Anaemia
Prevention of VTE in adult patients undergoing elective hip or knee replacement surgery	6.8% of patients	5.9% of patients
Prevention of VTE 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
Treatment of VTE and prevention of VTE recurrence in term neonates and children aged less than 18 years following initiation of standard anticoagulation treatment	39.5% of patients	4.6% 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 rivaroxaban in adult and paediatric patients are summarised in Table 5 below by system organ class (in MedDRA) and by frequency.

Frequencies are defined as: very common ($\geq 1/10$), common ($\geq 1/100$ to $< 1/10$), uncommon ($\geq 1/1000$ to $< 1/100$), rare ($\geq 1/10000$ to $< 1/1000$), very rare ($< 1/10000$), not known (cannot be estimated from the available data).

Table 5: All adverse reactions reported in adult patients in phase III clinical studies or through post- marketing use* and in two phase II and two phase III studies in paediatric patients

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)				
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,	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		
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, Anticoagulant related nephropathy
General disorders and administration site conditions				
Fever ^A , peripheral oedema, decreased general strength and energy (incl.	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,		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 in selected phase III studies. The incidence of adverse reactions did not increase and no new adverse reaction was identified after analysis of these studies.

Description of selected adverse reactions

Due to the pharmacological mode of action, the use of rivaroxaban 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, or anticoagulant-related nephropathy have been reported for rivaroxaban. Therefore, the possibility of haemorrhage is to be considered in evaluating the condition in any anticoagulated patient.

Paediatric population

Treatment of VTE and prevention of VTE recurrence

The safety assessment in children and adolescents is based on the safety data from two phase II and one phase III open-label active controlled studies in paediatric patients aged birth to less than 18 years. The safety findings were generally similar between rivaroxaban and comparator in the various paediatric age groups. Overall, the safety profile in the 412 children and adolescents treated with rivaroxaban was similar to that observed in the adult population and consistent across age subgroups, although assessment is limited by the small number of patients.

In paediatric patients, headache (very common, 16.7%), fever (very common, 11.7%), epistaxis (very common, 11.2%), vomiting (very common, 10.7%), tachycardia (common, 1.5%), increase in bilirubin (common, 1.5%) and bilirubin conjugated increased (uncommon, 0.7%) were reported more frequently as compared to adults. Consistent with adult population, menorrhagia was observed in 6.6% (common) of female adolescents after menarche. Thrombocytopenia as observed in the post-

marketing experience in adult population was common (4.6%) in paediatric clinical studies. The adverse drug reactions in paediatric patients were primarily mild to moderate in severity.

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. Healthcare professionals are asked to report any suspected adverse reactions the Yellow Card Scheme at: www.mhra.gov.uk/yellowcard or search for MHRA Yellow Card in the Google Play or Apple App Store.

4.9 Overdose

In adults, 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”). There are limited data available in children. 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 in adults, however, no data are available at supratherapeutic doses in children.

A specific reversal agent (andexanet alfa) antagonising the pharmacodynamic effect of rivaroxaban is available for adults, but not established in children (refer to the Summary of Product Characteristics 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 in adults. The half life in children estimated using population pharmacokinetic (popPK) modelling approaches is shorter (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 adults and in children 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 adults receiving rivaroxaban. There is no experience on the use of these agents in children 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 patients undergoing major orthopaedic surgery, the 5/95 percentiles for PT (Neoplastin) 2 - 4 hours after tablet intake (i.e. at the time of maximum effect) ranged from 13 to 25 s (baseline values before surgery 12 to 15 s).

In patients receiving rivaroxaban for treatment of DVT and PE and prevention of recurrence, the 5/95 percentiles for PT (Neoplastin) 2 - 4 hours after tablet intake (i.e. at the time of maximum effect) for 15 mg rivaroxaban twice daily ranged from 17 to 32 s and for 20 mg rivaroxaban once daily from 15 to 30 s. At trough (8 – 16 h after

tablet intake) the 5/95 percentiles for 15 mg twice daily ranged from 14 to 24 s and for 20 mg once daily (18 – 30 h after tablet intake) from 13 to 20 s.

In patients with non-valvular atrial fibrillation receiving rivaroxaban for the prevention of stroke and systemic embolism, the 5/95 percentiles for PT (Neoplastin) 1 - 4 hours after tablet intake (i.e. at the time of maximum effect) in patients treated with 20 mg once daily ranged from 14 to 40 s and in patients with moderate renal impairment treated with 15 mg once daily from 10 to 50 s. At trough (16 – 36 h after tablet intake) the 5/95 percentiles in patients treated with 20 mg once daily ranged from 12 to 26 s and in patients with moderate renal impairment treated with 15 mg once daily from 12 to 26 s.

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 thromboplastin 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).

Paediatric population

PT (neoplastin reagent), aPTT, and anti-Xa assay (with a calibrated quantitative test) display a close correlation to plasma concentrations in children. The correlation between anti-Xa to plasma concentrations is linear with a slope close to 1. Individual discrepancies with higher or lower anti-Xa values as compared to the corresponding plasma concentrations may occur. There is no need for routine monitoring of coagulation parameters during clinical treatment with rivaroxaban. However, if clinically indicated, rivaroxaban concentrations can be measured by calibrated quantitative anti- Factor Xa tests in mcg/L (see table 16 in section 5.2 for ranges of observed rivaroxaban plasma concentrations in children). The lower limit of quantifications must be considered when the anti-Xa test is used to quantify plasma concentrations of rivaroxaban in children. No threshold for efficacy or safety events has been established.

Clinical efficacy and safety

Prevention of VTE in adult patients undergoing elective hip or knee replacement surgery

The rivaroxaban clinical programme was designed to demonstrate the efficacy of rivaroxaban for the prevention of VTE, i.e. proximal and distal deep vein thrombosis (DVT) and pulmonary embolism (PE) in patients undergoing major orthopaedic surgery of the lower limbs. Over 9 500 patients (7 050 in total hip replacement surgery and 2 531 in total knee replacement surgery) were studied in controlled randomised double-blind phase III clinical studies, the RECORD-programme.

