SUMMARY OF PRODUCT CHARACTERISTICS

1. NAME OF THE MEDICINAL PRODUCT

Fluticasone Cipla 125 microgram per actuation pressurised inhalation, suspension

Fluticasone Cipla 250 microgram per actuation pressurised inhalation, suspension

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

One metered dose (ex-valve) contains 125 or 250 micrograms of fluticasone propionate respectively. This is equivalent to a delivered dose (ex-actuator) of 110 micrograms or 227 micrograms fluticasone propionate respectively.

For full list of excipients, see section 6.1.

3. PHARMACEUTICAL FORM

Pressurised inhalation, suspension

An inhaler comprising a fluorocarbon polymer treated aluminium alloy canister, which is sealed with a metering valve, actuator and dust cap.

4. CLINICAL PARTICULARS

4.1 Therapeutic indications

Fluticasone Cipla is indicated for the maintenance treatment of persistent asthma as prophylactic therapy. Fluticasone Cipla should not be used for rapid relief of bronchospasm

Fluticasone Cipla is indicated in adult and adolescent patients over 16 years of age.

4.2 Posology and method of administration

Fluticasone Cipla is for oral inhalation use only.

Patients should be made aware of the prophylactic nature of therapy with Fluticasone Cipla and that it should be taken regularly even when they are asymptomatic.

If patients find that relief with short-acting bronchodilator treatment becomes less effective or they need more inhalations than usual, medical attention must be sought.

The dose may be increased until control is achieved or reduced to the minimum effective dose, according to the individual response. Where the control of symptoms is maintained with the lowest strength of Fluticasone Cipla (125 microgram/actuation), the next step could include a swap to a different inhaled fluticasone product available in a lower strength (50 micrograms/actuation). The onset of therapeutic effect is within 4 to 7 days.

Prescribers should be aware that fluticasone propionate is as effective as other inhaled steroids approximately at half the microgram daily dose. For example, a 100 micrograms of fluticasone propionate is approximately equivalent to 200 micrograms dose of beclometasone dipropionate (CFC containing) or budesonide.

Adult and adolescent patients over 16 years of age:

50 to 500 micrograms twice daily.

For patients with severe asthma and during asthma exacerbations, as an alternative to oral corticosteroid therapy, a temporary increase in dose may be needed (up to 2000 micrograms daily in adult patients). The treatment effect should be monitored and for maintenance therapy the lowest effective dose should be used.

Fluticasone Cipla may be used with a Volumatic spacer device by patients who find it difficult to synchronise inspiration with aerosol actuation.

Starting doses:

For patients with mild asthma, a typical starting dose is 100 micrograms twice daily. In moderate and more severe asthma, starting doses may need to be 250 to 500 micrograms twice daily. Where additional clinical benefit is expected, doses of up to 1000 micrograms twice daily may be used.

Special patient groups:

There is no need to adjust the dose in elderly patients or in patients with renal impairment. There is no experience in patients with hepatic impairment**.**

Pediatric patients <16 years of age

Fluticasone Cipla is not recommended for use in children less than 16 years of age.

Method of Administration:

It is important to instruct the patient about correct inhalation technique (see package leaflet and instructions for use).

Testing your inhaler

1 When using your inhaler for the first time, test it to ensure that it is working. Remove the mouthpiece cover by gently squeezing the sides with your thumb and forefinger and pull apart.
2 To make sure that it works, shake the inhaler well, point the mouthpiece away from you and press the canister to release four puffs into the air. If you have not used the inhaler for a week or more, release two puffs of medicine into the air.

Using your inhaler

It is important to start to breathe as slowly as possible just before using your inhaler.

1. You should either stand up or sit upright when using your inhaler.
2. Remove the mouthpiece cover. Check inside and outside to make sure that the mouthpiece is clean and free of objects (figure A).

3. Shake the inhaler 4 or 5 times to ensure that any loose objects are removed and that the contents of the inhaler are evenly mixed (figure B).

