

## HIGHLIGHTS OF PRESCRIBING INFORMATION

These highlights do not include all the information needed to use MICARDIS safely and effectively. See full prescribing information for MICARDIS.

MICARDIS® (telmisartan) Tablets  
Initial U.S. Approval: 1998

### WARNING: AVOID USE IN PREGNANCY

See full prescribing information for complete boxed warnings.

When pregnancy is detected, discontinue MICARDIS as soon as possible. Drugs that act directly on the renin-angiotensin system can cause injury and even death to the developing fetus (5.1)

### RECENT MAJOR CHANGES

Indications and Usage, Cardiovascular Risk Reduction (1.2) [10/2009]  
Dosage and Administration, Cardiovascular Risk Reduction (2.2) [10/2009]  
Contraindications (4) [10/2009]  
Warnings and Precautions,  
Dual Blockade of the Renin-Angiotensin-Aldosterone System (5.6) [9/2009]

### INDICATIONS AND USAGE

MICARDIS is an angiotensin II receptor blocker (ARB) indicated for:

- Treatment of hypertension (1.1)
- Cardiovascular (CV) risk reduction in patients unable to take ACE inhibitors (1.2)

### DOSAGE AND ADMINISTRATION

- May be administered with or without food (2.1)
- When used for cardiovascular risk reduction, monitoring of blood pressure is recommended, and if appropriate, adjustment of medications that lower blood pressure may be necessary (2.2)

Indication	Starting Dose	Dose Range
Hypertension (2.1)	40 mg once daily	40 to 80 mg once daily
Cardiovascular Risk Reduction (2.2)	80 mg once daily	80 mg once daily

### DOSAGE FORMS AND STRENGTHS

- Tablets: 20 mg, 40 mg, 80 mg (3)

### CONTRAINDICATIONS

- None

### WARNINGS AND PRECAUTIONS

- Avoid fetal or neonatal exposure (5.1)
- Hypotension: Correct any volume or salt depletion before initiating therapy. Observe for signs and symptoms of hypotension (5.2)
- Monitor carefully in patients with impaired hepatic (5.4) or renal function (5.5)
- Avoid concomitant use of an ACE inhibitor and angiotensin receptor blocker (5.6)

### ADVERSE REACTIONS

- Hypertension: The most common adverse events ( $\geq 1\%$ ) reported in hypertension trials are back pain, sinusitis, and diarrhea (6.1)
- Cardiovascular risk reduction: The serious adverse events ( $\geq 1\%$ ) reported in cardiovascular risk reduction trials were intermittent claudication and skin ulcer (6.1)

To report SUSPECTED ADVERSE REACTIONS, contact Boehringer Ingelheim Pharmaceuticals, Inc. at (800) 542-6257 or (800) 459-9906 TTY, or FDA at 1-800-FDA-1088 or [www.fda.gov/medwatch](http://www.fda.gov/medwatch).

### USE IN SPECIFIC POPULATIONS

- Nursing Mothers: Choose to discontinue nursing or drug (8.3)
- Geriatric Patients: No overall difference in efficacy or safety vs. younger patients, but greater sensitivity of some older individuals cannot be ruled out (8.5)

See 17 for PATIENT COUNSELING INFORMATION and FDA-approved patient labeling.

Revised: [10/2009]

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## FULL PRESCRIBING INFORMATION

### WARNING: AVOID USE IN PREGNANCY

When used in pregnancy, drugs that act directly on the renin-angiotensin system can cause injury and even death to the developing fetus. When pregnancy is detected, MICARDIS tablets should be discontinued as soon as possible. *See Warnings and Precautions (5.1).*

## 1 INDICATIONS AND USAGE

### 1.1 Hypertension

MICARDIS is indicated for the treatment of hypertension. It may be used alone or in combination with other antihypertensive agents [*see Clinical Studies (14.1)*].

### 1.2 Cardiovascular Risk Reduction

MICARDIS is indicated for reduction of the risk of myocardial infarction, stroke, or death from cardiovascular causes in patients 55 years of age or older at high risk of developing major cardiovascular events who are unable to take ACE inhibitors.

High risk for cardiovascular events can be evidenced by a history of coronary artery disease, peripheral arterial disease, stroke, transient ischemic attack, or high-risk diabetes (insulin-dependent or non-insulin dependent) with evidence of end-organ damage [*see Clinical Studies (14.2)*]. MICARDIS can be used in addition to other needed treatment (such as antihypertensive, antiplatelet or lipid-lowering therapy) [*see Clinical Studies (14.2)*].

Studies of telmisartan in this setting do not exclude that it may not preserve a meaningful fraction of the effect of the ACE inhibitor to which it was compared. Consider using the ACE inhibitor first, and, if it is stopped for cough only, consider re-trying the ACE inhibitor after the cough resolves.

Use of telmisartan with an ACE inhibitor is not recommended [*see Warnings and Precautions (5.6)*].

## 2 DOSAGE AND ADMINISTRATION

### 2.1 Hypertension

Dosage must be individualized. The usual starting dose of MICARDIS tablets is 40 mg once a day. Blood pressure response is dose-related over the range of 20-80 mg [*see Clinical Studies (14.1)*].

Most of the antihypertensive effect is apparent within 2 weeks and maximal reduction is generally attained after 4 weeks. When additional blood pressure reduction beyond that achieved with 80 mg MICARDIS is required, a diuretic may be added.

No initial dosage adjustment is necessary for elderly patients or patients with renal impairment, including those on hemodialysis. Patients on dialysis may develop orthostatic hypotension; their blood pressure should be closely monitored.

MICARDIS tablets may be administered with other antihypertensive agents.

MICARDIS tablets may be administered with or without food.

### 2.2 Cardiovascular Risk Reduction

The recommended dose of MICARDIS tablets is 80 mg once a day and can be administered with or without food. It is not known whether doses lower than 80 mg of telmisartan are effective in reducing the risk of cardiovascular morbidity and mortality.

