



Blackrock Pharmaceuticals  
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19<sup>th</sup> August 2019

**Patient Access to Blackrock Pharmaceuticals, Hydroxychloroquine Sulfate 200 mg film coated tablets (HCQ); PL33271/0001**

Dear Sir/Madam

Hydroxychloroquine is used in the treatment of Systemic Lupus Erythematosus (SLE) and Rheumatoid Arthritis. SLE is a severe condition and its treatment aims at remission or low disease activity and prevention of flares. Hydroxychloroquine is recommended in all patients with SLE (<https://ard.bmj.com/content/78/6/736>).

We have been informed of an increasing number of serious incidents from around the UK (both direct from patients and via a patient organisation - Lupus UK), that many patients prescribed the Blackrock version of HCQ, are being told by pharmacies that this product is out of stock. Patients are being asked to take a different version of the brand which has previously presented tolerability issues with the patient. It appears that differences in tolerability of the different generic versions mean that some patients can only tolerate a specific version of HCQ<sup>1</sup>, and we are very concerned for the long-term wellbeing of those patients who need the Blackrock version<sup>2</sup> of this medication.

**We can confirm that this product has not been discontinued and is not out of stock; the product is available to pharmacy through major pharmaceutical wholesale suppliers (see below).**

| Wholesalers stocking Blackrock HCQ | Order code/PIP-Code                     |
|------------------------------------|---|
| Alliance Healthcare                | 6293716 or 1169523                      |
| Phoenix                            | 1169523 – expected availability 22.8.19 |
| DE Group                           | available shortly                       |

Yours faithfully,

Philip McFerran  
Managing Director  
Blackrock Pharmaceuticals Ltd.

<sup>1</sup>Increased Incidence of Gastrointestinal Side Effects in Patients Taking Hydroxychloroquine: A Brand-related Issue? Srinivasa A; Tosounidou S Gordon C; J Rheumatol. 2017 Mar;44(3):398.

<sup>2</sup>Blackrock previously supplied Teva with an own label version of this product, Teva discontinued the agreement in April 2019 therefore Blackrock product should be supplied as a like for like replacement where Teva product has been requested.

## 1. NAME OF THE MEDICINAL PRODUCT

Hydroxychloroquine sulfate 200mg film-coated Tablets

## 2. QUALITATIVE AND QUANTITATIVE COMPOSITION

Hydroxychloroquine sulfate 200mg

### Excipients with known effect

Each tablet contains 47.5 mg of lactose.

For the full list of excipients, see section 6.1.

## 3. PHARMACEUTICAL FORM

Film Coated Tablet

## 4. CLINICAL PARTICULARS

### 4.1 Therapeutic Indications

#### Adults

Treatment of rheumatoid arthritis, discoid and systemic lupus erythematosus, and dermatological conditions caused or aggravated by sunlight.

#### Paediatric Population

Treatment of juvenile idiopathic arthritis (in combination with other therapies), discoid and systemic lupus erythematosus.

### 4.2 Posology and method of administration

#### Adults (including the elderly)

The minimum effective dose should be employed. This dose should not exceed 6.5mg/kg/day (calculated from ideal body weight and not actual body weight) and will be either 200mg or 400mg per day.

#### In patients able to receive 400mg daily:

Initially 400mg daily in divided doses. The dose can be reduced to 200mg when no further improvement is evident. The maintenance dose should be increased to 400mg daily if the response lessens.

#### Paediatric Population

The minimum effective dose should be employed and should not exceed 6.5mg/kg/day based on ideal body weight. The 200mg tablet is therefore not suitable for use in children with an ideal body weight of less than 31kg.

Each dose should be taken with a meal or glass of milk.

Hydroxychloroquine is cumulative in action and will require several weeks to exert its beneficial effects, whereas minor side effects may occur relatively early. For rheumatic disease treatment should be discontinued if there is no improvement by 6 months. In light-sensitive diseases, treatment should only be given during periods of maximum exposure to light.