Hold the inhaler upright with your thumb on the base, below the mouthpiece. Breathe out as far as is comfortable (figure C). Do not breathe in again yet.

4. Place the mouthpiece in your mouth between your teeth. Close your lips around it. Do not bite (figure D).

5. Breathe in through your mouth. Just after starting to breathe in, press down on the top of the canister to release a puff of medicine. Do this while still breathing in steadily and deeply (figure D).
6. Hold your breath, take the inhaler from your mouth and your finger from the top of the inhaler. Continue holding your breath for a few seconds, or as long as is comfortable (figure E).

7. If your doctor has told you to take two puffs, wait about half a minute before you take another puff by repeating steps 3 to 7.
8. Afterwards, rinse your mouth with water and spit it out.
9. After use always replace the mouthpiece cover straight away to keep out dust. Replace the cover by firmly pushing and clicking into position.
10. Practise in front of a mirror for the first few times. If you see 'mist' coming from the top of your inhaler or the sides of your mouth you should start again.
11. Older children or people with weak hands may find it easier to hold the inhaler with both hands. Put the two forefingers on top of the inhaler and both thumbs on the bottom below the mouthpiece. If this does not help, Volumatic spacer device may make it easier. Your doctor, nurse or pharmacist will be able to advise you.

Cleaning your Inhaler:
To prevent your inhaler blocking, it is important to clean it at least once a week.

To clean your inhaler:
• Remove the mouthpiece cover.
• Do not remove the metal canister from the plastic casing at any time.
• Wipe the inside and outside of the mouthpiece and the plastic casing with a **dry cloth or tissue**.
• Replace the mouthpiece cover.

Do not put the metal canister in water.

4.3 Contraindications

Hypersensitivity to the active substance or to any of the excipients listed in section 6.1.

4.4 Special warnings and precautions for use

The management of asthma should follow a stepwise programme, and patient response should be monitored clinically and by lung function tests.

Before starting treatment, any bronchoconstriction should be treated, as otherwise the efficacy could be lesser than expected**.** Patient's inhaler technique should be checked regularly to make sure that inhaler actuation is synchronised with inspiration to ensure optimum delivery to the lungs. During inhalation, the patient should preferably sit or stand. The inhaler has been designed for use in a vertical position.

Fluticasone HFA Inhaler is not designed to relieve acute symptoms for which an inhaled short-acting bronchodilator is required. Patients should be advised to have such rescue medication available.

Increasing use of short-acting inhaled β_2-agonists to relieve symptoms indicates deterioration of asthma control. Under these conditions, the patient's therapy plan should be reassessed.

Sudden and progressive deterioration in asthma control is potentially life-threatening and consideration should be given to increasing corticosteroid dosage. In patients considered at risk, daily peak flow monitoring may be instituted.

Lack of response or severe exacerbations of asthma should be treated by increasing the dose of inhaled fluticasone propionate and, if necessary, by giving a systemic steroid and/or an antibiotic if there is an infection.

Systemic effects of inhaled corticosteroids may occur, particularly at high doses prescribed for prolonged periods. These effects are much less likely to occur than with oral corticosteroids (see section 4.9). Possible systemic effects include Cushing's syndrome, Cushingoid features, adrenal suppression, growth retardation in children and adolescents, decrease in bone mineral density, cataract and glaucoma and more rarely, a range of psychological or behavioural effects including psychomotor hyperactivity, sleep disorders, anxiety, depression or aggression (particularly in children). It is important therefore that the dose of inhaled corticosteroid is reviewed regularly and reduced to the lowest dose at which effective control of asthma is maintained (see section 4.8).