10 mg rivaroxaban once daily (od) started no sooner than 6 hours post-operatively was compared with enoxaparin 40 mg once daily started 12 hours pre-operatively.

In all three phase III studies (see table 6), rivaroxaban significantly reduced the rate of total VTE (any venographically detected or symptomatic DVT, non-fatal PE and death) and major VTE (proximal DVT, non-fatal PE and VTE-related death), the pre-specified primary and major secondary efficacy endpoints. Furthermore, in all three studies the rate of symptomatic VTE (symptomatic DVT, non-fatal PE, VTE-related death) was lower in rivaroxaban treated patients compared to patients treated with enoxaparin.

The main safety endpoint, major bleeding, showed comparable rates for patients treated with 10 mg rivaroxaban compared to 40 mg enoxaparin.

Table 6: Efficacy and safety results from phase III clinical studies

	RECORD 1			RECORD 2			RECORD 3		
Study population	4 541 patients undergoing total hip replacement surgery			2 509 patients undergoing total hip replacement surgery			2 531 patients undergoing total knee replacement surgery		
Treatment dose and duration after surgery	Rivaroxaban 10 mg od 35 ± 4 days	Enoxaparin 40 mg od 35 ± 4 days	p	Rivaroxaban 10 mg od 35 ± 4 days	Enoxaparin 40 mg od 12 ± 2 days	p	Rivaroxaban 10 mg od 12 ± 2 days	Enoxaparin 40 mg od 12 ± 2 days	p
Total VTE	18 (1.1%)	58 (3.7%)	<0.001	17 (2.0%)	81 (9.3%)	<0.001	79 (9.6%)	166 (18.9%)	<0.001
Major VTE	4 (0.2%)	33 (2.0%)	<0.001	6 (0.6%)	49 (5.1%)	<0.001	9 (1.0%)	24 (2.6%)	0.01
Symptomatic VTE	6 (0.4%)	11 (0.7%)		3 (0.4%)	15 (1.7%)		8 (1.0%)	24 (2.7%)	
Major bleedings	6 (0.3%)	2 (0.1%)		1 (0.1%)	1 (0.1%)		7 (0.6%)	6 (0.5%)	

The analysis of the pooled results of the phase III studies corroborated the data obtained in the individual studies regarding reduction of total VTE, major VTE and symptomatic VTE with 10 mg rivaroxaban once daily compared to 40 mg enoxaparin once daily.

In addition to the phase III RECORD programme, a post-authorisation, non-interventional, open-label cohort study (XAMOS) has been conducted in 17 413

patients undergoing major orthopaedic surgery of the hip or knee, to compare rivaroxaban with other pharmacological thromboprophylaxis (standard-of-care) under real-life setting. Symptomatic VTE occurred in 57 (0.6%) patients in the rivaroxaban group (n=8 778) and 88 (1.0%) of patients in the standard-of-care group (n=8 635; HR 0.63; 95% CI 0.43-0.91); safety population). Major bleeding occurred in 35 (0.4%) and 29 (0.3%) of patients in the rivaroxaban and standard-of-care groups (HR 1.10; 95% CI 0.67-1.80). Thus, the results were consistent with the results of the pivotal randomised studies.

Treatment of DVT, PE and prevention of recurrent DVT and PE

The rivaroxaban clinical programme was designed to demonstrate the efficacy of rivaroxaban in the initial and continued treatment of acute DVT and PE and prevention of recurrence.

Over 12 800 patients were studied in four randomised controlled phase III clinical studies (Einstein DVT, Einstein PE, Einstein Extension and Einstein Choice). and additionally a predefined pooled analysis of the Einstein DVT and Einstein PE studies was conducted. The overall combined treatment duration in all studies was up to 21 months.

In Einstein DVT 3 449 patients with acute DVT were studied for the treatment of DVT and the prevention of recurrent DVT and PE (patients who presented with symptomatic PE were excluded from this study). The treatment duration was for 3, 6 or 12 months depending on the clinical judgement of the investigator.

For the initial 3 week treatment of acute DVT 15 mg rivaroxaban was administered twice daily. This was followed by 20 mg rivaroxaban once daily.

In Einstein PE, 4 832 patients with acute PE were studied for the treatment of PE and the prevention of recurrent DVT and PE. The treatment duration was for 3, 6 or 12 months depending on the clinical judgement of the investigator.

For the initial treatment of acute PE 15 mg rivaroxaban was administered twice daily for three weeks. This was followed by 20 mg rivaroxaban once daily.

In both the Einstein DVT and the Einstein PE study, the comparator treatment regimen consisted of enoxaparin administered for at least 5 days in combination with vitamin K antagonist treatment until the PT/INR was in therapeutic range (≥ 2.0). Treatment was continued with a vitamin K antagonist dose-adjusted to maintain the PT/INR values within the therapeutic range of 2.0 to 3.0.

In Einstein Extension 1 197 patients with DVT or PE were studied for the prevention of recurrent DVT and PE. The treatment duration was for an additional 6 or 12 months in patients who had completed 6 to 12 months of treatment for venous thromboembolism depending on the clinical judgment of the investigator. 20 mg rivaroxaban once daily was compared with placebo.

Einstein DVT, PE and Extension used the same pre-defined primary and secondary efficacy outcomes. The primary efficacy outcome was symptomatic recurrent VTE

defined as the composite of recurrent DVT or fatal or non-fatal PE. The secondary efficacy outcome was defined as the composite of recurrent DVT, non-fatal PE and all-cause mortality.

In Einstein Choice, 3 396 patients with confirmed symptomatic DVT and/or PE who completed 6-12 months of anticoagulant treatment were studied for the prevention of fatal PE or non-fatal symptomatic recurrent DVT or PE. Patients with an indication for continued therapeutic-dosed anticoagulation were excluded from the study. The treatment duration was up to 12 months depending on the individual randomisation date (median: 351 days). 20 mg rivaroxaban once daily and 10 mg rivaroxaban once daily were compared with 100 mg acetylsalicylic acid once daily.

The primary efficacy outcome was symptomatic recurrent VTE defined as the composite of recurrent DVT or fatal or non-fatal PE.

