

SUMMARY OF PRODUCT CHARACTERISTICS

1 NAME OF THE MEDICINAL PRODUCT

Oxybutynin hydrochloride Aspire 10 mg prolonged release tablets

2 QUALITATIVE AND QUANTITATIVE COMPOSITION

Each prolonged release tablet contains 10 mg of oxybutynin hydrochloride

For the full list of excipients, see section 6.1.

Excipient(s) with known effect:

Each prolonged release tablet contains approximately 1.68 mg lactose.

Each prolonged release tablet contains less than 1 mmol sodium (23 mg), and is essentially 'sodium-free'.

3 PHARMACEUTICAL FORM

Prolonged release tablet.

10 mg: Pink coloured, round, biconvex tablets with orifice and "P10" imprinted with black ink.

4 CLINICAL PARTICULARS

4.1 Therapeutic indications

Adults

Oxybutynin is indicated in adults for the symptomatic treatment of urge incontinence and/or increased urinary frequency associated with urgency as may occur in patients with unstable bladder.

Paediatric population

Oxybutynin hydrochloride is indicated in children over 5 years of age for:

- Urinary incontinence, urgency and frequency in unstable bladder conditions due to idiopathic overactive bladder or neurogenic bladder disorders (detrusor overactivity).
- Nocturnal enuresis associated with detrusor overactivity, in conjunction with nondrug therapy, when other treatment has failed.

4.2 Posology and method of administration

Posology

Oxybutynin may be administered with or without food (see section 5.2).

Adults

Starting dose: the recommended starting dose is one 5 mg tablet once daily.

Maintenance dose/dose adjustment: In order to achieve a maintenance dose giving an optimal balance of efficacy and tolerability, after at least one week on 5 mg daily, the dose may be increased to 10 mg once daily, with subsequent incremental increases or decreases of 5 mg/day. There should be an interval of at least one week between dose changes.

Maximum dose: in patients requiring a higher dose, the total daily dose should not exceed 20 mg.

For patients currently taking oxybutynin immediate release, clinical judgement should be exercised in selecting the appropriate dose of Oxybutynin. The dosage should be adjusted to the minimum dose that achieves an optimal balance of efficacy and tolerability, taking into account the current immediate-release dose.

In case of a missed dose, the patient should wait and take the next dose at the regular time.

Elderly

No dosage adjustment is necessary in elderly patients.

Paediatric population

Children over the age of 5 years

Initial dose of 5 mg once a day increased in 5 mg increments up to a maximum of 15 mg once a day.

Oxybutynin should not be used in children below age of 5 years, because safety and efficacy have not been established (see sections 5.1 and 5.2).

Method of administration

Oxybutynin must be swallowed whole with the aid of liquid, and must not be chewed, divided, or crushed because the tablet is formulated to provide prolonged release.

Patients should be advised that the tablet membrane may pass through the gastrointestinal tract unchanged. This has no bearing on the efficacy of the product.

4.3 Contraindications

- Hypersensitivity to the active substance(s) or to any of the excipients listed in section 6.1
- Narrow-angle glaucoma or shallow anterior chamber
- Myasthenia gravis
- Urinary retention
- Gastrointestinal obstructive disorder, paralytic ileus or intestinal atony
- Severe ulcerative colitis
- Toxic megacolon
- Urinary frequency and nocturia due to heart or renal failure
- Porphyria.

4.4 Special warnings and precautions for use

Oxybutynin is associated with anticholinergic central nervous system (CNS) effects (see section 4.8). Anticholinergic CNS effects (e.g. hallucinations, agitation, confusion, somnolence) have been reported; monitoring recommended especially in

first few months after initiating therapy or increasing the dose; consider discontinuing therapy or reducing the dose if anticholinergic CNS effects develop.

Angioedema of the face, lips, tongue and/or larynx has been reported with oxybutynin. In some cases, angioedema occurred after the first dose. Angioedema associated with upper airway swelling has the potential to become life-threatening. If involvement of tongue, hypopharynx, or larynx occurs, oxybutynin should be promptly discontinued and appropriate therapy and/or measures necessary to ensure a patent airway should be promptly provided.