When initiating MICARDIS therapy for cardiovascular risk reduction, monitoring of blood pressure is recommended, and if appropriate adjustment of medications that lower blood pressure may be necessary.

## 3 DOSAGE FORMS AND STRENGTHS

- 20 mg, white or off-white, round, uncoated tablets imprinted with BI logo on one side and 50 H on the other side
- 40 mg, white or off-white, oblong, uncoated tablets imprinted with BI logo on one side and 51 H on the other side
- 80 mg, white or off-white, oblong, uncoated tablets imprinted with BI logo on one side and 52 H on the other side

## 4 CONTRAINDICATIONS

None.

## 5 WARNINGS AND PRECAUTIONS

### 5.1 Fetal/Neonatal Morbidity and Mortality

Drugs that act directly on the renin-angiotensin system can cause fetal and neonatal morbidity and death when administered to pregnant women. Several dozen cases have been reported in the world literature in patients who were taking angiotensin converting enzyme inhibitors. When pregnancy is detected, discontinue MICARDIS tablets as soon as possible [*see Boxed Warning*].

The use of drugs that act directly on the renin-angiotensin system during the second and third trimesters of pregnancy has been associated with fetal and neonatal injury, including hypotension, neonatal skull hypoplasia, anuria, reversible or irreversible renal failure, and death. Oligohydramnios has also been reported, presumably resulting from decreased fetal renal function; oligohydramnios in this setting has been associated with fetal limb contractures, craniofacial deformation, and hypoplastic lung development. Prematurity, intrauterine growth retardation, and patent ductus arteriosus have also been reported, although it is not clear whether these occurrences were related to exposure to the drug.

These adverse effects do not appear to have resulted from intrauterine drug exposure that has been limited to the first trimester. Inform mothers whose embryos and fetuses are exposed to an angiotensin II receptor antagonist only during the first trimester that most reports of fetal toxicity have been associated with second and third trimester exposure. Nonetheless, when patients become pregnant or are considering pregnancy, have the patient discontinue the use of MICARDIS tablets as soon as possible.

Rarely (probably less often than once in every thousand pregnancies), no alternative to an angiotensin II receptor antagonist will be found. In these rare cases, the mothers should be apprised of the potential hazards to their fetuses, and serial ultrasound examinations should be performed to assess the intra-amniotic environment.

If oligohydramnios is observed, MICARDIS should be discontinued unless they are considered life-saving for the mother. Contraction stress testing (CST), a non-stress test (NST), or biophysical profiling (BPP) may be appropriate, depending upon the week of pregnancy. Patients and physicians should be aware, however, that oligohydramnios may not appear until after the fetus has sustained irreversible injury.

Infants with histories of *in utero* exposure to an angiotensin II receptor antagonist should be closely observed for hypotension, oliguria, and hyperkalemia. If oliguria occurs, attention should be directed toward support of blood pressure and renal perfusion. Exchange transfusion or dialysis may be required as a means of reversing hypotension and/or substituting for disordered renal function.

### 5.2 Hypotension

In patients with an activated renin-angiotensin system, such as volume- or salt-depleted patients (e.g., those being treated with high doses of diuretics), symptomatic hypotension may occur after initiation of therapy with MICARDIS. Either correct this condition prior to administration of MICARDIS, or start treatment under close medical supervision with a reduced dose.

If hypotension does occur, the patient should be placed in the supine position and, if necessary, given an intravenous infusion of normal saline. A transient hypotensive response is not a contraindication to further treatment, which usually can be continued without difficulty once the blood pressure has stabilized.

### 5.3 Hyperkalemia

Hyperkalemia may occur in patients on ARBs, particularly in patients with advanced renal impairment, heart failure, on renal replacement therapy, or on potassium supplements, potassium-sparing diuretics, potassium-containing salt substitutes or other drugs that increase potassium levels. Consider periodic determinations of serum electrolytes to detect possible electrolyte imbalances, particularly in patients at risk.

### 5.4 Impaired Hepatic Function

As the majority of telmisartan is eliminated by biliary excretion, patients with biliary obstructive disorders or hepatic insufficiency can be expected to have reduced clearance. Initiate telmisartan at low doses and titrate slowly in these patients [see *Use in Specific Populations (8.6)*, and *Clinical Pharmacology (12.3)*].

### 5.5 Impaired Renal Function

As a consequence of inhibiting the renin-angiotensin-aldosterone system, anticipate changes in renal function in susceptible individuals. In patients whose renal function may depend on the activity of the renin-angiotensin-aldosterone system (e.g., patients with severe congestive heart failure or renal dysfunction), treatment with angiotensin-converting enzyme (ACE) inhibitors and angiotensin receptor antagonists has been associated with oliguria and/or progressive azotemia and (rarely) with acute renal failure and/or death. Similar results have been reported with MICARDIS [see *Clinical Pharmacology (12.3)*].

In studies of ACE inhibitors in patients with unilateral or bilateral renal artery stenosis, increases in serum creatinine or blood urea nitrogen were observed. There has been no long term use of MICARDIS in patients with unilateral or bilateral renal artery stenosis, but anticipate an effect similar to that seen with ACE inhibitors.

### 5.6 Dual Blockade of the Renin-Angiotensin-Aldosterone System

As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function (including acute renal failure) have been reported. Dual blockade of the renin-angiotensin-aldosterone system (e.g., by adding an ACE-inhibitor to an angiotensin II receptor antagonist) should include close monitoring of renal function.

The ONTARGET trial enrolled 25,620 patients  $\geq 55$  years old with atherosclerotic disease or diabetes with end-organ damage, randomizing them to telmisartan only, ramipril only, or the combination, and followed them for a median of 56 months. Patients receiving the combination of MICARDIS and ramipril did not obtain any additional benefit compared to monotherapy, but experienced an increased incidence of renal dysfunction (e.g., acute renal failure) compared with groups receiving telmisartan alone or ramipril alone. Concomitant use of MICARDIS and ramipril is not recommended.