In the Einstein DVT study (see Table 7) rivaroxaban was demonstrated to be non-inferior to enoxaparin/VKA for the primary efficacy outcome ($p < 0.0001$ (test for non-inferiority); Hazard Ratio (HR): 0.680 (0.443 - 1.042), $p=0.076$ (test for superiority)). The prespecified net clinical benefit (primary efficacy outcome plus major bleeding events) was reported with a HR of 0.67 ((95% CI: 0.47 - 0.95), nominal p value $p=0.027$) in favour of rivaroxaban. INR values were within the therapeutic range a mean of 60.3% of the time for the mean treatment duration of 189 days, and 55.4%, 60.1%, and 62.8% of the time in the 3-, 6-, and 12-month intended treatment duration groups, respectively. In the enoxaparin/VKA group, there was no clear relation between the level of mean centre TTR (Time in Target INR Range of 2.0 – 3.0) in the equally sized tertiles and the incidence of the recurrent VTE ($P=0.932$ for interaction). Within the highest tertile according to centre, the HR with rivaroxaban versus warfarin was 0.69 (95% CI: 0.35 - 1.35).

The incidence rates for the primary safety outcome (major or clinically relevant non-major bleeding events) as well as the secondary safety outcome (major bleeding events) were similar for both treatment groups.

Table 7: Efficacy and safety results from phase III Einstein DVT

Study population	3 449 patients with symptomatic acute deep vein thrombosis	
Treatment dose and duration	Rivaroxaban^{a)} 3, 6 or 12 months N=1 731	Enoxaparin/VKA^{b)} 3, 6 or 12 months N=1 718
Symptomatic recurrent VTE*	36 (2.1%)	51 (3.0%)
Symptomatic recurrent PE	20 (1.2%)	18 (1.0%)
Symptomatic recurrent DVT	14 (0.8%)	28 (1.6%)
Symptomatic PE and DVT	1 (0.1%)	0
Fatal PE/death where PE cannot be ruled out	4 (0.2%)	6 (0.3%)
Major or clinically relevant non-major bleeding	139 (8.1%)	138 (8.1%)

Major bleeding events	14 (0.8%)	20 (1.2%)
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^{a)} 15 mg rivaroxaban twice daily for 3 weeks followed by 20 mg once daily

^{b)} Enoxaparin for at least 5 days, overlapped with and followed by VKA

* $p < 0.0001$ (non-inferiority to a prespecified HR of 2.0); HR: 0.680 (0.443 – 1.042), $p=0.076$ (superiority)

In the Einstein PE study (see Table 8) rivaroxaban was demonstrated to be non-inferior to enoxaparin/VKA for the primary efficacy outcome ($p=0.0026$ (test for non-inferiority); HR: 1.123 (0.749 – 1.684)). The prespecified net clinical benefit (primary efficacy outcome plus major bleeding events) was reported with a HR of 0.849 ((95% CI: 0.633 – 1.139), nominal p value $p= 0.275$). INR values were within the therapeutic range a mean of 63% of the time for the mean treatment duration of 215 days, and 57%, 62%, and 65% of the time in the 3-, 6-, and 12-month intended treatment duration groups, respectively. In the enoxaparin/VKA group, there was no clear relation between the level of mean centre TTR (Time in Target INR Range of 2.0 – 3.0) in the equally sized tertiles and the incidence of the recurrent VTE ($p=0.082$ for interaction). Within the highest tertile according to centre, the HR with rivaroxaban versus warfarin was 0.642 (95% CI: 0.277 – 1.484).

The incidence rates for the primary safety outcome (major or clinically relevant non-major bleeding events) were slightly lower in the rivaroxaban treatment group (10.3% (249/2412)) than in the enoxaparin/VKA treatment group (11.4% (274/2405)). The incidence of the secondary safety outcome (major bleeding events) was lower in the rivaroxaban group (1.1% (26/2412)) than in the enoxaparin/VKA group (2.2% (52/2405)) with a HR 0.493 (95% CI: 0.308 – 0.789).

Table 8: Efficacy and safety results from phase III Einstein PE

Study population	4 832 patients with an acute symptomatic PE	
Treatment dose and duration	Rivaroxaban^{a)} 3, 6 or 12 months N=2 419	Enoxaparin/VKA^{b)} 3, 6 or 12 months N=2 413
Symptomatic recurrent VTE*	50 (2.1%)	44 (1.8%)
Symptomatic recurrent PE	23 (1.0%)	20 (0.8%)
Symptomatic recurrent DVT	18 (0.7%)	17 (0.7%)
Symptomatic PE and DVT	0	2 (<0.1%)
Fatal PE/death where PE cannot be ruled out	11 (0.5%)	7 (0.3%)
Major or clinically relevant non-major bleeding	249 (10.3%)	274 (11.4%)
Major bleeding events	26 (1.1%)	52 (2.2%)

^{a)} 15 mg rivaroxaban twice daily for 3 weeks followed by 20 mg once daily

^{b)} Enoxaparin for at least 5 days, overlapped with and followed by VKA

* $p < 0.0026$ (non-inferiority to a prespecified HR of 2.0); HR: 1.123 (0.749 – 1.684)

A prespecified pooled analysis of the outcome of the Einstein DVT and PE studies was conducted (see Table 9).

Table 9: Efficacy and safety results from pooled analysis of phase III Einstein DVT and Einstein PE

Study population	8 281 patients with an acute symptomatic DVT or PE	
Treatment dose and duration	Rivaroxaban^{a)} 3, 6 or 12 months N=4 150	Enoxaparin/VKA^{b)} 3, 6 or 12 months N=4 131
Symptomatic recurrent VTE*	86 (2.1%)	95 (2.3%)
Symptomatic recurrent PE	43 (1.0%)	38 (0.9%)
Symptomatic recurrent DVT	32 (0.8%)	45 (1.1%)
Symptomatic PE and DVT	1 (<0.1%)	2 (<0.1%)
Fatal PE/death where PE cannot be ruled out	15 (0.4%)	13 (0.3%)
Major or clinically relevant non-major bleeding	388 (9.4%)	412 (10.0%)
Major bleeding events	40 (1.0%)	72 (1.7%)

^{a)} 15 mg rivaroxaban twice daily for 3 weeks followed by 20 mg once daily

^{b)} Enoxaparin for at least 5 days, overlapped with and followed by VKA

*p < 0.0001 (non-inferiority to a prespecified HR of 1.75); HR: 0.886 (0.661 – 1.186)

The prespecified net clinical benefit (primary efficacy outcome plus major bleeding events) of the pooled analysis was reported with a HR of 0.771 ((95% CI: 0.614 – 0.967), nominal p value p = 0.0244).

