

# SUMMARY OF PRODUCT CHARACTERISTICS

## 1 NAME OF THE MEDICINAL PRODUCT

Iasibon 50 mg film coated tablets

Ibandronic Acid 50 mg film coated tablets

## 2 QUALITATIVE AND QUANTITATIVE COMPOSITION

Each film-coated tablet contains 50 mg of ibandronic acid (as sodium monohydrate).

Excipients with known effect:

Contains 0.86 mg lactose (as lactose monohydrate).

For the full list of excipients, see section 6.1.

## 3 PHARMACEUTICAL FORM

Film-coated tablets.

White round biconvex tablets

## 4 CLINICAL PARTICULARS

### 4.1 Therapeutic indications

Iasibon is indicated in adults for the prevention of skeletal events (pathological fractures, bone complications requiring radiotherapy or surgery) in patients with breast cancer and bone metastases.

### 4.2 Posology and method of administration

Iasibon therapy should only be initiated by physicians experienced in the

treatment of cancer.

### Posology

The recommended dose is one 50 mg film-coated tablet daily.

#### Special populations

##### *Patients with hepatic impairment*

No dose adjustment is required (see section 5.2).

##### *Patients with renal impairment*

No dose adjustment is necessary for patients with mild renal impairment (CLCr  $\geq 50$  and  $< 80$  mL/min).

For patients with moderate renal impairment (CLCr  $\geq 30$  and  $< 50$  mL/min) a dosage adjustment to one 50 mg film-coated tablet every second day is recommended (see section 5.2).

For patients with severe renal impairment (CLCr  $< 30$  mL/min) the recommended dose is one 50 mg film-coated tablet once weekly. See dosing instructions, above.

##### *Elderly population (> 65 years)*

No dose adjustment is necessary (see section 5.2).

##### *Paediatric population*

The safety and efficacy of Iasibon in children and adolescents below the age of 18 years have not been established. No data are available (see section 5.1 and 5.2).

### Method of administration

For oral use.

Iasibon tablets should be taken after an overnight fast (at least 6 hours) and before the first food or drink of the day. Medicinal products and supplements (including calcium) should similarly be avoided prior to taking Iasibon tablets. Fasting should be continued for at least 30 minutes after taking the tablet. Water may be taken at any time during the course of Iasibon treatment (see section 4.5). Water with a high concentration of calcium should not be used. If there is concern regarding potentially high levels of calcium in the tap water (hard water), it is advised to use bottled water with a low mineral content.

- The tablets should be swallowed whole with a full glass of water (180 to 240 mL) while the patient is standing or sitting in an upright position.
- Patients should not lie down for 60 minutes after taking Iasibon.
- Patients should not chew, suck or crush the tablet because of a potential for oropharyngeal ulceration.

- Water is the only drink that should be taken with Iasibon.

### 4.3 Contraindications

- Hypersensitivity to ibandronic acid or to any of the excipients listed in section 6.1.
- Hypocalcaemia
- Abnormalities of the oesophagus which delay oesophageal emptying such as stricture or achalasia
- Inability to stand or sit upright for at least 60 minutes

### 4.4 Special warnings and precautions for use

#### Patients with disturbances of bone and mineral metabolism

Hypocalcaemia and other disturbances of bone and mineral metabolism should be effectively treated before starting Iasibon therapy. Adequate intake of calcium and vitamin D is important in all patients. Patients should receive supplemental calcium and/or vitamin D if dietary intake is inadequate.

#### Gastrointestinal irritation

Orally administered bisphosphonates may cause local irritation of the upper gastrointestinal mucosa. Because of these possible irritant effects and a potential for worsening of the underlying disease, caution should be used when Iasibon is given to patients with active upper gastrointestinal problems (e.g. known Barrett's oesophagus, dysphagia, other oesophageal diseases, gastritis, duodenitis or ulcers).