## 6 ADVERSE REACTIONS

The following adverse reaction is described elsewhere in labeling:

Renal dysfunction upon use with ramipril [see *Warnings and Precautions (5.6)*]

### 6.1 Clinical Trials Experience

Because clinical studies are conducted under widely varying conditions, adverse reactions rates observed in the clinical studies of a drug cannot be directly compared to rates in the clinical studies of another drug and may not reflect the rates observed in practice.

#### *Hypertension*

MICARDIS has been evaluated for safety in more than 3700 patients, including 1900 treated for over 6 months and more than 1300 for over one year. Adverse experiences have generally been mild and transient in nature and have infrequently required discontinuation of therapy.

In placebo-controlled trials involving 1041 patients treated with various doses of MICARDIS (20-160 mg) monotherapy for up to 12 weeks, the overall incidence of adverse events was similar to that in patients treated with placebo.

Adverse events occurring at an incidence of  $\geq 1\%$  in patients treated with MICARDIS and at a greater rate than in patients treated with placebo, irrespective of their causal association, are presented in Table 1.

**Table 1 Adverse Events Occurring at an Incidence of  $\geq 1\%$  in Patients Treated with MICARDIS and at a Greater Rate Than Patients Treated with Placebo**

	Telmisartan n=1455 %	Placebo n=380 %
Upper respiratory tract infection	7	6
Back pain	3	1
Sinusitis	3	2
Diarrhea	3	2
Pharyngitis	1	0

In addition to the adverse events in the table, the following events occurred at a rate of  $\geq 1\%$  but were at least as frequent in the placebo group: influenza-like symptoms, dyspepsia, myalgia, urinary tract infection, abdominal pain, headache, dizziness, pain, fatigue, coughing, hypertension, chest pain, nausea and peripheral

edema. Discontinuation of therapy because of adverse events was required in 2.8% of 1455 patients treated with MICARDIS tablets and 6.1% of 380 placebo patients in placebo-controlled clinical trials.

The incidence of adverse events was not dose-related and did not correlate with gender, age, or race of patients.

The incidence of cough occurring with telmisartan in 6 placebo-controlled trials was identical to that noted for placebo-treated patients (1.6%).

In addition to those listed above, adverse events that occurred in more than 0.3% of 3500 patients treated with MICARDIS monotherapy in controlled or open trials are listed below. It cannot be determined whether these events were causally related to MICARDIS tablets:

*Autonomic Nervous System:* impotence, increased sweating, flushing; *Body as a Whole:* allergy, fever, leg pain, malaise; *Cardiovascular:* palpitation, dependent edema, angina pectoris, tachycardia, leg edema, abnormal ECG; *CNS:* insomnia, somnolence, migraine, vertigo, paresthesia, involuntary muscle contractions, hypoaesthesia; *Gastrointestinal:* flatulence, constipation, gastritis, vomiting, dry mouth, hemorrhoids, gastroenteritis, enteritis, gastroesophageal reflux, toothache, non-specific gastrointestinal disorders; *Metabolic:* gout, hypercholesterolemia, diabetes mellitus; *Musculoskeletal:* arthritis, arthralgia, leg cramps; *Psychiatric:* anxiety, depression, nervousness; *Resistance Mechanism:* infection, fungal infection, abscess, otitis media; *Respiratory:* asthma, bronchitis, rhinitis, dyspnea, epistaxis; *Skin:* dermatitis, rash, eczema, pruritus; *Urinary:* micturition frequency, cystitis; *Vascular:* cerebrovascular disorder; and *Special Senses:* abnormal vision, conjunctivitis, tinnitus, earache.

During initial clinical studies, a single case of angioedema was reported (among a total of 3781 patients treated).

#### *Clinical Laboratory Findings*

In placebo-controlled clinical trials, clinically relevant changes in standard laboratory test parameters were rarely associated with administration of MICARDIS tablets.

**Hemoglobin:** A greater than 2 g/dL decrease in hemoglobin was observed in 0.8% telmisartan patients compared with 0.3% placebo patients. No patients discontinued therapy because of anemia.

**Creatinine:** A 0.5 mg/dL rise or greater in creatinine was observed in 0.4% telmisartan patients compared with 0.3% placebo patients. One telmisartan-treated patient discontinued therapy because of increases in creatinine and blood urea nitrogen.

**Liver Enzymes:** Occasional elevations of liver chemistries occurred in patients treated with telmisartan; all marked elevations occurred at a higher frequency with placebo. No telmisartan-treated patients discontinued therapy because of abnormal hepatic function.

#### *Cardiovascular Risk Reduction*

Because common adverse reactions were well characterized in studies of telmisartan in hypertension, only adverse events leading to discontinuation and serious adverse events were recorded in subsequent studies of telmisartan for cardiovascular risk reduction. In TRANSCEND (N=5926, 4 years and 8 months of follow-up), discontinuations for adverse events were 8.4% on telmisartan and 7.6% on placebo. The only serious adverse events at least 1% more common on telmisartan than placebo were intermittent claudication (7% vs. 6%) and skin ulcer (3% vs. 2%).

## **6.2 Postmarketing Experience**

The following adverse reactions have been identified during post-approval use of MICARDIS. Because these reactions are reported voluntarily from a population of uncertain size, it is not always possible to estimate reliably their frequency or establish a causal relationship to drug exposure. Decisions to include these reactions in labeling are typically based on one or more of the following factors: (1) seriousness of the reaction, (2) frequency of reporting, or (3) strength of causal connection to MICARDIS.

The most frequently spontaneously reported events include: headache, dizziness, asthenia, coughing, nausea, fatigue, weakness, edema, face edema, lower limb edema, angioneurotic edema, urticaria, hypersensitivity, sweating increased, erythema, chest pain, atrial fibrillation, congestive heart failure, myocardial infarction, blood pressure increased, hypertension aggravated, hypotension (including postural hypotension), hyperkalemia, syncope, dyspepsia, diarrhea, pain, urinary tract infection, erectile dysfunction, back pain, abdominal pain, muscle cramps (including leg cramps), myalgia, bradycardia, eosinophilia, thrombocytopenia, uric acid increased, abnormal hepatic function/liver disorder, renal impairment including acute renal failure, anemia, increased CPK, anaphylactic reaction, and tendon pain (including tendonitis, tenosynovitis).