Oxybutynin should be given with caution in patients with the following conditions:

- hepatic or renal impairment
- clinically significant bladder outflow obstruction since anticholinergic drugs may aggravate bladder outflow and cause retention (see section 4.3)
- autonomic neuropathy
- Parkinson's disease
- gastrointestinal disorders: Anticholinergic medicinal products may decrease gastrointestinal motility and should be used with caution in patients with gastrointestinal obstructive disorders, intestinal atony and ulcerative colitis (see section 4.3)
- anticholinergic medicinal products should be used with caution in patients who have hiatal hernia/gastro-oesophageal reflux disease and/or who are concurrently taking medicinal products (such as bisphosphonates) that can cause or exacerbate oesophagitis.
- pre-existing dementia treated with cholinesterase inhibitors due to risk of aggravation of symptoms.

Oxybutynin should be used with caution in the frail elderly who may be more sensitive to the effects of oxybutynin. Anticholinergics should be used with caution in elderly patients due to the risk of cognitive impairment.

If urinary tract infection is present, an appropriate antibacterial therapy should be started.

Oxybutynin may aggravate tachycardia (and thus the symptoms of hyperthyroidism, congestive heart failure, cardiac arrhythmia, coronary heart disease, hypertension), cognitive disorders and symptoms of prostatic hypertrophy.

When oxybutynin is used in patients with fever or in high environmental temperatures, this can cause heat prostration, or heat stroke, due to decreased sweating.

Patients with rare hereditary problems of galactose intolerance, the Lapp lactase deficiency or glucose-galactose malabsorption should not take this medicine.

Oxybutynin may reduce salivary secretions, which could result in dental caries, parodontitis, or oral candidiasis.

As oxybutynin can cause angle-closure glaucoma, visual acuity and intraocular pressure should be monitored periodically during therapy. Patients should be advised

to contact a physician immediately if they are aware of a sudden loss of visual acuity or ocular pain.

Paediatric population

Oxybutynin hydrochloride is not recommended for use in children below age 5 years due to insufficient data on safety and efficacy.

There is limited evidence supporting the use of Oxybutynin in children with monosymptomatic nocturnal enuresis (not related to detrusor overactivity).

In children over 5 years of age, Oxybutynin hydrochloride should be used with caution as they may be more sensitive to the effects of the product, particularly the CNS and psychiatric adverse reactions

4.5 Interaction with other medicinal products and other forms of interaction

The anticholinergic activity of oxybutynin is increased by concurrent use of other anticholinergics or medicinal products with anticholinergic activity, such as amantadine and other anticholinergic antiparkinsonian medicinal products (e.g. biperiden, levodopa), antihistamines, antipsychotics (e.g. phenothiazines, butyrophenones, clozapine), quinidine, digitalis, tricyclic antidepressants, atropine and related compounds like atropinic antispasmodics and dipyridamole.

Anticholinergic agents may potentially alter the absorption of some concomitantly administered drugs due to anticholinergic effects on gastrointestinal motility. They may also antagonize the gastrointestinal prokinetic effects of metoclopramide and domperidone.

Sublingual nitrates may fail to dissolve under the tongue owing to dry mouth, resulting in reduced therapeutic effect.

Oxybutynin is metabolised by cytochrome P450 isoenzyme CYP3A4. Concomitant administration with a CYP3A4 inhibitor can inhibit oxybutynin metabolism and increase oxybutynin exposure. Mean oxybutynin chloride concentrations were approximately 2-fold higher when Oxybutynin was administered with ketoconazole, a potent CYP3A4 inhibitor. Other inhibitors of cytochrome P450 3A4 enzyme system, such as antimycotic agents (e.g. itraconazole and fluconazole) or macrolide antibiotics (e.g. erythromycin), may increase oxybutynin exposure. The clinical relevance of such potential interaction is not known. Caution should be used when such drugs are co-administered.

Concomitant use with cholinesterase inhibitors may result in reduced cholinesterase inhibitor efficacy.

Patients should be informed that alcohol may enhance the drowsiness caused by anticholinergic agents such as oxybutynin.