Adverse experiences such as oesophagitis, oesophageal ulcers and oesophageal erosions, in some cases severe and requiring hospitalization, rarely with bleeding or followed by oesophageal stricture or perforation, have been reported in patients receiving treatment with oral bisphosphonates. The risk of severe oesophageal adverse experiences appears to be greater in patients who do not comply with the dosing instruction and/or who continue to take oral bisphosphonates after developing symptoms suggestive of oesophageal irritation. Patients should pay particular attention and be able to comply with the dosing instructions (see section 4.2).

Physicians should be alert to any signs or symptoms signaling a possible oesophageal reaction and patients should be instructed to discontinue Iasibon and seek medical attention if they develop dysphagia, odynophagia, retrosternal pain or new or worsening heartburn.

While no increased risk was observed in controlled clinical trials there have been post-marketing reports of gastric and duodenal ulcers with oral

bisphosphonate use, some severe and with complications.

#### Acetylsalicylic acid and NSAIDs

Since Acetylsalicylic acid, Nonsteroidal Anti-Inflammatory medicinal products (NSAIDs) and bisphosphonates are associated with gastrointestinal irritation, caution should be taken during concomitant administration.

#### Osteonecrosis of the jaw

Osteonecrosis of the jaw (ONJ) has been reported very rarely in the post-marketing setting in patients receiving ibandronate for oncology indications (see section 4.8).

The start of treatment or of a new course of treatment should be delayed in patients with unhealed open soft tissue lesions in the mouth.

A dental examination with preventive dentistry and an individual benefit-risk assessment is recommended prior to treatment with ibandronate in patients with concomitant risk factors.

The following risk factors should be considered when evaluating a patient's risk of developing ONJ:

- Potency of the medicinal product that inhibit bone resorption (higher risk for highly potent compounds), route of administration (higher risk for parenteral administration) and cumulative dose of bone resorption therapy
- Cancer, co-morbid conditions (e.g. anaemia, coagulopathies, infection), smoking
- Concomitant therapies: corticosteroids, chemotherapy, angiogenesis inhibitors, radiotherapy to head and neck
- Poor oral hygiene, periodontal disease, poorly fitting dentures, history of dental disease, invasive dental procedures e.g. tooth extractions

All patients should be encouraged to maintain good oral hygiene, undergo routine dental check-ups, and immediately report any oral symptoms such as dental mobility, pain or swelling, or non-healing of sores or discharge during treatment with Iasibon. While on treatment, invasive dental procedures should be performed only after careful consideration and be avoided in close proximity to Iasibon administration.

The management plan of the patients who develop ONJ should be set up in close collaboration between the treating physician and a dentist or oral surgeon with expertise in ONJ. Temporary interruption of Iasibon treatment should be considered until the condition resolves and contributing risk factors are mitigated where possible.

#### Osteonecrosis of the external auditory canal

Osteonecrosis of the external auditory canal has been reported with bisphosphonates, mainly in association with long-term therapy. Possible risk factors for osteonecrosis of the external auditory canal include steroid use and chemotherapy and/or local risk factors such as infection or trauma. The possibility of osteonecrosis of the external auditory canal should be considered

in patients receiving bisphosphonates who present with ear symptoms including chronic ear infections.

#### Atypical fractures of the femur

Atypical subtrochanteric and diaphyseal femoral fractures have been reported with bisphosphonate therapy, primarily in patients receiving long-term treatment for osteoporosis. These transverse or short oblique fractures can occur anywhere along the femur from just below the lesser trochanter to just above the supracondylar flare. These fractures occur after minimal or no trauma and some patients experience thigh or groin pain, often associated with imaging features of stress fractures, weeks to months before presenting with a completed femoral fracture. Fractures are often bilateral; therefore the contralateral femur should be examined in bisphosphonate-treated patients who have sustained a femoral shaft fracture. Poor healing of these fractures has also been reported.