In the Einstein Extension study (see Table 10) rivaroxaban was superior to placebo for the primary and secondary efficacy outcomes. For the primary safety outcome (major bleeding events) there was a non-significant numerically higher incidence rate for patients treated with 20 mg rivaroxaban once daily compared to placebo. The secondary safety outcome (major or clinically relevant non-major bleeding events) showed higher rates for patients treated with 20 mg rivaroxaban once daily compared to placebo.

Table 10: Efficacy and safety results from phase III Einstein Extension

Study population	1 197 patients continued treatment and prevention of recurrent venous thromboembolism	
Treatment dose and duration	Rivaroxaban^{a)} 6 or 12 months N=602	Placebo 6 or 12 months N=594

Symptomatic recurrent VTE*	8 (1.3%)	42 (7.1%)
Symptomatic recurrent PE	2 (0.3%)	13 (2.2%)
Symptomatic recurrent DVT	5 (0.8%)	31 (5.2%)
Fatal PE/death where PE cannot be ruled out	1 (0.2%)	1 (0.2%)
Major bleeding events	4 (0.7%)	0 (0.0%)
Clinically relevant non-major bleeding	32 (5.4%)	7 (1.2%)

a) 20 mg rivaroxaban once daily

* p < 0.0001 (superiority), HR: 0.185 (0.087 - 0.393)

In the Einstein Choice study (Table 11) 20 mg and 10 mg rivaroxaban were both superior to 100 mg acetylsalicylic acid for the primary efficacy outcome. The principal safety outcome (major bleeding events) was similar for patients treated with 20 mg and 10 mg rivaroxaban once daily compared to 100 mg acetylsalicylic acid.

Table 11: Efficacy and safety results from phase III Einstein Choice

Study population	3 396 patients continued prevention of recurrent venous thromboembolism		
Treatment dose	20 mg rivaroxaban once daily N=1 107	10 mg rivaroxaban once daily N=1 127	100 mg ASA once daily N=1 131
Treatment duration median [interquartile range]	349 [189-362] days	353 [190-362] days	350 [186-362] days
Symptomatic recurrent VTE	17 (1.5%)*	13 (1.2%)**	50 (4.4%)
Symptomatic recurrent PE	6 (0.5%)	6 (0.5%)	19 (1.7%)
Symptomatic recurrent DVT	9 (0.8%)	8 (0.7%)	30 (2.7%)
Fatal PE/death where PE cannot be ruled out	2 (0.2%)	0	2 (0.2%)
Symptomatic recurrent VTE, MI, stroke, or non-CNS systemic embolism	19 (1.7%)	18 (1.6%)	56 (5.0%)
Major bleeding events	6 (0.5%)	5 (0.4%)	3 (0.3%)
Clinically relevant non-major bleeding	30 (2.7)	22 (2.0)	20 (1.8)
Symptomatic recurrent VTE or major bleeding (net clinical benefit)	23 (2.1%)+	17 (1.5%)++	53 (4.7%)

* p<0.001(superiority) 20 mg rivaroxaban od vs 100 mg ASA od; HR=0.34 (0.20–0.59)

** p<0.001 (superiority) 10 mg rivaroxaban od vs 100 mg ASA od; HR=0.26 (0.14–0.47)

+ 20 mg rivaroxaban od vs 100 mg ASA od; HR=0.44 (0.27–0.71), p=0.0009 (nominal)

++ 10 mg rivaroxaban od vs 100 mg ASA od; HR=0.32 (0.18–0.55), p<0.0001 (nominal)

In addition to the phase III EINSTEIN programme, a prospective, non-interventional, open-label cohort study (XALIA) with central outcome adjudication including recurrent VTE, major bleeding and death has been conducted. 5 142 patients with acute DVT were enrolled to investigate the long-term safety of rivaroxaban compared with standard-of-care anticoagulation therapy in clinical practice.

Rates of major bleeding, recurrent VTE and all-cause mortality for rivaroxaban were 0.7%, 1.4% and 0.5%, respectively. There were differences in patient baseline characteristics including age, cancer and renal impairment. A pre-specified propensity score stratified analysis was used to adjust for measured baseline differences but residual confounding may, in spite of this, influence the results. Adjusted HRs comparing rivaroxaban and standard-of-care for major bleeding, recurrent VTE and all-cause mortality were 0.77 (95% CI 0.40 - 1.50), 0.91 (95% CI 0.54 - 1.54) and 0.51 (95% CI 0.24 - 1.07), respectively.

These results in clinical practice are consistent with the established safety profile in this indication.

In a post-authorisation, non-interventional study, in more than 40 000 patients without a history of cancer from four countries, rivaroxaban was prescribed for the treatment or prevention of DVT and PE. The event rates per 100 patient-years for symptomatic/ clinically apparent VTE/thromboembolic events leading to hospitalisation ranged from 0.64 (95% CI 0.40 - 0.97) in the UK to 2.30 (95% CI 2.11 - 2.51) for Germany. Bleeding resulting in hospitalisation occurred at event rates per 100 patient-years of 0.31 (95% CI 0.23 - 0.42) for intracranial bleeding, 0.89 (95% CI 0.67 - 1.17) for gastrointestinal bleeding, 0.44 (95% CI 0.26 - 0.74) for urogenital bleeding and 0.41 (95% CI 0.31 - 0.54) for other bleeding.

Prevention of stroke and systemic embolism in patients with non-valvular atrial fibrillation

The rivaroxaban clinical programme was designed to demonstrate the efficacy of rivaroxaban for the prevention of stroke and systemic embolism in patients with non-valvular atrial fibrillation.