Paediatric population

Interaction studies have only been performed in adults. It is not known whether the extent of interactions in the paediatric population is similar to that in adults.

4.6 Fertility, pregnancy and lactation

Pregnancy

There are no adequate data on the use of oxybutynin in pregnant women. Studies in animals have shown minor reproductive toxicity (see section 5.3). Oxybutynin is not recommended during pregnancy.

Breastfeeding

When oxybutynin is used during breastfeeding, a small amount is excreted in the mother's milk. The effect on newborns/infants is unknown. Use of Oxybutynin during breastfeeding is therefore not recommended.

Fertility

Reproduction studies with oral oxybutynin in the mouse, rat, hamster, and rabbit showed no evidence of impaired fertility.

4.7 Effects on ability to drive and use machines

Oxybutynin has minor influence on the ability to drive and use machines. Oxybutynin may produce drowsiness or blurred vision; therefore, patients should be cautioned regarding activities requiring mental alertness such as driving, operating machinery or performing hazardous work while taking this drug.

4.8 Undesirable effects

Summary of the safety profile

The most common adverse reactions reported during clinical trials by > 5% of patients were dry mouth, constipation, diarrhoea, headache, somnolence and dizziness.

Serious adverse reactions associated with oxybutynin include anticholinergic central nervous system effects (see section 4.4).

List of adverse reactions

The safety of Oxybutynin was evaluated in five double-blind, controlled (i.e., placebo or active comparator) clinical trials for the management of overactive bladder, in which 759 adult subjects received doses ranging from 5 to 20 mg/day. Additionally, safety was evaluated in one open-label (i.e., active comparator) clinical trial, in which 60 paediatric subjects received doses of 10 or 15 mg/day. Table 1 below reflects the adverse drug reactions reported with Oxybutynin XL in clinical trials in adults and from postmarketing experience. Adverse drug reactions reported in the paediatric clinical trial are shown in Table 2.

Table 1: Adverse drug reactions reported in clinical trials in adults and from postmarketing experience

	Very Common ≥1/10	Common ≥1/100 to <1/10	Uncommon ≥1/1,000 to <1/100	Rare ≥1/10,000 to <1/1000	Not Known*
Infections and infestations		Urinary tract infection			
Immune System Disorders			Hypersensitivity		Anaphylactic reaction
Metabolism and nutrition disorders			Anorexia, Fluid retention, Decreased appetite		
Psychiatric disorders		Insomnia	Hallucinations, Confusional state, Agitation, Memory impairment		Psychotic disorder, Anxiety, Nightmares, and Paranoia, symptoms of depression, dependence (in patients with history of drug or substance abuse)
Nervous system disorders		Somnolence, Dizziness, Headache, Dysgeusia	Convulsions		Cognitive disorders
Eye disorders		Vision blurred, Dry eye	Angle closure glaucoma		Mydriasis, Ocular hypertension

Cardiac disorders		Palpitations	Arrhythmia, Tachycardia		
Vascular disorders			Hypertension, Flushing		
Respiratory, thoracic and mediastinal disorders		Oropharyngeal pain, Cough, Nasal dryness, Dry throat	Dysphonia, Nasal congestion, Throat irritation		
Gastrointestinal disorders	Dry mouth	Gastro-oesophageal reflux disease, Abdominal pain, Dyspepsia, Constipation, Diarrhoea, Nausea, Flatulence	Dysphagia, Abdominal discomfort, Frequent bowel movements, Vomiting		Pseudo-obstruction in patients at risk (elderly or patients with constipation and treated with other medicinal products that decrease intestinal motility)
Skin and subcutaneous tissue disorders		Dry skin, Pruritus	Urticaria, Rash		Angioedema, Hypohidrosis
Renal and urinary disorders		Dysuria, Urinary hesitation	Urinary retention, Residual urine		Impotence
General disorders and administration site conditions		Fatigue	Chest discomfort, Mucosal dryness, Thirst		
Investigations		Residual urine volume+			
Injury, poisoning and procedural complications			Fall		Heat stroke

*Cannot be estimated from the available clinical data.