Rare cases of rhabdomyolysis have been reported in patients receiving angiotensin II receptor blockers, including MICARDIS.

## **7 DRUG INTERACTIONS**

**Digoxin:** When MICARDIS was co-administered with digoxin, median increases in digoxin peak plasma concentration (49%) and in trough concentration (20%) were observed. Therefore, monitor digoxin levels when initiating, adjusting, and discontinuing telmisartan for the purpose of keeping the digoxin level within the therapeutic range.

**Lithium:** Reversible increases in serum lithium concentrations and toxicity have been reported during concomitant administration of lithium with angiotensin II receptor antagonists including MICARDIS. Therefore, monitor serum lithium levels during concomitant use.

**Ramipril and Ramiprilat:** Co-administration of telmisartan 80 mg once daily and ramipril 10 mg once daily to healthy subjects increases steady-state  $C_{max}$  and AUC of ramipril 2.3- and 2.1-fold, respectively, and  $C_{max}$  and AUC of ramiprilat 2.4- and 1.5-fold, respectively. In contrast,  $C_{max}$  and AUC of telmisartan decrease by 31% and 16%, respectively. When co-administering telmisartan and ramipril, the response may be greater because of the possibly additive pharmacodynamic effects of the combined drugs, and also because of the increased exposure to ramipril and ramiprilat in the presence of telmisartan. Concomitant use of MICARDIS and ramipril is not recommended.

**Other Drugs:** Co-administration of telmisartan did not result in a clinically significant interaction with acetaminophen, amlodipine, glyburide, simvastatin, hydrochlorothiazide, warfarin, or ibuprofen. Telmisartan is not metabolized by the cytochrome P450 system and had no effects *in vitro* on cytochrome P450 enzymes, except for some inhibition of CYP2C19. Telmisartan is not expected to interact with drugs that inhibit cytochrome P450 enzymes; it is also not expected to interact with drugs metabolized by cytochrome P450 enzymes, except for possible inhibition of the metabolism of drugs metabolized by CYP2C19.

## **8 USE IN SPECIFIC POPULATIONS**

### **8.1 Pregnancy**

**Teratogenic Effects, Pregnancy Categories C (first trimester) and D (second and third trimesters).** See *Warnings and Precautions (5.1)*.

### 8.3 Nursing Mothers

It is not known whether telmisartan is excreted in human milk, but telmisartan was shown to be present in the milk of lactating rats. Because of the potential for adverse effects on the nursing infant, decide whether to discontinue nursing or discontinue the drug, taking into account the importance of the drug to the mother.

### 8.4 Pediatric Use

Safety and effectiveness in pediatric patients have not been established.

### 8.5 Geriatric Use

Of the total number of patients receiving MICARDIS in hypertension clinical studies, 551 (19%) were 65 to 74 years of age and 130 (4%) were 75 years or older. No overall differences in effectiveness and safety were observed in these patients compared to younger patients and other reported clinical experience has not identified differences in responses between the elderly and younger patients, but greater sensitivity of some older individuals cannot be ruled out.

Of the total number of patients receiving MICARDIS in the cardiovascular risk reduction study (ONTARGET), the percentage of patients  $\geq 65$  to  $< 75$  years of age was 42%; 15% of patients were  $\geq 75$  years old. No overall differences in effectiveness and safety were observed in these patients compared to younger patients and other reported clinical experience has not identified differences in responses between the elderly and younger patients, but greater sensitivity of some older individuals cannot be ruled out.

### 8.6 Hepatic Insufficiency

Monitor carefully and uptitrate slowly in patients with biliary obstructive disorders or hepatic insufficiency [*Warnings and Precautions (5.4)*].

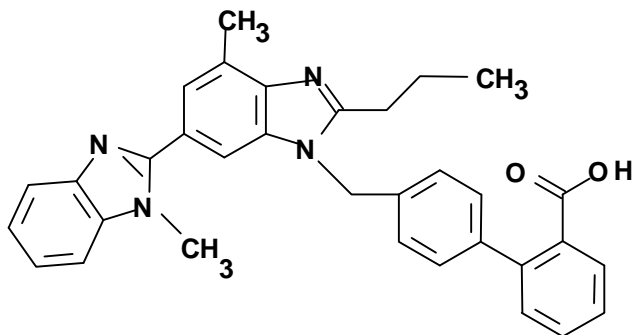
## 10 OVERDOSAGE

Limited data are available with regard to overdosage in humans. The most likely manifestation of overdosage with MICARDIS tablets would be hypotension, dizziness and tachycardia; bradycardia could occur from parasympathetic (vagal) stimulation. If symptomatic hypotension should occur, supportive treatment should be instituted. Telmisartan is not removed by hemodialysis.

## 11 DESCRIPTION

MICARDIS is a non-peptide angiotensin II receptor (type AT<sub>1</sub>) antagonist.

Telmisartan is chemically described as 4'-[(1,4'-dimethyl-2'-propyl [2,6'-bi-1H-benzimidazol]-1'-yl)methyl]-[1,1'-biphenyl]-2-carboxylic acid. Its empirical formula is C<sub>33</sub>H<sub>30</sub>N<sub>4</sub>O<sub>2</sub>, its molecular weight is 514.63, and its structural formula is:



Telmisartan is a white to slightly yellowish solid. It is practically insoluble in water and in the pH range of 3 to 9, sparingly soluble in strong acid (except insoluble in hydrochloric acid), and soluble in strong base.

MICARDIS is available as tablets for oral administration, containing 20 mg, 40 mg or 80 mg of telmisartan. The tablets contain the following inactive ingredients: sodium hydroxide, meglumine, povidone, sorbitol, and magnesium stearate. MICARDIS tablets are hygroscopic and require protection from moisture.

