

## HIGHLIGHTS OF PRESCRIBING INFORMATION

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

ZETIA® (ezetimibe) tablets, for oral use  
Initial U.S. Approval: 2002

### RECENT MAJOR CHANGES

Indications and Usage (1)	7/2023
Dosage and Administration (2)	7/2023
Contraindications (4)	7/2023
Warnings and Precautions (5.1, 5.2, 5.3)	7/2023

### INDICATIONS AND USAGE

ZETIA is indicated (1):

- In combination with a statin, or alone when additional low density lipoprotein cholesterol (LDL-C) lowering therapy is not possible, as an adjunct to diet to reduce elevated LDL-C in adults with primary hyperlipidemia, including heterozygous familial hypercholesterolemia (HeFH).
- In combination with a statin as an adjunct to diet to reduce elevated LDL-C in pediatric patients 10 years of age and older with HeFH.
- In combination with fenofibrate as an adjunct to diet to reduce elevated LDL-C in adults with mixed hyperlipidemia.
- In combination with a statin, and other LDL-C lowering therapies, to reduce elevated LDL-C levels in adults and in pediatric patients 10 years of age and older with homozygous familial hypercholesterolemia (HoFH).
- As an adjunct to diet for the reduction of elevated sitosterol and campesterol levels in adults and in pediatric patients 9 years of age and older with homozygous familial sitosterolemia.

When ZETIA is used in combination with a statin, fenofibrate, or other LDL-C lowering therapies, refer to the Prescribing Information of these products for information on the safe and effective use (1).

### DOSAGE AND ADMINISTRATION

- 10-mg orally once daily, with or without food (2)
- Administer ZETIA either  $\geq 2$  hours before or  $\geq 4$  hours after administration of a bile acid sequestrant. (2)
- Assess LDL-C when clinically appropriate, as early as 4 weeks after initiating ZETIA. (2)

### DOSAGE FORMS AND STRENGTHS

- Tablets: 10 mg (3)

### CONTRAINDICATIONS

- Hypersensitivity to ezetimibe or any excipient of ZETIA. (4)
- When used in combination with a statin, fenofibrate, or other LDL-C lowering therapy, ZETIA is contraindicated in patients for whom a statin, fenofibrate, or other LDL-C lowering therapy are contraindicated. Refer to the Prescribing Information of these products for a list of their contraindications. (4)

### WARNINGS AND PRECAUTIONS

- Risks Associated with Combination Treatment with a Statin, Fenofibrate, or Other LDL-C Lowering Therapies: Refer to the Prescribing Information of these products for a description of their risks including, but not limited to, the warnings and precautions. (5.1)
- Liver Enzyme Abnormalities and Monitoring: Increases in serum transaminases have been reported with use of ZETIA. Perform liver enzyme testing as clinically indicated and consider withdrawal of ZETIA if increases in ALT or AST  $\geq 3$  X ULN persist. (5.2)
- Skeletal Muscle Effects (e.g., Myopathy and Rhabdomyolysis): ZETIA may cause myopathy and rhabdomyolysis. In post-marketing reports, most patients who developed rhabdomyolysis were taking a statin or other agents known to be associated with an increased risk of rhabdomyolysis, such as fibrates. If myopathy is suspected, discontinue ZETIA and other concomitant medications, as appropriate. (5.3)

### ADVERSE REACTIONS

- Common adverse reactions in clinical trials:
  - ZETIA administered alone (incidence  $\geq 2\%$  and greater than placebo): upper respiratory tract infection, diarrhea, arthralgia, sinusitis, pain in extremity, fatigue, and influenza. (6.1)
  - ZETIA coadministered with a statin (incidence  $\geq 2\%$  and greater than statin alone): nasopharyngitis, myalgia, upper respiratory tract infection, arthralgia, diarrhea, back pain, influenza, pain in extremity, and fatigue. (6.1)

To report SUSPECTED ADVERSE REACTIONS, contact Organon LLC, a subsidiary of Organon & Co., at 1-844-674-3200 or FDA at 1-800-FDA-1088 or [www.fda.gov/medwatch](http://www.fda.gov/medwatch).