Discontinuation of bisphosphonate therapy in patients suspected to have an atypical femur fracture should be considered pending evaluation of the patient, based on an individual benefit risk assessment.

During bisphosphonate treatment patients should be advised to report any thigh, hip or groin pain and any patient presenting with such symptoms should be evaluated for an incomplete femur fracture.

#### Renal function

Clinical studies have not shown any evidence of deterioration in renal function with long term Iasibon therapy. Nevertheless, according to clinical assessment of the individual patient, it is recommended that renal function, serum calcium, phosphate and magnesium should be monitored in patients treated with Iasibon.

#### Rare hereditary problems

Iasibon tablets contain lactose and should not be administered to patients with rare hereditary problems of galactose intolerance, total lactase deficiency or glucose-galactose malabsorption.

#### Patients with known hypersensitivity to other bisphosphonates

Caution is to be taken in patients with known hypersensitivity to other bisphosphonates.

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

#### Medicinal product -Food Interactions

Products containing calcium and other multivalent cations (such as aluminium, magnesium, iron), including milk and food, are likely to interfere with absorption of Iasibon tablets. Therefore, with such products, including food, intake must be delayed at least 30 minutes

following oral administration.

Bioavailability was reduced by approximately 75% when Iasibon tablets were administered 2 hours after a standard meal. Therefore, it is recommended that the tablets should be taken after an overnight fast (at least 6 hours) and fasting should continue for at least 30 minutes after the dose has been taken (see section 4.2).

#### Interactions with other medicinal products

Metabolic interactions are not considered likely, since ibandronic acid does not inhibit the major human hepatic P450 isoenzymes and has been shown not to induce the hepatic cytochrome P450 system in rats (see section 5.2). Ibandronic acid is eliminated by renal excretion only and does not undergo any biotransformation.

#### H<sub>2</sub>-antagonists or other medicinal products that increase gastric pH.

In healthy male volunteers and postmenopausal women, intravenous ranitidine caused an increase in ibandronic acid bioavailability of about 20% (which is within the normal variability of the bioavailability of ibandronic acid), probably as a result of reduced gastric acidity. However, no dosage adjustment is required when Iasibon is administered with H<sub>2</sub>-antagonists or medicinal products that increase gastric pH.

#### Acetylsalicylic acid and NSAIDs

Since Acetylsalicylic acid, Nonsteroidal Anti-Inflammatory medicinal products (NSAIDs) and bisphosphonates are associated with gastrointestinal irritation, caution should be taken during concomitant administration (see section 4.4).

#### Aminoglycosides

Caution is advised when bisphosphonates are administered with aminoglycosides, since both substances can lower serum calcium levels for prolonged periods. Attention should also be paid to the possible existence of simultaneous hypomagnesaemia.

## **4.6 Fertility, pregnancy and lactation**

### Pregnancy

There are no adequate data from the use of ibandronic acid in pregnant women. Studies in rats have shown reproductive toxicity (see section 5.3). The potential risk for humans is unknown. Therefore, Iasibon should not be used during pregnancy.

### Breast-feeding

It is not known whether ibandronic acid is excreted in human milk. Studies in

lactating rats have demonstrated the presence of low levels of ibandronic acid in the milk following intravenous administration. Iasibon should not be used during breast-feeding.

#### Fertility

There are no data on the effects of ibandronic acid in humans. In reproductive studies in rats by the oral route, ibandronic acid decreased fertility. In studies in rats using the intravenous route, ibandronic acid decreased fertility at high daily doses (see section 5.3).

### **4.7 Effects on ability to drive and use machines**

On the basis of the pharmacodynamic and pharmacokinetic profile and reported adverse reactions, it is expected that Iasibon has no or negligible influence on the ability to drive and use machines.

### **4.8 Undesirable effects**

#### Summary of the safety profile

The most serious reported adverse reactions are anaphylactic reaction/shock, atypical fractures of the femur, osteonecrosis of the jaw, gastrointestinal irritation, and ocular inflammation (see paragraph “Description of selected adverse reactions” and section 4.4).