## 12 CLINICAL PHARMACOLOGY

### 12.1 Mechanism of Action

Angiotensin II is formed from angiotensin I in a reaction catalyzed by angiotensin-converting enzyme (ACE, kininase II). Angiotensin II is the principal pressor agent of the renin-angiotensin system, with effects that include vasoconstriction, stimulation of synthesis and release of aldosterone, cardiac stimulation, and renal reabsorption of sodium. Telmisartan blocks the vasoconstrictor and aldosterone-secreting effects of angiotensin II by selectively blocking the binding of angiotensin II to the AT<sub>1</sub> receptor in many tissues, such as vascular smooth muscle and the adrenal gland. Its action is therefore independent of the pathways for angiotensin II synthesis.

There is also an AT<sub>2</sub> receptor found in many tissues, but AT<sub>2</sub> is not known to be associated with cardiovascular homeostasis. Telmisartan has much greater affinity (>3,000 fold) for the AT<sub>1</sub> receptor than for the AT<sub>2</sub> receptor.

Blockade of the renin-angiotensin system with ACE inhibitors, which inhibit the biosynthesis of angiotensin II from angiotensin I, is widely used in the treatment of hypertension. ACE inhibitors also inhibit the degradation of bradykinin, a reaction also catalyzed by ACE. Because telmisartan does not inhibit ACE (kininase II), it does not affect the response to bradykinin. Whether this difference has clinical relevance is not yet known. Telmisartan does not bind to or block other hormone receptors or ion channels known to be important in cardiovascular regulation.

Blockade of the angiotensin II receptor inhibits the negative regulatory feedback of angiotensin II on renin secretion, but the resulting increased plasma renin activity and angiotensin II circulating levels do not overcome the effect of telmisartan on blood pressure.

### 12.2 Pharmacodynamics

In normal volunteers, a dose of telmisartan 80 mg inhibited the pressor response to an intravenous infusion of angiotensin II by about 90% at peak plasma concentrations with approximately 40% inhibition persisting for 24 hours.

Plasma concentration of angiotensin II and plasma renin activity (PRA) increased in a dose-dependent manner after single administration of telmisartan to healthy subjects and repeated administration to hypertensive patients. The once-daily administration of up to 80 mg telmisartan to healthy subjects did not influence plasma

aldosterone concentrations. In multiple dose studies with hypertensive patients, there were no clinically significant changes in electrolytes (serum potassium or sodium), or in metabolic function (including serum levels of cholesterol, triglycerides, HDL, LDL, glucose, or uric acid).

In 30 hypertensive patients with normal renal function treated for 8 weeks with telmisartan 80 mg or telmisartan 80 mg in combination with hydrochlorothiazide 12.5 mg, there were no clinically significant changes from baseline in renal blood flow, glomerular filtration rate, filtration fraction, renovascular resistance, or creatinine clearance.

### 12.3 Pharmacokinetics

Following oral administration, peak concentrations ( $C_{max}$ ) of telmisartan are reached in 0.5-1 hour after dosing. Food slightly reduces the bioavailability of telmisartan, with a reduction in the area under the plasma concentration-time curve (AUC) of about 6% with the 40 mg tablet and about 20% after a 160 mg dose. The absolute bioavailability of telmisartan is dose dependent. At 40 and 160 mg the bioavailability was 42% and 58%, respectively. The pharmacokinetics of orally administered telmisartan are nonlinear over the dose range 20-160 mg, with greater than proportional increases of plasma concentrations ( $C_{max}$  and AUC) with increasing doses. Telmisartan shows bi-exponential decay kinetics with a terminal elimination half life of approximately 24 hours. Trough plasma concentrations of telmisartan with once daily dosing are about 10-25% of peak plasma concentrations. Telmisartan has an accumulation index in plasma of 1.5 to 2.0 upon repeated once daily dosing.

#### *Distribution*

Telmisartan is highly bound to plasma proteins (>99.5%), mainly albumin and  $\alpha_1$  - acid glycoprotein. Plasma protein binding is constant over the concentration range achieved with recommended doses. The volume of distribution for telmisartan is approximately 500 liters indicating additional tissue binding.

#### *Metabolism and Elimination*

Following either intravenous or oral administration of  $^{14}C$ -labeled telmisartan, most of the administered dose (>97%) was eliminated unchanged in feces via biliary excretion; only minute amounts were found in the urine (0.91% and 0.49% of total radioactivity, respectively).

Telmisartan is metabolized by conjugation to form a pharmacologically inactive acyl glucuronide; the glucuronide of the parent compound is the only metabolite that has been identified in human plasma and urine. After a single dose, the glucuronide represents approximately 11% of the measured radioactivity in plasma. The cytochrome P450 isoenzymes are not involved in the metabolism of telmisartan.

Total plasma clearance of telmisartan is >800 mL/min. Terminal half-life and total clearance appear to be independent of dose.

#### *Special Populations*

##### Renal Insufficiency

No dosage adjustment is necessary in patients with decreased renal function. Telmisartan is not removed from blood by hemofiltration [see *Warnings and Precautions (5.5) and Dosage and Administration (2.1)*].

##### Hepatic Insufficiency

In patients with hepatic insufficiency, plasma concentrations of telmisartan are increased, and absolute bioavailability approaches 100% [see *Warnings and Precautions (5.4) and Use in Specific Populations (8.6)*].

##### Gender

Plasma concentrations of telmisartan are generally 2-3 times higher in females than in males. In clinical trials, however, no significant increases in blood pressure response or in the incidence of orthostatic hypotension were found in women. No dosage adjustment is necessary.

##### Geriatric Patients

The pharmacokinetics of telmisartan do not differ between the elderly and those younger than 65 years [see *Dosage and Administration (2.1)*].

##### Pediatric Patients

Telmisartan pharmacokinetics have not been investigated in patients <18 years of age.