The tablets are for oral administration.

### 4.3 Contra-indications

- hypersensitivity to hydroxychloroquine or to any of the excipients
- known hypersensitivity to 4-aminoquinoline compounds
- pre-existing maculopathy of the eye

- pregnancy (see section 4.6 Pregnancy and lactation)

#### 4.4 Special warnings and precautions for use

- Hydroxychloroquine has been shown to cause severe hypoglycaemia including loss of consciousness that could be life threatening in patients treated with and without antidiabetic medications. Patients treated with hydroxychloroquine should be warned about the risk of hypoglycaemia and the associated clinical signs and symptoms. Patients presenting with clinical symptoms suggestive of hypoglycaemia during treatment with hydroxychloroquine should have their blood glucose level checked and treatment reviewed as necessary.
- The occurrence of retinopathy is very uncommon if the recommended daily dose is not exceeded. The administration of doses in excess of the recommended maximum is likely to increase the risk of retinopathy, and accelerate its onset.
- All patients should have an ophthalmological examination before initiating treatment with Hydroxychloroquine sulfate. Thereafter, ophthalmological examinations must be repeated at least every 12 months.  
The examination should include testing visual acuity, careful ophthalmoscopy, fundoscopy, central visual field testing with a red target, and colour vision.  
This examination should be more frequent and adapted to the patient in the following situations:
  - daily dosage exceeds 6.5mg/kg lean body weight. Absolute body weight used as a guide to dosage could result in an overdose in the obese
  - renal insufficiency
  - visual acuity below 6/8
  - age above 65 years
  - cumulative dose more than 200g.
- Hydroxychloroquine sulfate should be discontinued immediately in any patient who develops a pigmentary abnormality, visual field defect, or any other abnormality not explainable by difficulty in accommodation or presence of corneal opacities. Patients should continue to be observed for possible progression of the changes.
- Patients should be advised to stop taking the drug immediately and seek the advice of their prescribing doctor if any disturbances of vision are noted, including abnormal colour vision.
- Cases of cardiomyopathy resulting in cardiac failure, in some cases with fatal outcome, have been reported in patients treated with hydroxychloroquine sulfate (see section 4.8 and 4.9). Clinical monitoring for signs and symptoms of cardiomyopathy is advised and hydroxychloroquine sulfate should be discontinued if cardiomyopathy develops. Chronic toxicity should be considered when conduction disorders (bundle branch block / atrio-ventricular heart block) as well as biventricular hypertrophy are diagnosed (see section 4.8).
- Hydroxychloroquine sulfate should be used with caution in patients taking medicines which may cause adverse ocular or skin reactions. Caution should also be applied when it is used in the following:
  - patients with hepatic or renal disease, and in those taking drugs known to affect those organs. Estimation of plasma hydroxychloroquine levels should be undertaken in patients with severely compromised renal or hepatic function and dosage adjusted accordingly.
  - patients with severe gastrointestinal, neurological or blood disorders.

Although the risk of bone marrow depression is low, periodic blood counts are advisable as anaemia, aplastic anaemia, agranulocytosis, a decrease in white blood cells, and thrombocytopenia have been reported. Hydroxychloroquine sulfate should be discontinued if abnormalities develop.

- caution is also advised in patients with a sensitivity to quinine, those with glucose-6-phosphate dehydrogenase deficiency, those with porphyria cutanea tarda which can be exacerbated by hydroxychloroquine and in patients with psoriasis since it appears to increase the risk of skin reactions.
- patients with rare hereditary problems of galactose intolerance, the Lapp lactase deficiency or glucose-galactose malabsorption should not take this medicine.
- Small children are particularly sensitive to the toxic effects of 4-aminoquinolines; therefore patients should be warned to keep Hydroxychloroquine sulfate out of the reach of children.
- All patients on long-term therapy should undergo periodic examination of skeletal muscle function and tendon reflexes. If weakness occurs, the drug should be withdrawn.
- Extrapyramidal disorders may occur with Hydroxychloroquine sulfate (see section 4.8).