Treatment was most frequently associated with a decrease in serum calcium to below normal range (hypocalcaemia), followed by dyspepsia.

#### Tabulated list of adverse reactions

Table 1 lists adverse reactions from 2 pivotal phase III studies (Prevention of skeletal events in patients with breast cancer and bone metastases: 286 patients treated with ibandronic acid 50 mg administered orally), and from post-marketing experience.

Adverse reactions are listed according to MedDRA system organ class and frequency category. Frequency categories are defined using the following convention: very common ( $>1/10$ ), common ( $\geq 1/100$  to  $< 1/10$ ), uncommon ( $\geq 1/1,000$  to  $< 1/100$ ), rare ( $\geq 1/10,000$  to  $< 1/1,000$ ), very rare ( $<1/10,000$ ), not known (cannot be estimated from the available data). Within each frequency grouping, adverse reactions are presented in order of decreasing seriousness.

Table 1 Adverse Drug Reactions Reported for Oral Administration of Ibandronate

System Organ Class	Very common	Common	Uncommon	Rare	Very rare	Not known
Blood and lymphatic system disorders			Anaemia			
Immune system disorders					Hypersensitivity†, bronchospasm†, angioedema†, Anaphylactic reaction/shock†***	Asthma exacerbation
Metabolism and nutrition disorders		Hypocalcaemia**				
Nervous system disorders			Paraesthesia, dysgeusia (taste perversion)			
Eye disorders				Ocular inflammation†**		
Gastrointestinal disorders		Oesophagitis, abdominal pain, dyspepsia, nausea	Haemorrhage, duodenal ulcer, gastritis, dysphagia, dry mouth			
Skin and subcutaneous tissue disorders			Pruritus		Stevens-Johnson Syndrome†, Erythema Multiforme†, Dermatitis Bullous†	
Musculoskeletal and connective tissue disorders				Atypical subtrochanteric and diaphyseal femoral fractures†	Osteonecrosis of jaw†***, osteonecrosis of the external auditory canal (bisphosphonate class adverse reaction)†	
Renal and urinary disorders			Azotaemia (uraemia)			



System Organ Class	Very common	Common	Uncommon	Rare	Very rare	Not known
General disorders and administration site conditions		Asthenia	Chest pain, influenza-like illness, malaise, pain			
Investigations			Blood parathyroid hormone increased			

\*\*See further information below

†Identified in post-marketing experience.

### Description of selected adverse reactions

#### Hypocalcaemia

Decreased renal calcium excretion may be accompanied by a fall in serum phosphate levels not requiring therapeutic measures. The serum calcium level may fall to hypocalcaemic values.

#### Osteonecrosis of jaw

Cases of osteonecrosis of the jaw have been reported, predominantly in cancer patients treated with medicinal products that inhibit bone resorption, such as ibandronic acid (see section 4.4.) Cases of ONJ have been reported in the post-marketing setting for ibandronic acid.

#### Ocular inflammation

Ocular inflammation events such as uveitis, episcleritis and scleritis have been reported with ibandronic acid. In some cases, these events did not resolve until the ibandronic acid was discontinued.

#### Anaphylactic reaction/shock

Cases of anaphylactic reaction/shock, including fatal events, have been reported in patients treated with intravenous ibandronic acid.

### 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 via the Yellow Card Scheme Website: [www.mhra.gov.uk/yellowcard](http://www.mhra.gov.uk/yellowcard) or search for MHRA Yellow Card in the Google Play or Apple App Store.

## 4.9 Overdose

No specific information is available on the treatment of overdose with Iasibon. However, oral overdose may result in upper gastrointestinal events, such as upset stomach, heartburn, oesophagitis, gastritis or ulcer. Milk or antacids should be given to bind Iasibon. Due to the risk of oesophageal irritation, vomiting should not be induced and the patient should remain fully upright.