## 13 NONCLINICAL TOXICOLOGY

### 13.1 Carcinogenesis, Mutagenesis, Impairment of Fertility

There was no evidence of carcinogenicity when telmisartan was administered in the diet to mice and rats for up to 2 years. The highest doses administered to mice (1000 mg/kg/day) and rats (100 mg/kg/day) are, on a mg/m<sup>2</sup> basis, about 59 and 13 times, respectively, the maximum recommended human dose (MRHD) of telmisartan. These same doses have been shown to provide average systemic exposures to telmisartan >100 times and >25 times, respectively, the systemic exposure in humans receiving the MRHD (80 mg/day).

Genotoxicity assays did not reveal any telmisartan-related effects at either the gene or chromosome level. These assays included bacterial mutagenicity tests with *Salmonella* and *E. coli* (Ames), a gene mutation test with Chinese hamster V79 cells, a cytogenetic test with human lymphocytes, and a mouse micronucleus test.

No drug-related effects on the reproductive performance of male and female rats were noted at 100 mg/kg/day (the highest dose administered), about 13 times, on a mg/m<sup>2</sup> basis, the MRHD of telmisartan. This dose in the rat resulted in an average systemic exposure (telmisartan AUC as determined on day 6 of pregnancy) at least 50 times the average systemic exposure in humans at the MRHD (80 mg/day).

### 13.3 Developmental Toxicity

There is no clinical experience with the use of MICARDIS tablets in pregnant women. No teratogenic effects were observed when telmisartan was administered to pregnant rats at oral doses of up to 50 mg/kg/day and to pregnant rabbits at oral doses up to 45 mg/kg/day. In rabbits, embryoletality associated with maternal toxicity (reduced body weight gain and food consumption) was observed at 45 mg/kg/day [about 12 times the maximum recommended human dose (MRHD) of 80 mg on a mg/m<sup>2</sup> basis]. In rats, maternally toxic (reduction in body weight gain and food consumption) telmisartan doses of 15 mg/kg/day (about 1.9 times the MRHD on a mg/m<sup>2</sup> basis), administered during late gestation and lactation, were observed to produce adverse effects in neonates, including reduced viability, low birth weight, delayed maturation, and decreased weight gain. Telmisartan has been shown to be present in rat fetuses during late gestation and in rat milk. The no observed effect doses for developmental toxicity in rats and rabbits, 5 and 15 mg/kg/day, respectively, are about 0.64 and 3.7 times, on a mg/m<sup>2</sup> basis, the maximum recommended human dose of telmisartan (80 mg/day).

## 14 CLINICAL STUDIES

### 14.1 Hypertension

The antihypertensive effects of MICARDIS have been demonstrated in six principal placebo-controlled clinical trials, studying a range of 20-160 mg; one of these examined the antihypertensive effects of telmisartan and hydrochlorothiazide in combination. The studies involved a total of 1773 patients with mild to moderate hypertension (diastolic blood pressure of 95-114 mmHg), 1031 of whom were treated with telmisartan. Following once daily administration of telmisartan, the magnitude of blood pressure reduction from baseline after placebo subtraction was approximately (SBP/DBP) 6-8/6 mmHg for 20 mg, 9-13/6-8 mmHg for 40 mg, and 12-13/7-8 mmHg for 80 mg. Larger doses (up to 160 mg) did not appear to cause a further decrease in blood pressure.

Upon initiation of antihypertensive treatment with telmisartan, blood pressure was reduced after the first dose, with a maximal reduction by about 4 weeks. With cessation of treatment with MICARDIS tablets, blood pressure gradually returned to baseline values over a period of several days to one week. During long term studies (without placebo control) the effect of telmisartan appeared to be maintained for up to at least one year. The antihypertensive effect of telmisartan is not influenced by patient age, gender, weight, or body mass index. Blood pressure response in black patients (usually a low-renin population) is noticeably less than that in Caucasian patients. This has been true for most, but not all, angiotensin II antagonists and ACE inhibitors.

In a controlled study, the addition of telmisartan to hydrochlorothiazide produced an additional dose-related reduction in blood pressure that was similar in magnitude to the reduction achieved with telmisartan monotherapy. Hydrochlorothiazide also had an added blood pressure effect when added to telmisartan.

The onset of antihypertensive activity occurs within 3 hours after administration of a single oral dose. At doses of 20, 40, and 80 mg, the antihypertensive effect of once daily administration of telmisartan is maintained for the full 24-hour dose interval. With automated ambulatory blood pressure monitoring and conventional blood pressure measurements, the 24-hour trough-to-peak ratio for 40-80 mg doses of telmisartan was 70-100% for both systolic and diastolic blood pressure. The incidence of symptomatic orthostasis after the first dose in all controlled trials was low (0.04%).

There were no changes in the heart rate of patients treated with telmisartan in controlled trials.

#### 14.2 Cardiovascular Risk Reduction

Support for use to reduce the risk of cardiovascular events was obtained in a pair of studies. Both enrolled subjects age  $\geq 55$  years, at high cardiovascular risk as evidenced by coronary artery disease (75%), diabetes mellitus (27%) accompanied with end-organ damage (e.g., retinopathy, left ventricular hypertrophy, and, in ONTARGET only, macro- or microalbuminuria), stroke (16%), peripheral vascular disease (13%), or transient ischemic attack (4%). Patients without a history of intolerance to ACE inhibitors entered ONTARGET, and those with such a history, usually cough (90%), entered TRANSCEND, but patients with  $>1+$  proteinuria on dipstick were excluded from TRANSCEND. For both ONTARGET and TRANSCEND trials, the primary 4-component composite endpoint was death from cardiovascular causes, myocardial infarction, stroke, and hospitalization for heart failure. The secondary 3-component composite endpoint was death from cardiovascular causes, myocardial infarction, and stroke.

ONTARGET was a randomized, active-controlled, multinational, double-blind study in 25,620 patients who were randomized to telmisartan 80 mg, ramipril 10 mg, or their combination. The population studied was 73% male, 74% Caucasian, 14% Asian, and 57% were 65 years of age or older. Baseline therapy included acetylsalicylic acid (76%), lipid lowering agents (64%), beta-blockers (57%), calcium channel blockers (34%), nitrates (29%) and diuretics (28%). The mean duration of follow up was about 4 years and 6 months. During the study, 22.0% (n=1878) of telmisartan patients discontinued the active treatment, compared to 24.4% (n=2095) of ramipril patients and 25.3% (n=2152) of telmisartan/ramipril patients.