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

##### Digoxin

Hydroxychloroquine sulfate has been reported to increase plasma digoxin levels: serum digoxin levels should be closely monitored in patients receiving combined therapy.

##### Chloroquine

Hydroxychloroquine sulfate may also be subject to several of the known interactions of chloroquine even though specific reports have not appeared. These include: potentiation of its direct blocking action at the neuromuscular junction by aminoglycoside antibiotics; inhibition of its metabolism by cimetidine which may increase plasma concentration of the antimalarial; antagonism of effect of neostigmine and pyridostigmine; reduction of the antibody response to primary immunisation with intradermal human diploid-cell rabies vaccine.

##### Antacids

As with chloroquine, antacids may reduce absorption of hydroxychloroquine so it is advised that a 4 hour interval be observed between Hydroxychloroquine sulfate and antacid dosaging.

##### Anti-diabetics

As hydroxychloroquine may enhance the effects of a hypoglycaemic treatment, a decrease in doses of insulin or antidiabetic drugs may be required.

##### Halofantrine

Halofantrine prolongs the QT interval and should not be administered with other drugs that have the potential to induce cardiac arrhythmias, including hydroxychloroquine. Also, there may be an increased risk of inducing ventricular arrhythmias if hydroxychloroquine is used concomitantly with other arrhythmogenic drugs, such as amiodarone and moxifloxacin.

##### Ciclosporin

An increased plasma ciclosporin level was reported when ciclosporin and hydroxychloroquine were co-administered.

##### Antimalarials

Hydroxychloroquine can lower the convulsive threshold. Co-administration of hydroxychloroquine with other antimalarials known to lower the convulsion threshold (e.g mefloquine) may increase the risk of convulsions.

#### Antiepileptics

Also, the activity of antiepileptic drugs might be impaired if co-administered with hydroxychloroquine.

#### Praziquantel

In a single-dose interaction study, chloroquine has been reported to reduce the bioavailability of praziquantel. It is not known if there is a similar effect when hydroxychloroquine and praziquantel are coadministered. Per extrapolation, due to the similarities in structure and pharmacokinetic parameters between hydroxychloroquine and chloroquine, a similar effect may be expected for hydroxychloroquine.

#### Agalsidase

There is a theoretical risk of inhibition of intra-cellular  $\alpha$ -galactosidase activity when hydroxychloroquine is co-administered with agalsidase.

### **4.6 Use during pregnancy and lactation**

#### Pregnancy:

Hydroxychloroquine crosses the placenta. Data are limited regarding the use of hydroxychloroquine during pregnancy. It should be noted that 4-aminoquinolines in therapeutic doses have been associated with central nervous system damage, including ototoxicity (auditory and vestibular toxicity, congenital deafness), retinal hemorrhages and abnormal retinal pigmentation. Therefore Hydroxychloroquine sulfate should not be used in pregnancy.

#### Lactation:

Careful consideration should be given to using hydroxychloroquine during lactation, since it has been shown to be excreted in small amounts in human breast milk, and it is known that infants are extremely sensitive to the toxic effects of 4-aminoquinolines.

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

Impaired visual accommodation soon after the start of treatment has been reported and patients should be warned regarding driving or operating machinery. If the condition is not self-limiting, it will resolve on reducing the dose or stopping treatment.

### **4.8 Undesirable effects**

The following CIOMS frequency rating is used, when applicable:

Very common ( $\geq 1/10$ ); 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).