## **5 PHARMACOLOGICAL PROPERTIES**

### **5.1 Pharmacodynamic properties**

Pharmaco-therapeutic group: Medicinal products for treatment of bone diseases, bisphosphonate, ATC Code: M05BA06

Ibandronic acid belongs to the bisphosphonate group of compounds which act specifically on bone. Their selective action on bone tissue is based on the high affinity of bisphosphonates for bone mineral. Bisphosphonates act by inhibiting osteoclast activity, although the precise mechanism is still not clear.

*In vivo*, ibandronic acid prevents experimentally-induced bone destruction caused by cessation of gonadal function, retinoids, tumours or tumour extracts. The inhibition of endogenous bone resorption has also been documented by<sup>45</sup> Ca kinetic studies and by the release of radioactive tetracycline previously incorporated into the skeleton.

At doses that were considerably higher than the pharmacologically effective doses, ibandronic acid did not have any effect on bone mineralisation.

Bone resorption due to malignant disease is characterized by excessive bone resorption that is not balanced with appropriate bone formation. Ibandronic acid selectively inhibits osteoclast activity, reducing bone resorption and thereby reducing skeletal complications of the malignant disease. Clinical studies in patients with breast cancer and bone metastases have shown that there is a dose dependent inhibitory effect on bone osteolysis, expressed by markers of bone resorption, and a dose dependent effect on skeletal events.

Prevention of skeletal events in patients with breast cancer and bone metastases with Ibandronate 50 mg tablets was assessed in two randomized placebo controlled phase III trials with a duration of 96 weeks. Female patients with breast cancer and radiologically confirmed bone metastases were randomised to receive placebo (277 patients) or 50 mg Ibandronate (287 patients). The results from these trials are summarised below.

*Primary efficacy endpoints*

The primary endpoint of the trials was the skeletal morbidity period rate (SMPR). This was a composite endpoint which had the following skeletal related events (SREs) as sub-components:

- radiotherapy to bone for treatment of fractures/impending fractures
- surgery to bone for treatment of fractures
- vertebral fractures
- non-vertebral fractures

The analysis of the SMPR was time-adjusted and considered that one or more events occurring in a single 12 week period could be potentially related. Multiple events were therefore, counted only once in any given 12 week period for the purposes of the analysis. Pooled data from these studies demonstrated a significant advantage for Ibandronate 50 mg p.o. over placebo in the reduction in SREs measured by the SMPR (p=0.041). There was also a 38% reduction in the risk of developing an SRE for Ibandronate treated patients when compared with placebo (relative risk 0.62, p=0.003). Efficacy results are summarised in Table 2.

Table 2 Efficacy Results (Breast Cancer Patients with Metastatic Bone Disease)

	All Skeletal Related Events (SREs)		
	Placebo n=277	Ibandronate 50 mg	p-value
SMPR (per patient year)	1.15	0.99	p=0.041
SRE relative risk	-	0.62	p=0.003

*Secondary efficacy endpoints*

A statistically significant improvement in bone pain score was shown for Ibandronate 50 mg compared to placebo. The pain reduction was consistently below baseline throughout the entire study and accompanied by a significantly reduced use of analgesics compared to placebo. The deterioration in Quality of Life and WHO performance status was significantly less in Ibandronate treated patients compared with placebo. Urinary concentrations of the bone resorption marker CTx (C-terminal telopeptide released from Type I collagen) were significantly reduced in the Ibandronate group compared to placebo. This reduction in urinary CTx levels was significantly correlated with the primary efficacy endpoint SMPR (Kendall-tau-b (p<0.001)). A tabular summary of the secondary efficacy results is presented in Table 3.