TRANSCEND randomized patients to telmisartan 80 mg (n=2954) or placebo (n=2972). The mean duration of follow up was 4 years and 8 months. The population studied was 57% male, 62% Caucasian, 21% Asian, and 60% were 65 years of age or older. Baseline therapy included acetylsalicylic acid (75%), lipid lowering agents (58%), beta-blockers (58%), calcium channel blockers (41%), nitrates (34%) and diuretics (33%). During the study, 17.7% (n=523) of telmisartan patients discontinued the active treatment, compared to 19.4% (n=576) of placebo patients.

The results for the TRANSCEND trial are summarized in Table 2, and the results for ONTARGET are summarized in Table 3, below:

**Table 2 Incidence of the Primary and Secondary Outcomes from TRANSCEND**

	Telmisartan vs. Placebo (n=2954) (n=2972)		
	No. of Events Telmisartan / Placebo	Hazard Ratio 95% CI	p-value
*Composite of CV death, myocardial infarction, stroke, or hospitalization for heart failure	465 (15.7%) / 504 (17.0%)	0.92 (0.81 – 1.05)	0.2129
*Composite of CV death, myocardial infarction, or stroke	384 (13.0%) / 440 (14.8%)	0.87 (0.76 – 1.00)	0.0483
Individual components of the primary composite endpoint	No. of Events Telmisartan / Placebo	Hazard Ratio 95% CI	p-value
**All non-fatal MI	114 (3.9%) / 145 (4.9%)	0.79 (0.62 – 1.01)	0.0574
** All non-fatal strokes	112 (3.8%) / 136 (4.6%)	0.83 (0.64 – 1.06)	0.1365

\*The primary endpoint was defined as the time to first event. In case of multiple simultaneous events, all individual events were considered; the sum of patients with individual outcomes may exceed the number of patients with composite (primary or secondary) outcomes.

\*\*For individual components of the primary composite endpoints, all events, regardless whether or not they were the first event, were considered. Therefore, they are more than the first events considered for the primary or secondary composite endpoint.

**Table 3 Incidence of the Primary and Secondary Outcomes from ONTARGET**

	Telmisartan vs. Ramipril (n=8542) (n=8576)	
	No. of Events Telmisartan / Ramipril	Hazard Ratio 97.5% CI
Composite of CV death, myocardial infarction, stroke, or hospitalization for heart failure	1423 (16.7%) / 1412 (16.5%)	1.01 (0.93 – 1.10)
Composite of CV death, myocardial infarction, or stroke	1190 (13.9%) / 1210 (14.1%)	0.99 (0.90 – 1.08)

Although the event rates in ONTARGET were similar on telmisartan and ramipril, the results did not unequivocally rule out that MICARDIS may not preserve a meaningful fraction of the effect of ramipril in reducing cardiovascular events. However, the results of both ONTARGET and TRANSCEND do adequately support MICARDIS being more effective than placebo would be in this setting, particularly for the end point of time to cardiovascular death, myocardial infarction, or stroke.

In ONTARGET, there was no evidence that combining ramipril and MICARDIS reduced the risk of death from cardiovascular causes, myocardial infarction, stroke, or hospitalization for heart failure greater than ramipril alone; instead, patients who received the combination of ramipril and telmisartan in ONTARGET experienced an increased incidence of clinically important renal dysfunction (e.g., acute renal failure) compared to patients receiving MICARDIS or ramipril alone.

Multiple sub-group analyses did not demonstrate any differences in the 4-component composite primary endpoint based on age, gender, or ethnicity for either ONTARGET or TRANSCEND trial.

**16 HOW SUPPLIED/STORAGE AND HANDLING**

MICARDIS is available as white or off-white, uncoated tablets containing telmisartan 20 mg, 40 mg or 80 mg. Tablets are marked with the BOEHRINGER INGELHEIM logo on one side, and on the other side, with either 50H, 51H or 52H for the 20 mg, 40 mg, and 80 mg strengths, respectively. Tablets are provided as follows:

MICARDIS tablets 20 mg are round and individually blister-sealed in cartons of 30 tablets as 3 x 10 cards (NDC 0597-0039-37).

MICARDIS tablets 40 mg are oblong shaped and individually blister-sealed in cartons of 30 tablets as 3 x 10 cards (NDC 0597-0040-37).

MICARDIS tablets 80 mg are oblong shaped and individually blister-sealed in cartons of 30 tablets as 3 x 10 cards (NDC 0597-0041-37).

*Storage*  
**Store at 25°C (77°F); excursions permitted to 15°-30°C (59°-86°F)** [see USP Controlled Room Temperature]. Tablets should not be removed from blisters until immediately before administration.

**17 PATIENT COUNSELING INFORMATION**

*See FDA-approved Patient Labeling (17.2).*

**17.1 Pregnancy**

Inform female patients of childbearing age about the consequences of exposure to drugs that act on the renin-angiotensin system. Advise these patients to report pregnancies to their physicians as soon as possible [see *Warnings and Precautions (5.1)*].

**17.2 FDA-Approved Patient Labeling**

Patient labeling is provided as a tear-off leaflet at the end of this prescribing information.

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## Patient Information

### MICARDIS<sup>®</sup> (my-CAR-dis) (telmisartan) Tablets

Read this Patient Information before you start taking MICARDIS tablets and each time you get a refill. There may be new information. This information does not take the place of talking to your doctor about your medical condition or your treatment.

#### **What is the most important information I should know about MICARDIS tablets?**

MICARDIS is not for pregnant women. Taking MICARDIS tablets during your pregnancy can cause injury and even death to your unborn baby. If you get pregnant, stop taking MICARDIS tablets and call your doctor right away. If you plan to become pregnant, talk to your doctor about other ways to lower your blood pressure.