### DRUG INTERACTIONS

- Cyclosporine: Combination increases exposure of ZETIA and cyclosporine. Cyclosporine concentrations should be monitored in patients taking ZETIA concomitantly. (7)
- Fibrates: Coadministration of ZETIA with fibrates other than fenofibrate is not recommended until use in patients is adequately studied. If cholelithiasis is suspected in a patient receiving ZETIA and fenofibrate, gallbladder studies are indicated, and alternative lipid-lowering therapy should be considered. (7)
- Bile Acid Sequestrants: Cholestyramine combination decreases exposure of ZETIA. (7)

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

Revised: 2/2024

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## FULL PRESCRIBING INFORMATION

### 1 INDICATIONS AND USAGE

ZETIA® is indicated:

- In combination with a statin, or alone when additional low-density lipoprotein cholesterol (LDL-C) lowering therapy is not possible, as an adjunct to diet to reduce elevated LDL-C in adults with primary hyperlipidemia, including heterozygous familial hypercholesterolemia (HeFH).
- In combination with a statin as an adjunct to diet to reduce elevated LDL-C in pediatric patients 10 years of age and older with HeFH.
- In combination with fenofibrate as an adjunct to diet to reduce elevated LDL-C in adults with mixed hyperlipidemia.
- In combination with a statin, and other LDL-C lowering therapies, to reduce elevated LDL-C levels in adults and in pediatric patients 10 years of age and older with homozygous familial hypercholesterolemia (HoFH).
- As an adjunct to diet for the reduction of elevated sitosterol and campesterol levels in adults and in pediatric patients 9 years of age and older with homozygous familial sitosterolemia.

When ZETIA is used in combination with a statin, fenofibrate, or other LDL-C lowering therapies, refer to the Prescribing Information of these products for information on the safe and effective use.

### 2 DOSAGE AND ADMINISTRATION

- The recommended dose of ZETIA is 10 mg orally once daily, administered with or without food.
- If a dose is missed, take the missed dose as soon as possible. Do not double the next dose.
- Assess LDL-C when clinically appropriate, as early as 4 weeks after initiating ZETIA.
- Administer ZETIA at least 2 hours before or 4 hours after administration of a bile acid sequestrant [see *Drug Interactions (7)*].

### 3 DOSAGE FORMS AND STRENGTHS

Tablets: 10-mg white to off-white, capsule-shaped, and debossed with "414" on one side.

### 4 CONTRAINDICATIONS

ZETIA is contraindicated in patients with a known hypersensitivity to ezetimibe or any of the excipients in ZETIA. Hypersensitivity reactions including anaphylaxis, angioedema, rash, and urticaria have been reported [see *Adverse Reactions (6.2)*].

When used in combination with a statin, fenofibrate, or other LDL-C lowering therapy, ZETIA is contraindicated in patients for whom a statin, fenofibrate, or other LDL-C lowering therapy are contraindicated. Refer to the Prescribing Information of these products for a list of their contraindications [see *Warnings and Precautions (5.1)*].

### 5 WARNINGS AND PRECAUTIONS

#### 5.1 Risks Associated with Combination Treatment with a Statin, Fenofibrate, or Other LDL-C Lowering Therapies

If ZETIA is administered with a statin, fenofibrate, or other LDL-C lowering therapies, refer to the Prescribing Information of these products for a description of their risks including, but not limited to, the warnings and precautions [see *Contraindications (4)*].