+The bundled term residual urine volume consists of the preferred terms residual urine volume and residual urine volume increased.

Description of selected adverse reactions

The following postmarketing adverse reactions listed in Table 1 are from postmarketing reports only (not seen in clinical trials), with the frequency category estimated from clinical trial safety data comprising 759 patients: hallucinations, agitation, memory impairment, and convulsions. These estimates represent the upper limit of the 95% CI.

As with other oxybutynin formulations, dry mouth was the most frequently reported adverse drug reaction. However, in clinical studies, dry mouth has been less frequently reported with Oxybutynin than with oxybutynin immediate release formulations. For patients who required final doses of 5 or 10 mg of Oxybutynin, the relative incidence of dry mouth that occurred at any dose level was 1.8 times lower compared with patients who required final doses > 10 mg.

Paediatric population

The safety of Oxybutynin was evaluated in 60 paediatric subjects (age range 5 to 15 years; dose range 10-15 mg/day) who participated in an open-label, active control, three-arm clinical trial. Adverse drug reactions reported by Oxybutynin-treated paediatric subjects in this clinical trial are shown in Table 2

Table 2: Adverse drug reactions reported in clinical trials with paediatric subjects

	Very Common ≥1/10	Common ≥1/100 to <1/10	Uncommon ≥1/1,000 to <1/100	Rare ≥1/10,000 to <1/1000
Metabolism and nutrition disorders		Anorexia		
Psychiatric disorders		Insomnia		
Nervous system disorders		Headache		
Vascular disorders		Flushing		
Gastrointestinal disorders	Constipation	Diarrhoea		
Skin and subcutaneous tissue disorders		Rash, Pruritus		

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 or search for MHRA Yellow Card in the Google Play or Apple App Store).

4.9 Overdose

The symptoms of overdose with oxybutynin progress from an intensification of the usual CNS disturbances (from restlessness and excitement to psychotic behaviour),

circulatory changes (flushing, fall in blood pressure, circulatory failure etc.), respiratory failure, paralysis and coma.

Measures to be taken include administration of physostigmine by slow intravenous injection.

Fever should be treated symptomatically with tepid sponging or ice packs.

In pronounced restlessness or excitation, diazepam may be given by intravenous injection. Tachycardia may be treated with intravenous propranolol and urinary retention managed by bladder catheterisation.

In the event of progression of curare-like effects to paralysis of the respiratory muscles, mechanical ventilation will be required.

The continuous release of oxybutynin from this medicinal product should be considered in the treatment of overdose. Patients should be monitored for at least 24 hours.

5 PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: urinary antispasmodic, ATC code: G04B D04.

Mechanism of action

Oxybutynin acts as a competitive antagonist of acetylcholine at post-ganglionic muscarinic receptors, resulting in relaxation of bladder smooth muscle.

Pharmacodynamic effects

In patients with overactive bladder, characterized by detrusor muscle instability or hyperreflexia, cystometric studies have demonstrated that oxybutynin increases maximum urinary bladder capacity and increases the volume to first detrusor contraction. Oxybutynin thus decreases urinary urgency and frequency of both incontinence episodes and voluntary urination.

Oxybutynin is a racemic (50:50) mixture of R- and S- isomers. Antimuscarinic activity resides predominantly in the R-isomer. The R-isomer of oxybutynin shows greater selectivity for the M1 and M3 muscarinic subtypes (predominant in bladder detrusor muscle and parotid gland) compared to the M2 subtype (predominant in cardiac tissue). The active metabolite, N-desethyloxybutynin, has pharmacological activity on the human detrusor muscle that is similar to that of oxybutynin in vitro studies, but has a greater binding affinity for parotid tissue than oxybutynin. The free base form of oxybutynin is pharmacologically equivalent to oxybutynin hydrochloride.

Paediatric population

An open-label study was conducted to evaluate the efficacy and safety of Oxybutynin in children aged 6-15 years with detrusor hyperreflexia due to neurogenic conditions, all used clean intermittent catheterisation, and all were current users of 10 or 15 mg oxybutynin hydrochloride administered as Ditropan syrup, Ditropan tablets or Ditropan XL extended-release tablets.