#### **What is MICARDIS?**

MICARDIS is a prescription medicine used:

- to treat high blood pressure (hypertension)
- in certain high risk people aged 55 years and older to help lower their risk of having certain cardiovascular problems such as stroke, heart attack, or death

It is not known if MICARDIS is safe and effective in children.

#### **What should I tell my doctor before taking MICARDIS tablets?**

Before you take MICARDIS tablets, tell your doctor if you:

- have liver problems
- have kidney problems
- have heart problems
- have any other medical conditions
- are pregnant or are planning to become pregnant. See “**What is the most important information I should know about MICARDIS tablets?**”
- are breast-feeding or plan to breast-feed. It is not known if MICARDIS passes into your breast milk. You and your doctor should decide if you will take MICARDIS tablets or breast-feed. You should not do both. Talk with your doctor about the best way to feed your baby if you take MICARDIS tablets.

**Tell your doctor about all the medicines you take**, including prescription and non-prescription medicines, vitamins, and herbal supplements.

MICARDIS may affect the way other medicines work, and other medicines may affect how MICARDIS works. Especially tell your doctor if you take:

- digoxin (Lanoxin<sup>®</sup>, Lanoxicaps<sup>®</sup>)
- lithium (Eskalith<sup>®</sup>, Lithobid<sup>®</sup>)

- ramipril (Altace<sup>®</sup>) or other medicines used to treat your high blood pressure or heart problem
- water pills (diuretic)

Know the medicines you take. Keep a list of them and show it to your doctor or pharmacist when you get a new medicine.

### **How should I take MICARDIS tablets?**

- Take MICARDIS tablets exactly as your doctor tells you to take it.
- Your doctor will tell you how much MICARDIS to take and when to take it.
- Do not change your dose unless your doctor tells you to.
- Take MICARDIS one time each day at the same time.
- Take MICARDIS tablets with or without food.
- If you miss a dose, take it as soon as you remember. If it is close to your next dose, do not take the missed dose. Take the next dose at your regular time.
- If you take too much MICARDIS, call your doctor, or go to the nearest hospital emergency room right away.
- Read the “**How to Open the Blister**” at the end of this leaflet before you use MICARDIS. Talk with your doctor if you do not understand the instructions.

### **What are the possible side effects of MICARDIS tablets?**

#### **MICARDIS tablets may cause serious side effects, including**

- **Injury or death to your unborn baby.** See “**What is the most important information I should know about MICARDIS tablets?**”
- **Low blood pressure (hypotension)** is most likely to happen if you also:
  - take water pills (diuretics)
  - are on a low-salt diet
  - get dialysis treatments
  - have heart problems
  - get sick with vomiting or diarrhea

**If you feel faint or dizzy, lie down and call your doctor right away.**

- **Kidney problems**, which may get worse if you already have kidney disease. You may have changes in your kidney test results, and you may need a lower dose of MICARDIS tablets. Call your doctor if you get:
  - swelling in your feet, ankles, or hands
  - unexplained weight gain

**Call your doctor right away if you get any of the symptoms listed above.**

- **High potassium in the blood (hyperkalemia).** Your doctor may check your potassium levels as needed.

Rare, serious allergic reactions may happen. Tell your doctor right away if you get any of these symptoms:

- swelling of the face, tongue, throat

- difficulty breathing

**The most common side effects of MICARDIS tablets include:**

- sinus pain and congestion (sinusitis)
- back pain
- diarrhea

These are not all the possible side effects with MICARDIS tablets. Tell your doctor if you have any side effect that bothers you or that does not go away. Call your doctor for medical advice about side effects. You may report side effects to FDA at 1-800-FDA-1088.

**How should I store MICARDIS tablets?**

- Store MICARDIS tablets between 59°F to 86°F (15°C to 30°C).
- Do not remove MICARDIS tablets from blisters until right before you take them.

**Keep MICARDIS tablets and all medicines out of the reach of children.**

**General information about MICARDIS tablets**

Medicines are sometimes prescribed for purposes other than those listed in a Patient Information leaflet. Do not use MICARDIS tablets for a condition for which it was not prescribed. Do not give MICARDIS tablets to other people, even if they have the same condition you have. It may harm them.

This Patient Information leaflet summarizes the most important information about MICARDIS tablets. If you would like more information, talk with your doctor. You can ask your pharmacist or doctor for information about MICARDIS tablets that is written for health professionals.

For more information, call Boehringer Ingelheim Pharmaceuticals, Inc. at 1-800-542-6257, or (TTY) 1-800-459-9906.

**What are the ingredients in MICARDIS tablets?**

**Active Ingredient:** telmisartan

**Inactive Ingredients:** sodium hydroxide, meglumine, povidone, sorbitol, and magnesium stearate

**What is High Blood Pressure (Hypertension)?**

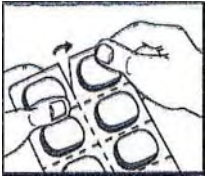
Blood pressure is the force in your blood vessels when your heart beats and when your heart rests. You have high blood pressure when the force is too much. MICARDIS tablets can help your blood vessels relax so your blood pressure is lower. High blood pressure makes the heart work harder to pump blood throughout the body and causes damage to the blood vessels. If high blood pressure is not treated, it can lead to stroke, heart attack, heart failure, kidney failure, and vision problems.

**What is Cardiovascular Risk?**

Patients older than 55 years of age who have been diagnosed with blood vessel disease in the heart, legs, or brain (coronary, peripheral, or cerebral vascular disease) or diabetes with end organ damage (for example: kidney, heart, and brain) are at higher risk of cardiovascular events (for example: death from cardiovascular causes, stroke, and/or heart attack).

**How to open the blister:**

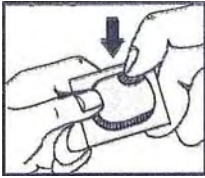
1. Tear (You may also use scissors to tear the blister apart)



2. Peel (Peel off the paper layer from the aluminum foil)



3. Push (Push the tablet through the foil)



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