#### 5.2 Liver Enzymes

Increases in serum transaminases have been reported with use of ZETIA [see *Adverse Reactions (6.1)*]. In controlled clinical combination studies of ZETIA initiated concurrently with a statin, the incidence of

consecutive elevations ( $\geq 3$  X ULN) in hepatic transaminase levels was 1.3% for patients treated with ZETIA administered with statins and 0.4% for patients treated with statins alone. Perform liver enzyme testing as clinically indicated and consider withdrawal of ZETIA if increases in ALT or AST  $\geq 3$  X ULN persist.

### 5.3 Myopathy/Rhabdomyolysis

ZETIA may cause myopathy [muscle pain, tenderness, or weakness associated with elevated creatine kinase (CK)] and rhabdomyolysis [see *Adverse Reactions (6.1)*]. In post-marketing reports, most patients who developed rhabdomyolysis were taking a statin or other agents known to be associated with an increased risk of rhabdomyolysis, such as fibrates. If myopathy is suspected, discontinue ZETIA and other concomitant medications, as appropriate.

## 6 ADVERSE REACTIONS

The following serious adverse reactions are discussed in greater detail in other sections of the label:

- Liver enzyme abnormalities [see *Warnings and Precautions (5.2)*]
- Rhabdomyolysis and myopathy [see *Warnings and Precautions (5.3)*]

### 6.1 Clinical Trials Experience

Because clinical studies are conducted under widely varying conditions, adverse reaction 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 clinical practice.

#### *Monotherapy*

In 10 double-blind, placebo-controlled clinical trials, 2,396 patients with primary hyperlipidemia (age range 9 to 86 years; 50% female, 90% White, 5% Black or African American, 2% Asian, 3% other races; 3% identified as Hispanic or Latino ethnicity) and elevated LDL-C were treated with ZETIA 10 mg daily for a median treatment duration of 12 weeks (range 0 to 39 weeks).

Adverse reactions reported in  $\geq 2\%$  of patients treated with ZETIA and at an incidence greater than placebo in placebo-controlled studies of ZETIA are shown in Table 1.

**TABLE 1: Adverse Reactions Occurring  $\geq 2\%$  and Greater than Placebo in ZETIA-treated Patients**

Adverse Reaction	Placebo (%) n = 1,159	ZETIA 10 mg (%) n = 2,396
Upper respiratory tract infection	2.5	4.3
Diarrhea	3.7	4.1
Arthralgia	2.2	3.0
Sinusitis	2.2	2.8
Pain in extremity	2.5	2.7
Fatigue	1.5	2.4
Influenza	1.5	2.0

#### *Combination with a Statin*

In 28 double-blind, controlled (placebo or active-controlled) clinical trials, 11,308 patients with primary hyperlipidemia (age range 10 to 93 years, 48% female, 85% White, 7% Black or African American, 3% Asian, 5% other races; 4% identified as Hispanic or Latino ethnicity) and elevated LDL-C were treated with ZETIA 10 mg/day concurrently with or added to on-going statin therapy for a median treatment duration of 8 weeks (range 0 to 112 weeks).

The incidence of consecutive increased transaminases ( $\geq 3$  X ULN) was higher in patients receiving ZETIA administered with statins (1.3%) than in patients treated with statins alone (0.4%).

Adverse reactions reported in  $\geq 2\%$  of patients treated with ZETIA + statin and at an incidence greater than statin are shown in Table 2.

**TABLE 2: Adverse Reactions Occurring  $\geq 2\%$  in ZETIA-treated Patients Coadministered with a Statin and at an Incidence Greater than Statin**

<b>Adverse Reaction</b>	<b>All Statins* (%) n = 9,361</b>	<b>ZETIA + All Statins* (%) n = 11,308</b>
Nasopharyngitis	3.3	3.7
Myalgia	2.7	3.2
Upper respiratory tract infection	2.8	2.9
Arthralgia	2.4	2.6
Diarrhea	2.2	2.5
Back pain	2.3	2.4
Influenza	2.1	2.2
Pain in extremity	1.9	2.1
Fatigue	1.6	2.0