Certain individuals can show greater susceptibility to the effects of inhaled corticosteroid than do most patients**.**

Prolonged treatment with high doses of inhaled corticosteroids may result in adrenal suppression and acute adrenal crisis. In very rare cases, adrenal suppression and acute adrenal crisis has occurred at doses of between 500 and 1000 micrograms of fluticasone propionate**.** Situations, which could potentially trigger acute adrenal crisis, include trauma, surgery, infection or any rapid reduction in dosage. Presenting symptoms are typically vague and may include anorexia, abdominal pain, weight loss, tiredness, headache, nausea, vomiting, decreased level of consciousness, hypoglycaemia, and seizures. The possibility of residual impaired adrenal response should always be considered in emergency (medical or surgical) and elective situations likely to produce stress, adrenocortical function should be regularly monitored, and appropriate corticosteroid treatment considered (see section 4.9).

As systemic absorption is largely through the lungs, the use of Volumatic spacer plus metered dose inhaler may increase drug delivery to the lungs. It should be noted that this could potentially lead to an increase in the risk of systemic adverse effects.

Treatment with Fluticasone HFA Inhaler should not be stopped abruptly due to the risk of exacerbations. Tapering of the dose should be done under medical supervision**.**

As with all inhaled corticosteroids, special care is necessary in patients with active or quiescent pulmonary tuberculosis.

There have been very rare reports of increases in blood glucose levels, (see section 4.8). This should be considered when prescribing to patients with a history of diabetes mellitus.

As with other inhalation therapy, paradoxical bronchospasm may occur with an immediate increase in wheezing after dosing. Fluticasone HFA Inhaler should be discontinued immediately, the patient assessed and alternative therapy instituted if necessary.

During post-marketing use, there have been reports of clinically significant drug interactions in patients receiving fluticasone propionate and ritonavir, resulting in systemic corticosteroid effects including Cushing's syndrome and adrenal suppression. Ritonavir may greatly increase plasma levels of fluticasone propionate. Therefore, concomitant use of fluticasone propionate and ritonavir should be avoided, unless the potential benefit to the patient outweighs the risk of systemic corticosteroid side-effects. There is also an increased risk of systemic side effects when combining fluticasone propionate with other potent CYP3A inhibitors (see section 4.5).

For the transfer of patients being treated with oral corticosteroids:

Adrenal function and adrenal reserve usually remain within the normal range on recommended doses of fluticasone propionate therapy. The benefits of inhaled fluticasone propionate should minimise the need for oral steroids. However, the possibility of adverse effects in patients, resulting from prior or intermittent administration of oral steroids, may persist for some time. The extent of adrenal impairment may require specialist advice before elective procedures. The possibility of residual impaired adrenal response should always be considered in emergency (medical or surgical) and elective situations likely to produce stress, and appropriate corticosteroid treatment considered (see 4.9 Overdose).

Because of the possibility of impaired adrenal response, patients transferring from oral steroid therapy to inhaled fluticasone propionate therapy should be treated with special care, and adrenocortical function regularly monitored.

Following introduction of inhaled fluticasone propionate, withdrawal of systemic therapy should be gradual and patients encouraged to carry a steroid warning card indicating the possible need for additional therapy in times of stress.

For patients dependent on oral corticosteroids, fluticasone propionate should be administered concomitantly with systemic steroid therapy for 10 days**.** Thereafter, gradual withdrawal of the systemic steroid is commenced at a rate of 2.5 mg of prednisolone (or equivalent) per month, to the lowest possible level.

Some patients feel unwell in a non-specific way during the withdrawal phase despite maintenance or even improvement of the respiratory function. They should be encouraged to persevere with inhaled fluticasone propionate and to continue withdrawal of systemic steroid, unless there are objective signs of adrenal insufficiency.

Replacement of systemic steroid treatment with inhaled therapy sometimes unmasks allergies such as allergic rhinitis or eczema previously controlled by the systemic drug. These allergies should be symptomatically treated with antihistamine and/or topical preparations, including topical steroids.

An increase in the incidence of pneumonia, including pneumonia requiring hospitalisation, has been observed in patients with COPD receiving inhaled corticosteroids. There is some evidence of an increased risk of pneumonia with increasing steroid dose but this has not been demonstrated conclusively across all studies.

There is no conclusive clinical evidence for intra-class differences in the magnitude of the pneumonia risk among inhaled corticosteroid products.