#### Tabulated list of adverse reactions

| System Organ class      | Frequency | Adverse reaction  |
|-------------------------|-----------|---|
| Immune system disorders | Not known | Urticaria, angioedema, bronchospasm                               |
| Eye disorders           | Common    | Blurring of vision due to a disturbance of accommodation which is |

|  |             |  |
|--|-------------|--|
|  |             | dose dependent and reversible  |
|  | Uncommon    | <i>Retinopathy</i> with changes in pigmentation and visual field defects can occur, but appears to be uncommon if the recommended daily dose is not exceeded. In its early form it appears reversible on discontinuation of hydroxychloroquine sulfate. If allowed to develop, there may be a risk of progression even after treatment withdrawal. Patients with retinal changes may be asymptomatic initially, or may have scotomatous vision with paracentral, pericentral ring types, temporal scotomas and abnormal colour vision. Corneal changes including oedema and opacities have been reported. They are either symptomless or may cause disturbances such as haloes, blurring of vision or photophobia. They may be transient and are reversible on stopping treatment. |
|  | Not known   | Cases of maculopathies and macular degeneration have been reported (the onset ranging from 3 months to several years of exposure to hydroxychloroquine) and may be irreversible  |
| <i>Skin and subcutaneous tissue disorders</i>          | Common      | Skin rash, Pruritus  |
|  | Uncommon    | Pigmentary disorders in skin and mucous membranes, bleaching of hair, alopecia<br>These usually resolve readily on stopping treatment.   |
|  | Not known   | Bullous eruptions including erythema multiforme, Stevens-Johnson syndrome and toxic epidermal necrolysis, Drug Rash with Eosinophilia and Systemic Symptoms (DRESS syndrome) photosensitivity, exfoliative dermatitis, acute generalised exanthematous pustulosis (AGEP).<br>Acute generalised exanthematous pustulosis (AGEP) has to be distinguished from psoriasis, although hydroxychloroquine may precipitate attacks of psoriasis. It may be associated with fever and hyperleukocytosis. Outcome is usually favourable after drug withdrawal.   |
| <i>Gastrointestinal disorders</i>                      | Very common | Abdominal pain, nausea   |
|  | Common      | diarrhoea, vomiting<br>These symptoms usually resolve immediately on reducing the dose or on stopping treatment.   |
| <i>Nervous system disorders</i>                        | Common      | Headache   |
|  | Uncommon    | Dizziness  |
|  | Not known   | Convulsions have been reported with this class of drugs. Extrapyrimalid disorders such as dystonia, dyskinesia, tremor (see section 4.4).  |
| <i>Cardiac disorders</i>                               | Not known   | Cardiomyopathy which may result in cardiac failure and in some cases a fatal outcome (see SPC section 4.4 and 4.9)<br>Chronic toxicity should be considered when conduction disorders (bundle branch block/atrioventricular heart block) as well as biventricular hypertrophy are found. Drug withdrawal may lead to recovery.   |
| <i>Musculoskeletal and connective tissue disorders</i> | Uncommon    | Sensory motor disorders  |
|  | Not known   | Skeletal muscle myopathy or neuromyopathy leading to progressive weakness and atrophy of proximal muscle groups.<br>Myopathy may be reversible after drug discontinuation, but recovery may take many months.<br>Depression of tendon reflexes and abnormal nerve conduction   |

|   |           |   |
|---|-----------|---|
|   |           | studies.  |
| <i>Blood and lymphatic system disorders</i> | Not known | Bone-marrow depression, anaemia, aplastic anaemia, agranulocytosis, leucopenia and thrombocytopenia |
| <i>Hepatobiliary disorders</i>              | Uncommon  | Abnormal liver function tests   |
|   | Not known | Fulminant hepatic failure   |
| <i>Metablism and nutrition disorders</i>    | Not known | Hypoglycaemia (see section 4.4), Hydroxychloroquine may precipitate or exacerbate porphyria.        |
|   | Common    | Anorexia  |
| <i>Ear and labyrinth disorders</i>          | Uncommon  | Vertigo, tinnitus   |
|   | Not known | Hearing loss  |
| <i>Psychiatric disorders</i>                | Common    | Affect lability   |
|   | Uncommon  | Nervousness   |
|   | Not known | Psychosis   |

### Reporting of side effects

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 at [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

Overdosage with the 4-aminoquinolines is dangerous particularly in infants, as little as 1-2g having proved fatal.