In the pivotal double-blind ROCKET AF study, 14 264 patients were assigned either to 20 mg rivaroxaban once daily (15 mg once daily in patients with creatinine clearance 30 – 49 ml/min) or to warfarin titrated to a target INR of 2.5 (therapeutic range 2.0 to 3.0). The median time on treatment was 19 months and overall treatment duration was up to 41 months. 34.9% of patients were treated with acetylsalicylic acid and 11.4% were treated with class III antiarrhythmic including amiodarone.

Rivaroxaban was non-inferior to warfarin for the primary composite endpoint of stroke and non-CNS systemic embolism. In the per-protocol population on treatment, stroke or systemic embolism occurred in 188 patients on rivaroxaban (1.71% per year) and 241 on warfarin (2.16% per year) (HR 0.79; 95% CI, 0.66 - 0.96; P<0.001 for non-inferiority). Among all randomised patients analysed according to ITT, primary events occurred in 269 on rivaroxaban (2.12% per year) and 306 on warfarin (2.42% per year) (HR 0.88; 95% CI, 0.74 - 1.03; P<0.001 for non-inferiority; P=0.117 for superiority). Results for secondary endpoints as tested in hierarchical order in the ITT analysis are displayed in Table 12.

Among patients in the warfarin group, INR values were within the therapeutic range (2.0 to 3.0) a mean of 55% of the time (median, 58%; interquartile range, 43 to 71). The effect of rivaroxaban did not differ across the level of centre TTR (Time in Target INR Range of 2.0 - 3.0) in the equally sized quartiles (P=0.74 for interaction). Within the highest quartile according to centre, the Hazard Ratio (HR) with rivaroxaban versus warfarin was 0.74 (95% CI, 0.49 - 1.12).

The incidence rates for the principal safety outcome (major and non-major clinically relevant bleeding events) were similar for both treatment groups (see Table 13).

Table 12: Efficacy results from phase III ROCKET AF

Study population	ITT analyses of efficacy in patients with non-valvular atrial fibrillation		
Treatment dose	Rivaroxaban 20 mg once daily (15 mg once daily in patients with moderate renal impairment) Event rate (100 pt-yr)	Warfarin titrated to a target INR of 2.5 (therapeutic range 2.0 to 3.0) Event rate (100 pt-yr)	HR (95% CI) p-value, test for superiority
Stroke and non-CNS systemic embolism	269 (2.12)	306 (2.42)	0.88 (0.74 - 1.03) 0.117
Stroke, non-CNS systemic embolism and vascular death	572 (4.51)	609 (4.81)	0.94 (0.84 - 1.05) 0.265
Stroke, non-CNS systemic embolism, vascular death and myocardial infarction	659 (5.24)	709 (5.65)	0.93 (0.83 - 1.03) 0.158
Stroke	253 (1.99)	281 (2.22)	0.90 (0.76 - 1.07) 0.221
Non-CNS systemic embolism	20 (0.16)	27 (0.21)	0.74 (0.42 - 1.32) 0.308

Myocardial infarction	130 (1.02)	142 (1.11)	0.91 (0.72 - 1.16) 0.464
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Table 13: Safety results from phase III ROCKET AF

Study population	Patients with non-valvular atrial fibrillation ^{a)}		
	Rivaroxaban 20 mg once daily (15 mg once daily in patients with moderate renal impairment) Event rate (100 pt-yr)	Warfarin titrated to a target INR of 2.5 (therapeutic range 2.0 to 3.0) Event rate (100 pt-yr)	HR (95% CI) p-value
Major and non-major clinically relevant bleeding events	1 475 (14.91)	1 449 (14.52)	1.03 (0.96 - 1.11) 0.442
Major bleeding events	395 (3.60)	386 (3.45)	1.04 (0.90 - 1.20) 0.576
Death due to bleeding*	27 (0.24)	55 (0.48)	0.50 (0.31 - 0.79) 0.003
Critical organ bleeding*	91 (0.82)	133 (1.18)	0.69 (0.53 - 0.91) 0.007
Intracranial haemorrhage*	55 (0.49)	84 (0.74)	0.67 (0.47 - 0.93) 0.019
Haemoglobin drop*	305 (2.77)	254 (2.26)	1.22 (1.03 - 1.44) 0.019
Transfusion of 2 or more units of packed red blood cells or whole blood*	183 (1.65)	149 (1.32)	1.25 (1.01 - 1.55) 0.044
Non-major clinically relevant bleeding events	1 185 (11.80)	1 151 (11.37)	1.04 (0.96 - 1.13) 0.345
All-cause mortality	208 (1.87)	250 (2.21)	0.85 (0.70 - 1.02) 0.073

^{a)} Safety population, on treatment

* Nominally significant

In addition to the phase III ROCKET AF study, a prospective, single-arm, post-authorisation, non-interventional, open-label cohort study (XANTUS) with central outcome adjudication including thromboembolic events and major bleeding has been conducted. 6,704 patients with non-valvular atrial fibrillation were enrolled for

prevention of stroke and non-central nervous system (CNS) systemic embolism in clinical practice. The mean CHADS2 score was 1.9 and HAS-BLED score was 2.0 in XANTUS, compared to a mean CHADS2 and HAS-BLED score of 3.5 and 2.8 in ROCKET AF, respectively. Major bleeding occurred in 2.1 per 100 patient years. Fatal haemorrhage was reported in 0.2 per 100 patient years and intracranial haemorrhage in 0.4 per 100 patient years. Stroke or non-CNS systemic embolism was recorded in 0.8 per 100 patient years.

These observations in clinical practice are consistent with the established safety profile in this indication.

In a post-authorisation, non-interventional study, in more than 162 000 patients from four countries, rivaroxaban was prescribed for the prevention of stroke and systemic embolism in patients with non-valvular atrial fibrillation. The event rate for ischaemic stroke was 0.70 (95% CI 0.44 - 1.13) per 100 patient-years. Bleeding resulting in hospitalisation occurred at event rates per 100 patient-years of 0.43 (95% CI 0.31 - 0.59) for intracranial bleeding, 1.04 (95% CI 0.65 - 1.66) for gastrointestinal bleeding, 0.41 (95% CI 0.31 - 0.53) for urogenital bleeding and 0.40 (95% CI 0.25 - 0.65) for other bleeding.