Physicians should remain vigilant for the possible development of pneumonia in patients with COPD as the clinical features of such infections overlap with the symptoms of COPD exacerbations.
Risk factors for pneumonia in patients with COPD include current smoking, older age, low body mass index (BMI) and severe COPD.

Visual disturbance

Visual disturbance may be reported with systemic and topical corticosteroid use. If a patient presents with symptoms such as blurred vision or other visual disturbances, the patient should be considered for referral to an ophthalmologist for evaluation of possible causes which may include cataract, glaucoma or rare diseases such as central serous chorioretinopathy (CSCR) which have been reported after use of systemic and topical corticosteroids.

4.5 Interaction with other medicinal products and other forms of interaction

Under normal circumstances, low plasma concentrations of fluticasone propionate are achieved after inhaled dosing, due to extensive first pass metabolism and high systemic clearance mediated by cytochrome P450 3A4 in the gut and liver. Hence, clinically significant drug interactions mediated by fluticasone propionate are unlikely.

In an interaction study in healthy subjects with intranasal fluticasone propionate, ritonavir (a highly potent cytochrome P450 3A4 inhibitor) 100 mg b.i.d. increased the fluticasone propionate plasma concentrations several hundred fold, resulting in markedly reduced serum cortisol concentrations. Information about this interaction is lacking for inhaled fluticasone propionate, but a marked increase in fluticasone propionate plasma levels is expected. Cases of Cushing's syndrome and adrenal suppression have been reported. The combination should be avoided unless the benefit outweighs the increased risk of systemic glucocorticoid side-effects.

Co-treatment with CYP3A inhibitors, including cobicistat-containing products, is expected to increase the risk of systemic side-effects. The combination should be avoided unless the benefit outweighs the increased risk of systemic corticosteroid side-effects, in which case patients should be monitored for systemic corticosteroid side-effects.

In a small study in healthy volunteers, the slightly less potent CYP3A inhibitor ketoconazole increased the exposure of fluticasone propionate after a single inhalation by 150%. This resulted in a greater reduction of plasma cortisol as compared with fluticasone propionate alone. Co-treatment with other potent CYP3A inhibitors, such as itraconazole, clarithromycin, telithromycin, atazanavir, indinavir, nelfinavir or saquinavir is also expected to increase the systemic fluticasone propionate exposure and the risk of systemic side-effects. Caution is recommended and long-term treatment with such drugs should, if possible, be avoided.

Studies have also shown that erythromycin causes a negligible increase in systemic exposure to fluticasone propionate without any significant reduction in serum cortisol concentration.

4.6 Fertility, pregnancy and lactation

Fertility:

There are no clinical data on human fertility. Animal studies indicates no effects of fluticasone propionate on male or female fertility.

Pregnancy:

There are limited data in pregnant women. Administration of fluticasone propionate during pregnancy should only be considered if the expected benefit to the mother is greater than any possible risk to the fetus. The dose of inhaled corticosteroid is titrated to the lowest dose at which effective control is maintained.
Results from a retrospective epidemiological study did not find an increased risk of major congenital malformations (MCMs) following exposure to fluticasone propionate when compared to other inhaled corticosteroids, during the first trimester of pregnancy.

Reproductive studies in animals have shown only those effects characteristic of glucocorticosteroids at systemic exposures in excess of those seen at the recommended inhaled therapeutic dose.

Breast-feeding:

The excretion of fluticasone propionate into human breast milk has not been investigated. When measurable plasma levels were obtained in lactating laboratory rats following subcutaneous administration there was evidence of fluticasone propionate in the breast milk. However, plasma levels in humans after inhalation at recommended doses are likely to be low.

The benefit of therapy with fluticasone propionate for the woman and the benefit of breastfeeding for the child must be weighed against the potential hazards to the baby.

4.7 Effects on ability to drive and use machines

Fluticasone propionate is unlikely to produce an effect.