Table 3 Secondary Efficacy Results (Breast Cancer Patients with Metastatic Bone Disease)

	Placebo n=277	Ibandronate 50 mg n=287	p-value

Bone pain *	0.20	-0.10	p=0.001
Analgesic use *	0.85	0.60	p=0.019
Quality of Life *	-26.8	-8.3	p=0.032
WHO performance score *	0.54	0.33	p=0.008
Urinary CTx **	10.95	-77.32	p=0.001

\* Mean change from baseline to last assessment.

\*\* Median change from baseline to last assessment

*Paediatric population (see section 4.2 and section 5.2)*

The safety and efficacy of Iasibon in children and adolescents below the age of 18 years have not been established. No data are available.

## 5.2 Pharmacokinetic properties

### *Absorption*

The absorption of ibandronic acid in the upper gastrointestinal tract is rapid after oral administration. Maximum observed plasma concentrations were reached within 0.5 to 2 hours (median 1 hour) in the fasted state and absolute bioavailability was about 0.6%. The extent of absorption is impaired when taken together with food or beverages (other than water). Bioavailability is reduced by about 90% when ibandronic acid is administered with a standard breakfast in comparison with bioavailability seen in fasted subjects. When taken 30 minutes before a meal, the reduction in bioavailability is approximately 30%. There is no meaningful reduction in bioavailability provided ibandronic acid is taken 60 minutes before a meal.

Bioavailability was reduced by approximately 75% when Iasibon tablets were administered 2 hours after a standard meal. Therefore, it is recommended that the tablets should be taken after an overnight fast (minimum 6 hours) and fasting should continue for at least 30 minutes after the dose has been taken (see section 4.2).

### *Distribution*

After initial systemic exposure, ibandronic acid rapidly binds to bone or is excreted into urine. In humans, the apparent terminal volume of distribution is at least 90 l and the amount of dose reaching the bone is estimated to be 40-50% of the circulating dose. Protein binding in human plasma is approximately 87% at therapeutic concentrations, and thus interaction with other medicinal products, due to displacement is unlikely.

### *Biotransformation*

There is no evidence that ibandronic acid is metabolized in animals or humans.

### *Elimination*

The absorbed fraction of ibandronic acid is removed from the circulation via bone absorption (estimated to be 40-50%) and the remainder is eliminated unchanged by the kidney. The unabsorbed fraction of ibandronic acid is eliminated unchanged in the faeces.

The range of observed apparent half-lives is broad and dependent on dose and assay sensitivity, but the apparent terminal half-life is generally in the range of 10-60 hours. However, early plasma levels fall quickly, reaching 10% of peak values within 3 and 8 hours after intravenous or oral administration respectively.

Total clearance of ibandronic acid is low with average values in the range 84-160 mL/min. Renal clearance (about 60 mL/min in healthy postmenopausal females) accounts for 50-60% of total clearance and is related to creatinine clearance. The difference between the apparent total and renal clearances is considered to reflect the uptake by bone.

The secretory pathway of renal elimination does not appear to include known acidic or basic transport systems involved in the excretion of other active substances. In addition, ibandronic acid does not inhibit the major human hepatic P450 isoenzymes and does not induce the hepatic cytochrome P450 system in rats.

### *Pharmacokinetics in special populations*

#### *Gender*

Bioavailability and pharmacokinetics of ibandronic acid are similar in both men and women.

#### *Race*

There is no evidence for clinically relevant interethnic differences between Asians and Caucasians in ibandronic acid disposition. There are only very few data available on patients with African origin.

#### *Patients with renal impairment*

Exposure to ibandronic acid in patients with various degree of renal impairment is related to creatinine clearance (CL<sub>Cr</sub>). Subjects with severe renal impairment (CL<sub>Cr</sub> ≤ 30 mL/min) receiving oral administration of 10 mg ibandronic acid daily for 21 days, had 2-3 fold higher plasma concentrations than subjects with normal renal function (CL<sub>Cr</sub> ≥ 80 mL/min). Total clearance of ibandronic acid was reduced to 44 mL/min in the subjects with severe renal impairment compared with 129 mL/min in subjects with normal renal function. No dosage adjustment is necessary for patients with mild renal impairment (CL<sub>Cr</sub> ≥ 50 and < 80 mL/min). For patients with moderate renal impairment (CL<sub>Cr</sub> ≥ 30 and < 50 mL/min) or severe renal impairment (CL<sub>Cr</sub> < 30 mL/min) an adjustment in the dose is recommended (see section 4.2).