Patients undergoing cardioversion

A prospective, randomised, open-label, multicentre, exploratory study with blinded endpoint evaluation (X-VERT) was conducted in 1504 patients (oral anticoagulant naive and pre-treated) with non-valvular atrial fibrillation scheduled for cardioversion to compare rivaroxaban with dose-adjusted VKA (randomised 2:1), for the prevention of cardiovascular events. TEE- guided (1 - 5 days of pre- treatment) or conventional cardioversion (at least three weeks of pre-treatment) strategies were employed. The primary efficacy outcome (all stroke, transient ischaemic attack, non-CNS systemic embolism, myocardial infarction (MI) and cardiovascular death) occurred in 5 (0.5%) patients in the rivaroxaban group (n = 978) and 5 (1.0%) patients in the VKA group (n = 492; RR 0.50; 95% CI 0.15- 1.73; modified ITT population). The principal safety outcome (major bleeding) occurred in 6 (0.6%) and 4 (0.8%) patients in the rivaroxaban (n = 988) and VKA (n = 499) groups, respectively (RR 0.76; 95% CI 0.21-2.67; safety population). This exploratory study showed comparable efficacy and safety between rivaroxaban and VKA treatment groups in the setting of cardioversion.

Patients with non-valvular atrial fibrillation who undergo PCI with stent placement

A randomised, open-label, multicentre study (PIONEER AF-PCI) was conducted in 2 124 patients with non-valvular atrial fibrillation who underwent PCI with stent placement for primary atherosclerotic disease to compare safety of two rivaroxaban regimens and one VKA regimen. Patients were randomly assigned in a 1:1:1 fashion for an overall 12-month-therapy. Patients with a history of stroke or TIA were excluded.

Group 1 received 15 mg rivaroxaban once daily (10 mg once daily in patients with creatinine clearance 30 – 49 ml/min) plus P2Y₁₂ inhibitor. Group 2 received 2.5 mg rivaroxaban twice daily plus DAPT (dual antiplatelet therapy i.e. clopidogrel 75 mg [or alternate P2Y₁₂ inhibitor] plus low-dose acetylsalicylic acid [ASA]) for 1, 6 or 12 months followed by 15 mg rivaroxaban (or 10 mg for subjects with creatinine

clearance 30 – 49 ml/min) once daily plus low-dose ASA. Group 3 received dose-adjusted VKA plus DAPT for 1, 6 or 12 months followed by dose-adjusted VKA plus low-dose ASA.

The primary safety endpoint, clinically significant bleeding events, occurred in 109 (15.7%), 117 (16.6%), and 167 (24.0%) subjects in group 1, group 2 and group 3, respectively (HR 0.59; 95% CI 0.47-0.76; $p < 0.001$, and HR 0.63; 95% CI 0.50-0.80; $p < 0.001$, respectively). The secondary endpoint (composite of cardiovascular events CV death, MI, or stroke) occurred in 41 (5.9%), 36 (5.1%), and 36 (5.2%) subjects in the group 1, group 2 and group 3, respectively. Each of the rivaroxaban regimens showed a significant reduction in clinically significant bleeding events compared to the VKA regimen in patients with non-valvular atrial fibrillation who underwent a PCI with stent placement.

The primary objective of PIONEER AF-PCI was to assess safety. Data on efficacy (including thromboembolic events) in this population are limited.

Treatment of VTE and prevention of VTE recurrence in paediatric patients

A total of 727 children with confirmed acute VTE, of whom 528 received rivaroxaban, were studied in 6 open-label, multicentre paediatric studies. Body weight-adjusted dosing in patients from birth to less than 18 years resulted in rivaroxaban exposure similar to that observed in adult DVT patients treated with 20 mg rivaroxaban once daily as confirmed in the phase III study (see section 5.2).

The EINSTEIN Junior phase III study was a randomised, active-controlled, open-label multicentre clinical study in 500 paediatric patients (aged from birth to < 18 years) with confirmed acute VTE. There were 276 children aged 12 to < 18 years, 101 children aged 6 to < 12 years, 69 children aged 2 to < 6 years, and 54 children aged < 2 years.

Index VTE was classified as either central venous catheter-related VTE (CVC-VTE; 90/335 patients in the rivaroxaban group, 37/165 patients in the comparator group), cerebral vein and sinus thrombosis (CVST; 74/335 patients in the rivaroxaban group, 43/165 patients in the comparator group), and all others including DVT and PE (non-CVC-VTE; 171/335 patients in the rivaroxaban group, 85/165 patients in the comparator group). The most common presentation of index thrombosis in children aged 12 to < 18 years was non-CVC-VTE in 211 (76.4%); in children aged 6 to < 12 years and aged 2 to < 6 years was CVST in 48 (47.5%) and 35 (50.7%), respectively; and in children aged < 2 years was CVC-VTE in 37 (68.5%). There were no children < 6 months with CVST in the rivaroxaban group. 22 of the patients with CVST had a CNS infection (13 patients in the rivaroxaban group and 9 patients in comparator group).

VTE was provoked by persistent, transient, or both persistent and transient risk factors in 438 (87.6%) children.

Patients received initial treatment with therapeutic doses of UFH, LMWH, or fondaparinux for at least 5 days, and were randomised 2:1 to receive either body

weight-adjusted doses of rivaroxaban or comparator group (heparins, VKA) for a main study treatment period of 3 months (1 month for children < 2 years with CVC-VTE). At the end of the main study treatment period, the diagnostic imaging test, which was obtained at baseline, was repeated, if clinically feasible. The study treatment could be stopped at this point, or at the discretion of the Investigator continued for up to 12 months (for children < 2 years with CVC-VTE up to 3 months) in total.

The primary efficacy outcome was symptomatic recurrent VTE. The primary safety outcome was the composite of major bleeding and clinically relevant non-major bleeding (CRNMB). All efficacy and safety outcomes were centrally adjudicated by an independent committee blinded for treatment allocation. The efficacy and safety results are shown in Tables 14 and 15 below.