The symptoms of overdosage may include headache, visual disturbances, cardiovascular collapse, convulsions, hypokalaemia; rhythm and conduction disorders, including QT prolongation, Torsade de Pointes, ventricular tachycardia and ventricular fibrillation followed by sudden and early respiratory and cardiac arrest. Since these effects may appear soon after taking a massive dose, treatment should be prompt and symptomatic.

The stomach should be immediately evacuated, either by emesis or by gastric lavage. Activated charcoal in a dose at least five times of the overdose may inhibit further absorption if introduced into the stomach by tube following lavage and within 30 minutes of ingestion of the overdose.

Consideration should be given to administration of parenteral diazepam in cases of overdosage; it has been shown to be beneficial in reversing chloroquine cardiotoxicity.

Respiratory support and shock management should be instituted as necessary.

## 5. PHARMACOLOGICAL PROPERTIES

### 5.1 Pharmacodynamic properties

**ATC Code: P01BA02**

**Pharmacotherapeutic group: Anti rheumatic**

Antimalarial agents like chloroquine and hydroxychloroquine have several pharmacological actions which may be involved in their therapeutic effect in the treatment of rheumatic disease, but the role of each is not known. These include interaction with sulphhydryl groups, interference with enzyme activity (including phospholipase, NADH - cytochrome C reductase, cholinesterase, proteases and hydrolases), DNA binding, stabilisation of lysosomal membranes, inhibition of prostaglandin formation, inhibition of polymorphonuclear cell chemotaxis and phagocytosis, possible interference with interleukin 1 production from monocytes and inhibition of neutrophil superoxide release.

## **5.2 Pharmacokinetic properties**

Hydroxychloroquine has actions, pharmacokinetics and metabolism similar to those of chloroquine. Following oral administration, hydroxychloroquine is rapidly and almost completely absorbed. In one study, mean peak plasma hydroxychloroquine concentrations following a single dose of 400mg in healthy subjects ranged from 53-208ng/ml with a mean of 105ng/ml. The mean time to peak plasma concentration was 1.83 hours. The mean plasma elimination half-life varied, depending on the post-administration period, as follows: 5.9 hours at  $C_{max}$ -10 hours), 26.1 hours (at 10-48 hours) and 299 hours (at 48-504 hours). The parent compound and metabolites are widely distributed in the body and elimination is mainly via the urine, where 3% of the administered dose was recovered over 24 hours in one study.

## **5.3 Preclinical safety data**

There are no preclinical safety data of relevance to the prescriber, which are additional to that already included in other sections of the SPC.

# **6. PHARMACEUTICAL PARTICULARS**

## **6.1 List of excipients**

Lactose Monohydrate  
Maize Starch  
Hypromellose  
Croscarmellose Sodium  
Magnesium Stearate  
Talc  
Titanium Dioxide  
Macrogol 6000  
Iron Oxide Yellow E172  
Polysorbate 80

## **6.2 Major Incompatibilities**

No incompatibilities are known.

## **6.3 Shelf life**

3 years

## **6.4 Special precautions for storage**

Do not store above 25°C.

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



250µm clear PVC/20µm aluminium foil blister pack containing 10 tablets.  
The blister packs are packed in a outer cardboard carton containing 28, 30 or 60 tablets. Not all pack sizes may be marketed.

**6.6 Special precautions for disposal and other handling**

None

**7. MARKETING AUTHORISATION HOLDER**

Blackrock Pharmaceuticals Ltd.  
Abbey Place  
24-28 Easton Street  
High Wycombe  
HP11 1NT  
United Kingdom

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

PL 33271/0001

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

September 2009

**10. DATE OF REVISION OF THE TEXT**

February 2018