\* All Statins = all doses of all statins

#### *Combination with Fenofibrate*

This clinical trial involving 625 patients with mixed dyslipidemia (age range 20 to 76 years; 44% female, 79% White, 1% Black or African American, 20% other races; 11% identified as Hispanic or Latino ethnicity) treated for up to 12 weeks and 576 patients treated for up to an additional 48 weeks evaluated coadministration of ZETIA and fenofibrate. Incidence rates for clinically important elevations ( $\geq 3$  X ULN, consecutive) in hepatic transaminase levels were 4.5% and 2.7% for fenofibrate monotherapy (n=188) and ZETIA coadministered with fenofibrate (n=183), respectively, adjusted for treatment exposure. Corresponding incidence rates for cholecystectomy were 0.6% and 1.7% for fenofibrate monotherapy and ZETIA coadministered with fenofibrate, respectively [see *Drug Interactions (7)*].

## **6.2 Post-Marketing Experience**

Because the reactions below are reported voluntarily from a population of uncertain size, it is generally not possible to reliably estimate their frequency or establish a causal relationship to drug exposure.

The following additional adverse reactions have been identified during post-approval use of ZETIA:

*Blood Disorders:* thrombocytopenia

*Gastrointestinal Disorders:* abdominal pain; pancreatitis; nausea

*Hepatobiliary Disorders:* elevations in liver transaminases, including elevations more than 5 X ULN; hepatitis; cholelithiasis; cholecystitis

*Immune System Disorders:* Hypersensitivity reactions including: anaphylaxis, angioedema, rash, and urticaria

*Musculoskeletal Disorders:* elevated creatine phosphokinase; myopathy/rhabdomyolysis

*Nervous System Disorders:* dizziness; paresthesia; depression; headache

*Skin and Subcutaneous Tissue Disorders:* erythema multiforme

## 7 DRUG INTERACTIONS

Table 3 includes a list of drugs with clinically important drug interactions when administered concomitantly with ZETIA and instructions for preventing or managing them.

**Table 3: Clinically Important Drug Interactions with ZETIA**

<b>Cyclosporine</b>	
<i>Clinical Impact:</i>	Concomitant use of ZETIA and cyclosporine increases ezetimibe and cyclosporine concentrations. The degree of increase in ezetimibe exposure may be greater in patients with severe renal insufficiency [see <i>Clinical Pharmacology (12.3)</i> ].
<i>Intervention:</i>	Monitor cyclosporine concentrations in patients receiving ZETIA and cyclosporine. In patients treated with cyclosporine, weigh the potential effects of the increased exposure to ezetimibe from concomitant use against the benefits of alterations in lipid levels provided by ZETIA.
<b>Fibrates</b>	
<i>Clinical Impact:</i>	Both fenofibrate and ezetimibe may increase cholesterol excretion into the bile, leading to cholelithiasis. Co-administration of ZETIA with fibrates other than fenofibrate is not recommended [see <i>Adverse Reactions (6.1)</i> ].
<i>Intervention:</i>	If cholelithiasis is suspected in a patient receiving ZETIA and fenofibrate, gallbladder studies are indicated, and alternative lipid-lowering therapy should be considered.
<b>Bile Acid Sequestrants</b>	
<i>Clinical Impact:</i>	Concomitant cholestyramine administration decreased the mean exposure of total ezetimibe. This may result in a reduction of efficacy [see <i>Clinical Pharmacology (12.3)</i> ].
<i>Intervention:</i>	In patients taking a bile acid sequestrant, administer ZETIA at least 2 hours before or 4 hours after the bile acid sequestrant [see <i>Dosage and Administration (2)</i> ].