4.8 Undesirable effects

Adverse events are listed below by system organ class and frequency. Frequencies are defined as: very common (≥ 1/10), common (≥ 1/100 and <1/10), uncommon (≥ 1/1000 and <1/100), rare (≥ 1/10,000 and <1/1000), very rare (<1/10,000) including isolated reports and not known (cannot be estimated from the available data). Very common, common and uncommon events were generally determined from clinical trial data. Rare and very rare events were generally determined from spontaneous data.

System Organ Class	Adverse Event	Frequency
Infections and infestations	Candidiasis of the mouth and throat	Very Common
	Pneumonia (in COPD patients)	Common
Immune system disorders	Hypersensitivity reactions with the following manifestations:	
	Cutaneous hypersensitivity reactions	Uncommon
	Angioedema (mainly facial and oropharyngeal oedema)	Very Rare
	Respiratory symptoms (dyspnoea and/or bronchospasm)	Very Rare
	Anaphylactic reactions	Very Rare
Endocrine disorders	Cushing's syndrome, Cushingoid features, adrenal suppression, growth retardation in children and adolescents, decreased bone mineral density, cataract, glaucoma	Very Rare
Metabolism and nutrition disorders	Hyperglycaemia (see section 4.4)	Very Rare

System Organ Class	Adverse Event	Frequency
Psychiatric disorders	Anxiety, sleep disorders, behavioural changes, including hyperactivity and irritability (predominantly in children)	Very Rare
	Depression, aggression (predominantly in children)	Not known
Eye disorders	Vision blurred (see also section 4.4)	Not known
Respiratory, thoracic and mediastinal disorders	Throat irritation Hoarseness/dysphonia Epistaxis	Common Common Unknown
Skin and subcutaneous tissue disorders	Contusions	Common

Hoarseness and candidiasis of the mouth and throat (thrush) occurs in some patients. Such patients may find it helpful to rinse out their mouth with water after using the inhaler. Symptomatic candidiasis can be treated with topical anti-fungal therapy whilst still continuing with Fluticasone HFA Inhaler.

Possible systemic effects include Cushing's syndrome, Cushingoid features, adrenal suppression, growth retardation, decreased bone mineral density, cataract, glaucoma (see section 4.4).

As with other inhalation therapy, paradoxical bronchospasm may occur (see section 4.4).

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 national reporting system listed in Appendix V.

4.9 Overdose

Acute: Inhalation of the drug in doses in excess of those approved may lead to temporary suppression of adrenal function. This does not necessitate emergency action being taken. In these patients treatment with fluticasone propionate by inhalation should be continued at a dose sufficient to control asthma adrenal function recovers in a few days and can be verified by measuring plasma cortisol. *Chronic:* If higher than approved doses are continued over prolonged periods, significant adrenocortical suppression is possible. There have been very rare reports of acute adrenal crisis occurring in children exposed to higher than approved doses (typically 1000 micrograms daily and above), over prolonged periods (several months or years); observed features included hypoglycaemia and sequelae of decreased consciousness and/or convulsions. Situations which could potentially trigger acute adrenal crisis include exposure to trauma, surgery infection or any rapid reduction in dosage**.** Monitoring of adrenal reserve may be indicated. Treatment with inhaled fluticasone propionate should be continued at a dose sufficient to control asthma.

5. PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: Other agents for obstructive airways diseases (glucocorticoids), ATC code: R03BA05

Fluticasone propionate is a glucocorticoid with anti-inflammatory effects**.** Fluticasone propionate given by inhalation at recommended doses has a potent glucocorticoid anti-inflammatory action within the lungs, resulting in a reduction of both symptoms and exacerbations of asthma, with a lower incidence and severity of adverse effects than those observed when corticosteroids are administered systemically. Treatment with fluticasone propionate is a prophylactic treatment. Full effect is achieved after 4-7 days of treatment. The majority of particles are less than 5 micrometers.