The study results showed that there was an increase from baseline in mean urine volume per catheterisation, an increase from baseline in mean urine volume after morning awakening, from baseline in the mean percentage of catheterisations without a leaking episode, an increase from baseline in mean maximum cystometric capacity, a decrease from baseline in mean detrusor pressure at maximum cystometric pressure and a reduction in the percentage of patients demonstrating uninhibited detrusor contractions as shown in the table below.

Change in Baseline to Week 24			
Parameter	n	Mean (SEM)	Range
Average volume per catheterisation (mL)	109	25.5 (5.9)	-292 to 245
Volume of 1 st catheterisation after morning awakening (mL)	109	33.0 (8.3)	-223 to 450
Maximal bladder capacity (mL)*	105	75.4 (9.8)	-150 to 420
Detrusor pressure at maximal bladder capacity (cm H ₂ O)*	105	-9.2 (2.3)	-102 to 64
Intravesical pressure at maximal bladder capacity (cm H ₂ O)*	105	-7.5 (2.5)	-108 to 76
*Urodynamic studies			
At baseline, 66 of 116 (56.9%) patients had uninhibited detrusor contractions \geq 15 cm H ₂ O. At Week 24, 30 of 105 (28.6%) patients had uninhibited contractions \geq 15 cm H ₂ O. The percentage of catheterisations without a leaking accident increased from 36.0% at baseline to 55.5% at Week 24.			

5.2 Pharmacokinetic properties

Absorption

Following the first dose of Oxybutynin, oxybutynin plasma concentrations rise for 4 to 6 hours; thereafter, concentrations are maintained for up to 24 hours, thus reducing the fluctuations between peak and trough concentrations associated with oxybutynin immediate release formulations. Absolute bioavailability of immediate release oxybutynin has been estimated to be 2-11%. The relative bioavailabilities of R-oxybutynin and S-oxybutynin from Oxybutynin are 156% and 187% respectively, compared with oxybutynin immediate release. After a 10 mg single dose of Oxybutynin, the peak plasma concentrations of R-oxybutynin and S-oxybutynin, achieved after 12.7 \pm 5.4 and 11.8 \pm 5.3 hours respectively, are 1.0 \pm 0.6 and 1.8 \pm 1.0 ng/ml, and the plasma concentration time profiles of both enantiomers are similar in shape.

The pharmacokinetics of Oxybutynin are unaffected by food intake.

Distribution

Oxybutynin is widely distributed in body tissues following systemic absorption. The volume of distribution was estimated to be 193 L after intravenous administration of 5 mg oxybutynin hydrochloride. Both enantiomers of oxybutynin are highly bound (>99%) to plasma proteins. Both enantiomers of desethyloxybutynin are also highly bound (>97%) to plasma proteins. The major binding protein is alpha-1 acid glycoprotein.

Biotransformation and Excretion

Oxybutynin is extensively metabolised by the liver, primarily by the cytochrome P450 enzyme system, particularly CYP3A4 found mostly in the liver and gut wall. Its metabolic products include phenylcyclohexylglycolic acid, which is pharmacologically inactive, and desethyloxybutynin, which is pharmacologically active. Following Oxybutynin XL administration, area under the plasma concentration profiles of R- and S-desethyloxybutynin are 73% and 92%, respectively of those observed with oxybutynin immediate release formulations. Following intravenous administration of 5 mg oxybutynin, clearance was estimated to be 26 L/h. Less than 0.1% of the administered dose is excreted unchanged in the urine. The elimination half-life is 13.2±10.3 hours for R-oxybutynin and 12.4±6.1 hours for S-oxybutynin.

Special Populations

Paediatric population

The steady-state pharmacokinetics of Oxybutynin were evaluated in a limited number of children aged 6-15 years with detrusor overactivity associated with a neurological condition (e.g., spina bifida) receiving 10 or 15 mg total daily doses of Oxybutynin. The pharmacokinetics of Oxybutynin in these paediatric patients were consistent with those reported for adults. The table below summarizes maximum and average plasma concentrations for each of the four analytes, R- and S-Oxybutynin and R- and S-Desethyloxybutynin, by age group and total daily dose.