Recurrent VTEs occurred in the rivaroxaban group in 4 of 335 patients and in the comparator group in 5 of 165 patients. The composite of major bleeding and CRNMB was reported in 10 of 329 patients (3%) treated with rivaroxaban and in 3 of 162 patients (1.9%) treated with comparator. Net clinical benefit (symptomatic recurrent VTE plus major bleeding events) was reported in the rivaroxaban group in 4 of 335 patients and in the comparator group in 7 of 165 patients. Normalisation of the thrombus burden on repeat imaging occurred in 128 of 335 patients with rivaroxaban treatment and in 43 of 165 patients in the comparator group. These findings were generally similar among age groups. There were 119 (36.2%) children with any treatment-emergent bleeding in the rivaroxaban group and 45 (27.8%) children in the comparator group.

Table 14: Efficacy results at the end of the main treatment period

Event	Rivaroxaban N=335*	Comparator N=165*
Recurrent VTE (primary efficacy outcome)	4 (1.2%, 95% CI 0.4% – 3.0%)	5 (3.0%, 95% CI 1.2% - 6.6%)
Composite: Symptomatic recurrent VTE + asymptomatic deterioration on repeat imaging	5 (1.5%, 95% CI 0.6% – 3.4%)	6 (3.6%, 95% CI 1.6% – 7.6%)
Composite: Symptomatic recurrent VTE + asymptomatic deterioration + no change on repeat imaging	21 (6.3%, 95% CI 4.0% – 9.2%)	19 (11.5%, 95% CI 7.3% – 17.4%)
Normalisation on repeat imaging	128 (38.2%, 95% CI 33.0% - 43.5%)	43 (26.1%, 95% CI 19.8% - 33.0%)
Composite: Symptomatic recurrent VTE + major bleeding (net clinical benefit)	4 (1.2%, 95% CI 0.4% - 3.0%)	7 (4.2%, 95% CI 2.0% - 8.4%)
Fatal or non-fatal pulmonary embolism	1 (0.3%, 95% CI 0.0% – 1.6%)	1 (0.6%, 95% CI 0.0% – 3.1%)

* FAS= full analysis set, all children who were randomized

Table 15: Safety results at the end of the main treatment period

	Rivaroxaban N=329*	Comparator N=162*
Composite: Major bleeding + CRNMB (primary safety outcome)	10 (3.0%, 95% CI 1.6% - 5.5%)	3 (1.9%, 95% CI 0.5% - 5.3%)
Major bleeding	0 (0.0%, 95% CI 0.0% - 1.1%)	2 (1.2%, 95% CI 0.2% - 4.3%)
Any treatment-emergent bleedings	119 (36.2%)	45 (27.8%)

* SAF= safety analysis set, all children who were randomised and received at least 1 dose of study medicinal product.

The efficacy and safety profile of rivaroxaban was largely similar between the paediatric VTE population and the DVT/PE adult population, however, the proportion of subjects with any bleeding was higher in the paediatric VTE population as compared to the DVT/PE adult population.

Patients with high risk triple positive antiphospholipid syndrome

In an investigator-sponsored, randomised, open-label multicentre 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 randomised to 20 mg rivaroxaban (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 randomised to rivaroxaban (4 ischaemic strokes and 3 myocardial infarctions). No events were reported in patients randomised to warfarin. Major bleeding occurred in 4 patients (7%) of the rivaroxaban group and 2 patients (3%) of the warfarin group.

Paediatric population

The European Medicines Agency has waived the obligation to submit the results of studies with the reference medicinal product containing rivaroxaban in all subsets of the paediatric population in the prevention of thromboembolic events (see section 4.2 for information on paediatric use).

5.2 Pharmacokinetic properties

Absorption

The following information is based on the data obtained in adults.

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 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. 2.5 mg and 10 mg rivaroxaban doses can be taken with or without food.

Due to a reduced extent of absorption an oral bioavailability of 66% was determined for the 20 mg dose under fasting conditions. When 20 mg rivaroxaban is taken together with food increases in mean AUC by 39% were observed when compared to medicinal product intake under fasting conditions, indicating almost complete absorption and high oral bioavailability. 15 mg and 20 mg rivaroxaban doses are to be taken with food (see section 4.2).

Rivaroxaban pharmacokinetics are approximately linear up to about 15 mg once daily in fasting state. Under fed conditions 10 mg, 15 mg and 20 mg rivaroxaban doses demonstrated dose-proportionality. 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%, apart from on the day of surgery and the following day when variability in exposure is high (70%).

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.

Paediatric population

Children received rivaroxaban tablet or oral suspension during or closely after feeding or food intake and with a typical serving of liquid to ensure reliable dosing in children. As in adults, rivaroxaban is readily absorbed after oral administration as tablet or granules for oral suspension formulation in children. No difference in the absorption rate nor in the extent of absorption between the tablet and granules for oral suspension formulation was observed. No PK data following intravenous administration to children are available so that the absolute bioavailability of rivaroxaban in children is unknown. A decrease in the relative bioavailability for increasing doses (in mg/kg bodyweight) was found, suggesting absorption limitations for higher doses, even when taken together with food.

15 and 20 mg rivaroxaban doses (3 and 4 ml of suspension) should be taken with feeding or with food (see section 4.2).

Distribution

Plasma protein binding in adults 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.

Paediatric population

No data on rivaroxaban plasma protein binding specific to children are available. No PK data following intravenous administration of rivaroxaban to children are available. V_{ss} estimated via population PK modelling in children (age range 0 to < 18 years) following oral administration of rivaroxaban is dependent on body weight and can be described with an allometric function, with an average of 113 L for a subject with a body weight of 82.8 kg.

Biotransformation and elimination

In adults, 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.

Paediatric population

No metabolism data specific to children are available. No PK data following intravenous administration of rivaroxaban to children are available. CL estimated via population PK modelling in children (age range 0 to < 18 years) following oral administration of rivaroxaban is dependent on body weight and can be described with an allometric function, with an average of 8 L/h for a subject with body weight of 82.8 kg. The geometric mean values for disposition half-lives ($t_{1/2}$) estimated via population PK modelling decrease with decreasing age and ranged from 4.2 h in adolescents to approximately 3 h in children aged 2-12 years down to 1.9 and 1.6 h in children aged 0.5-< 2 years and less than 0.5 years, respectively.