5.2 Pharmacokinetic properties

Absorption
In patients with asthma (FEV 1 < 75% predicted) the mean systemic absolute bioavailability is reduced as compared to healthy volunteers. Systemic absorption occurs mainly through the lungs and has been shown to be linearly related to dose over the dose range 500 to 2000 micrograms. Absorption is initially rapid then prolonged and the remainder of the dose may be swallowed. Absolute oral bioavailability is negligible (<1%) due to a combination of incomplete absorption from the GI tract and extensive first-pass metabolism.

Distribution

After an intravenous dose, fluticasone propionate is extensively distributed in the body. Plasma clearance is high (approximately 1150 ml/min) and volume of distribution at steady state is large (approximately 300 L). The binding of fluticasone to plasma proteins is 91%.

Biotransformation

Fluticasone is metabolized by the enzyme CYP3A4 to an inactive major carboxyacid metabolite.

Elimination

87-100% of an oral dose is excreted in the faeces, up to 75% as parent compound. Other metabolites with unknown structure have also been identified in faeces. The terminal half-life is about 8 hours**.**

5.3 Preclinical safety data

Administration of corticosteroids to pregnant animals can cause abnormalities of fetal development, including cleft palate and intra-uterine growth retardation. There may therefore be a very small risk of such effects in the human fetus. It should be noted, however, that the fetal changes in animals occur after relatively high systemic exposure.

Toxicology has shown only those class effects typical of potent corticosteroids, and these only at doses greatly in excess of that proposed for therapeutic use. No novel effects or effects on fertility were identified in repeat dose toxicity tests, reproductive studies or teratology studies. Fluticasone propionate is devoid of mutagenic activity in vitro and in vivo and showed no tumorigenic potential in rodents. It is both non-irritant and non-sensitising in animal models.

The non-CFC propellant, HFA 134a, has been shown to have no toxic effect at very high vapour concentrations, far in excess of those likely to be experienced by patients, in a wide range of animal species exposed daily for periods of two years.

The use of HFA 134a as a propellant has not altered the toxicity profile of fluticasone propionate compared to that using the conventional CFC propellant.

Environmental risk assessment studies have shown that fluticasone propionate may pose a risk for the aquatic compartment (See section 6.6).

6. PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Norflurane (HFA 134a)

6.2 Incompatibilities

Not applicable

6.3 Shelf life

2 years

6.4 Special precautions for storage

The canister contains a pressurized liquid. Do not expose to temperatures higher than 50°C. Do not pierce the canister. Do not refrigerate or freeze. Protect from frost and direct sunlight.
As with most medicines in pressurised canisters, the therapeutic effect of this medication may decrease when the canister is cold.

If the inhaler gets very cold, take the metal canister out of the plastic case and warm it in your hands for a few minutes before use. Never use anything else to warm it up.

The canister should not be punctured, broken or burnt even when apparently empty.
Replace the mouthpiece cover firmly and snap into position.

6.5 Nature and contents of container

An inhaler comprising a fluorocarbon polymer treated aluminium alloy canister, which is sealed with a metering valve, actuator and dust cap.

Each canister contains 120 metered actuations of either 125 or 250 micrograms of fluticasone propionate.

Pack sizes:
Single pack - Each single pack contain a canister with 120 actuations.
Multipack - Bundle pack of 2 or 3 single packs.
Hospital pack - Bundle pack of 10 single packs.

Not all pack sizes may be marketed.

6.6 Special precautions for disposal <and other handling>

The aerosol spray is inhaled through the mouth into the lungs. After shaking the inhaler the patient should exhale, the mouthpiece should be placed in the mouth and the lips closed around it. The actuator is depressed to release a spray, which must coincide with inspiration of breath.

This medicinal product may pose a risk to the environment. (See section 5.3). Any unused medicinal product or waste material should be disposed of in accordance with local requirements.

For detailed instructions for use refer to the package leaflet in every pack.

7. MARKETING AUTHORISATION HOLDER

<[To be completed nationally]>

8. MARKETING AUTHORISATION NUMBER(S)

<[To be completed nationally]>

9. DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUTHORISATION

<[To be completed nationally]>

10. DATE OF REVISION OF THE TEXT

2026-05-28