Mean (SD) Maximum and Average Concentrations (ng/mL) of R- and S-Oxybutynin and R- and S-Desethyloxybutynin in Children Following Administration of 10 and 15 mg Oxybutynin Once Daily				
Dose/Analyte	Age <10 yrs^a		Age >10 yrs^b	
	C_{max}	C_{avg}	C_{max}	C_{avg}
10 mg Dose				
R-Oxybutynin	1.39 (0.1)	0.91 (0.2)	1.37 (0.9)	1.06 (0.8)
S-Oxybutynin	2.46 (0.5)	1.58 (0.5)	2.45 (1.7)	2.00 (1.5)
R-Desethyloxybutynin	15.4 (2.2)	8.74 (2.8)	13.2 (9.7)	9.48 (6.8)
S-Desethyloxybutynin	6.81 (0.9)	4.38 (1.8)	8.05 (6.7)	6.70 (6.1)
15 mg Dose				
R-Oxybutynin	2.59 (1.4)	1.78 (0.8)	2.16 (2.0)	1.86 (2.0)

S-Oxybutynin	5.03 (3.2)	3.67 (2.1)	3.29 (2.7)	2.80 (2.7)
R-Desethyloxybutynin	23.0 (11.0)	16.2 (6.0)	27.8 (22)	20.8 (22)
S-Desethyloxybutynin	13.3 (7.9)	10.3 (6.1)	12.2 (6.8)	9.13 (7.5)
a – 10 mg: n=3; 15 mg: n=6				
b – 10 mg: n=5; 15 mg: n=2				

Linearity/non-linearity

The pharmacokinetic parameters (C_{max} and AUC) of oxybutynin and desethyloxybutynin are dose proportional following administration of 5-20 mg of Oxybutynin. Steady state oxybutynin plasma concentrations are achieved by Day 3 of repeated Oxybutynin dosing, with no observed change in oxybutynin and desethyloxybutynin pharmacokinetic parameters over time. These characteristics support linearity in the pharmacokinetics for oxybutynin

5.3 Preclinical safety data

Non-clinical data reveal no special hazard for humans based on studies of acute toxicity, repeat dose toxicity, genotoxicity, carcinogenic potential and local toxicity. In a fertility study of subcutaneous oxybutynin injections in rats, female fertility was impaired while no effect was noted in male animals. In a rabbit embryotoxicity study, organ anomalies were observed in the presence of maternal toxicity at a dose of 0.4 mg/kg/day subcutaneously. The relevance to human safety is unknown.

6 PHARMACEUTICAL PARTICULARS

6.1 List of excipients

10 mg

Tablet Core

Polyethylene oxide
 Hypromellose
 Sodium chloride
 Butylated hydroxytoluene
 Colloidal silicon dioxide
 Magnesium stearate
 Iron oxide red (E172)
 Iron oxide black (E172)

Film coating:

Cellulose acetate
 Polyethylene glycol 3350
 Hypromellose

Titanium Dioxide
Lactose Monohydrate
Triacetin
Iron oxide red (E172)

Printing Ink
Shellac (E904)
Propylene glycol
Iron oxide black
Purified water

6.2 Incompatibilities

Not applicable.

6.3 Shelf life

2 years

6.4 Special precautions for storage

Keep the bottle tightly closed in order to protect from moisture.

This medicinal product does not require any special temperature storage conditions.

6.5 Nature and contents of container

High density polyethylene bottles with polypropylene child resistant closure and silica gel or purified rayon desiccant.

Pack sizes 14, 28, 30, 56, 60, 84, 90, 100 or 500 tablets.

Not all pack sizes may be marketed.

6.6 Special precautions for disposal

Do not remove or swallow the sachet of granules in the bottle. This contains a desiccant, which keeps the tablets dry.

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

7 MARKETING AUTHORISATION HOLDER

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GU32 3QG
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8 MARKETING AUTHORISATION NUMBER(S)

PL 35533/0143

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

26/10/2023

10 DATE OF REVISION OF THE TEXT

26/10/2023