Special populations

Gender

In adults, there were no clinically relevant differences in pharmacokinetics and pharmacodynamics between male and female patients. An exploratory analysis did not reveal relevant differences in rivaroxaban exposure between male and female children.

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

In adults, 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.

In children, rivaroxaban is dosed based on body weight. An exploratory analysis did not reveal a relevant impact of underweight or obesity on rivaroxaban exposure in children.

Inter-ethnic differences

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

An exploratory analysis did not reveal relevant inter-ethnic differences in rivaroxaban exposure among Japanese, Chinese or Asian children outside Japan and China compared to the respective overall paediatric population.

Hepatic impairment

Cirrhotic adult 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.

Rivaroxaban 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).

No clinical data are available in children with hepatic impairment.

Renal impairment

In adults, 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. Rivaroxaban is to be used with caution in patients with creatinine clearance 15 - 29 ml/min (see section 4.4).

No clinical data are available in children 1 year or older with moderate or severe renal impairment (glomerular filtration rate < 50 ml/min/1.73 m²).

Pharmacokinetic data in patients

In patients receiving rivaroxaban for prevention of VTE 10 mg once daily the geometric mean concentration (90% prediction interval) 2 – 4 h and about 24 h after dose (roughly representing maximum and minimum concentrations during the dose interval) was 101 (7 - 273) and 14 (4 - 51) mcg/l, respectively.

In patients receiving rivaroxaban for treatment of acute DVT 20 mg once daily the geometric mean concentration (90% prediction interval) 2 – 4 h and about 24 h after dose (roughly representing maximum and minimum concentrations during the dose interval) was 215 (22 - 535) and 32 (6 - 239) mcg/L, respectively.

In paediatric patients with acute VTE receiving body weight-adjusted rivaroxaban leading to an exposure similar to that in adult DVT patients receiving a 20 mg once daily dose, the geometric mean concentrations (90% interval) at sampling time intervals roughly representing maximum and minimum concentrations during the dose interval are summarised in Table 16.

Table 16: Summary statistics (geometric mean (90% interval)) of rivaroxaban steady state plasma concentrations (mcg/L) by dosing regimen and age

Time intervals								
o.d.	N	12 - < 18 years	N	6 - < 12 years				
2.5-4h post	17 1	241.5 (105-484)	24	229.7 (91.5-777)				
20-24h post	15 1	20.6 (5.69-66.5)	24	15.9 (3.42-45.5)				
b.i.d.	N	6 - < 12 years	N	2 - < 6 years	N	0.5 - < 2 years		
2.5-4h post	36	145.4 (46.0-343)	38	171.8 (70.7-438)	2	n.c.		
10-16h post	33	26.0 (7.99-94.9)	37	22.2 (0.25-127)	3	10.7 (n.c.-n.c.)		
t.i.d.	N	2 - < 6 years	N	Birth - < 2 years	N	0.5 - < 2 years	N	Birth - < 0.5 years
0.5-3h post	5	164.7 (108-283)	25	111.2 (22.9-320)	1 3	114.3 (22.9-346)	1 2	108.0 (19.2-320)
7-8h post	5	33.2 (18.7-99.7)	23	18.7 (10.1-36.5)	1 2	21.4 (10.5-65.6)	1 1	16.1 (1.03-33.6)

o.d. = once daily, b.i.d. = twice daily, t.i.d. three times daily, n.c. = not calculated

Values below lower limit of quantification (LLOQ) were substituted by 1/2 LLOQ for the calculation of statistics (LLOQ = 0.5 mcg/L).

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. In patients, baseline factor Xa and PT were influenced by the surgery resulting in a difference in the concentration-PT slope between the day post- surgery and steady state.

Paediatric population

Safety and efficacy have not been established in other indications than the treatment of VTE and prevention of VTE recurrence 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.

Rivaroxaban was tested in juvenile rats up to 3-month treatment duration starting at postnatal day 4 showing a non dose-related increase in periinsular haemorrhage. No evidence of target organ-specific toxicity was seen.

6 PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Xanthan gum

Propylene glycol (E1520)

Sodium benzoate (E211)

Potassium sorbate (E212)

Disodium hydrogen phosphate heptahydrate

Sucralose

Xylitol

Maltitol, liquid (E965)

Glycerol (E422)

Sorbitol, liquid (non-crystallising) (E420)

Citric acid monohydrate

Sodium laurilsulfate

Water, purified

Strawberry RS1 flavouring agent (propylene glycol, nature identical flavouring substances, natural flavouring substances)

6.2 Incompatibilities

None

6.3 Shelf life

Unopened bottle: 3 years

Use within 100 days of first opening.

6.4 Special precautions for storage

This medicinal product does not require any special storage conditions.

6.5 Nature and contents of container

Amber glass bottle with child-resistant closure (PP) with sealing insert (LDPE).

The pack contains a 5 ml oral dosing syringe (PP barrel, LDPE plunger) and press in bottle adaptor (LDPE) for graduated dosing of 2, 3 and 4 ml.

Pack size: 1 x 200 ml

6.6 Special precautions for disposal

Any unused medicinal product or waste material should be disposed of in accordance with local requirements.

The suspension may also be given through gastric tubes after confirmation of the correct gastric placement of the tube. The suspension should be administered in a small amount of water via a gastric tube after which it should be flushed with water. Since rivaroxaban absorption is dependent on the site of active substance release, administration of rivaroxaban distal to the stomach should be avoided, as this can

result in reduced absorption and thereby, reduced active substance exposure. After the administration, the feeding tube should be flushed with water.

After the administration of a 15 mg or 20 mg dose (3 or 4 ml of suspension), the dose should then be immediately followed by enteral feeding. Enteral feeding is not required immediately after administration of the 10 mg dose (2 ml of suspension).

7 MARKETING AUTHORISATION HOLDER

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