#### *Patients with hepatic impairment (see section 4.2)*

There are no pharmacokinetic data for ibandronic acid in patients who have

hepatic impairment. The liver has no significant role in the clearance of ibandronic acid since it is not metabolized but is cleared by renal excretion and by uptake into bone. Therefore dosage adjustment is not necessary in patients with hepatic impairment. Further, as protein binding of ibandronic acid is approximately 87% at therapeutic concentrations, hypoproteinaemia in severe liver disease is unlikely to lead to clinically significant increases in free plasma concentration.

*Elderly (see section 4.2)*

In a multivariate analysis, age was not found to be an independent factor of any of the pharmacokinetic parameters studied. As renal function decreases with age, this is the only factor to take into consideration (see renal impairment section).

*Paediatric population (see section 4.2 and section 5.1)*

There are no data on the use of Iasibon in patients less than 18 years old.

### **5.3 Preclinical safety data**

Effects in non-clinical studies were observed only at exposures sufficiently in excess of the maximum human exposure indicating little relevance to clinical use. As with other bisphosphonates, the kidney was identified to be the primary target organ of systemic toxicity.

*Mutagenicity/Carcinogenicity:*

No indication of carcinogenic potential was observed. Tests for genotoxicity revealed no evidence of genetic activity for ibandronic acid.

*Reproductive toxicity:*

No evidence of direct foetal toxicity or teratogenic effects was observed for ibandronic acid in intravenously or orally treated rats and rabbits. In reproductive studies in rats by the oral route effects on fertility consisted of increased preimplantation losses at dose levels of 1 mg/kg/day and higher. In reproductive studies in rats by the intravenous route, ibandronic acid decreased sperm counts at doses of 0.3 and 1 mg/kg/day and decreased fertility in males at 1 mg/kg/day and in females at 1.2 mg/kg/day. Adverse effects of ibandronic acid in reproductive toxicity studies in the rat were those expected for this class of medicinal products (bisphosphonates). They include a decreased number of implantation sites, interference with natural delivery (dystocia), an increase in visceral variations (renal pelvis ureter syndrome) and teeth abnormalities in F1 offspring in rats.

## **6 PHARMACEUTICAL PARTICULARS**

### **6.1 List of excipients**

Tablet core:

Povidone  
Cellulose, microcrystalline  
Crospovidone  
Maize starch pregelatinised  
Glycerol dibehenate  
Silica, anhydrous colloidal

Tablet coat:

Lactose monohydrate  
Macrogol 4000  
Hypromellose (E464)  
Titanium dioxide E171

### **6.2 Incompatibilities**

Not applicable.

### **6.3 Shelf life**

5 years.

### **6.4 Special precautions for storage**

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

### **6.5 Nature and contents of container**

Iasibon 50 mg film coated tablets are supplied in Polyamide/Al/PVC - Aluminum foil blister with 3, 6, 9, 28 or 84 tablets, packaged in a cardboard box.

Not all pack sizes may be marketed.

## **6.6 Special precautions for disposal**

Any unused medicinal product or waste material should be disposed of in accordance with local requirements. The release of pharmaceuticals in the environment should be minimized.

## **7 MARKETING AUTHORISATION HOLDER**

Pharmathen S.A.  
Dervenakion 6  
15351 Pallini, Attiki  
Greece

## **8 MARKETING AUTHORISATION NUMBER(S)**

PLGB 17277/0401

## **9 DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUTHORISATION**

01/01/2021

## **10 DATE OF REVISION OF THE TEXT**

29/11/2022