## 8 USE IN SPECIFIC POPULATIONS

### 8.1 Pregnancy

#### Risk Summary

There are insufficient data on ezetimibe use in pregnant women to evaluate for a drug-associated risk of major birth defects, miscarriage or adverse maternal or fetal outcomes. In animal reproduction studies, no adverse developmental effects were observed in pregnant rats and rabbits orally administered ezetimibe during the period of organogenesis at doses that resulted in up to 10 and 150 times, respectively, the human exposure at the MRHD, based on AUC (see *Data*). ZETIA should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. When ZETIA is administered with a statin, refer to the Prescribing Information for the statin.

The estimated background risk of major birth defects and miscarriage for the indicated population is unknown. In the U.S. general population, the estimated risk of major birth defects and miscarriage in clinically recognized pregnancies is 2 to 4% and 15 to 20%, respectively.

#### Data

##### *Animal Data*

In oral (gavage) embryo-fetal development studies of ezetimibe conducted in rats (gestation days 6-15) and rabbits (gestation days 7-19), there was no evidence of maternal toxicity or embryo-lethal effects at the doses tested (250, 500, 1,000 mg/kg/day). In rats, increased incidences of common fetal skeletal findings (extra pair of thoracic ribs, unossified cervical vertebral centra, shortened ribs) were observed at 1,000 mg/kg/day (~10 times the human exposure at 10 mg daily based on AUC<sub>0-24hr</sub> for total ezetimibe). In rabbits treated with ezetimibe, an increased incidence of extra thoracic ribs was observed at 1,000 mg/kg/day (150 times the human exposure at 10 mg daily based on AUC<sub>0-24hr</sub> for total ezetimibe). The animal-to-human exposure multiple for total ezetimibe at the no-observed effect level was 6 times for rat and 134 times for rabbit. Fetal exposure to ezetimibe (conjugated and unconjugated) was confirmed in subsequent placental transfer studies conducted using a maternal dose of 1,000 mg/kg/day. The fetal

maternal plasma exposure ratio (total ezetimibe) was 1.5 for rats on gestation day 20 and 0.03 for rabbits on gestation day 22.

The effect of ezetimibe on prenatal and postnatal development and maternal function was evaluated in pregnant rats at doses of 100, 300 or 1,000 mg/kg/day from gestation day 6 through lactation day 21. No maternal toxicity or adverse developmental outcomes were observed up to and including the highest dose tested (17 times the human exposure at 10 mg daily based on AUC<sub>0-24hr</sub> for total ezetimibe).

Multiple-dose studies of ezetimibe given in combination with statins in rats and rabbits during organogenesis resulted in higher ezetimibe and statin exposures. Reproductive findings occurred at lower doses in combination therapy compared to monotherapy.

## **8.2 Lactation**

### Risk Summary

There is no information about the presence of ezetimibe in human milk. Ezetimibe is present in rat milk (see *Data*). When a drug is present in animal milk, it is likely that the drug will be present in human milk. There is no information about the effects of ezetimibe on the breastfed infant or the effects of ezetimibe on milk production. ZETIA should not be used in nursing mothers unless the potential benefit justifies the potential risk to the infant.

### Data

Ezetimibe was present in the milk of lactating rats. The pup to maternal plasma ratio for total ezetimibe was 0.5 on lactation day 12.

## **8.4 Pediatric Use**

The safety and effectiveness of ZETIA in combination with a statin as an adjunct to diet to reduce LDL-C have been established in pediatric patients 10 years of age and older with HeFH. Use of ZETIA for this indication is based on a double-blind, placebo-controlled clinical trial in 248 pediatric patients (142 males and 106 postmenarchal females) 10 years of age and older with HeFH [see *Clinical Studies (14)*]. In this limited controlled trial, there was no significant effect on growth or sexual maturation in the adolescent males or females, or on menstrual cycle length in females.

The safety and effectiveness of ZETIA in combination with a statin, and other LDL-C lowering therapies, to reduce LDL-C have been established in pediatric patients 10 years of age and older with HoFH. Use of ZETIA for this indication is based on a 12-week double-blind, placebo-controlled clinical trial followed by an uncontrolled extension period in 7 pediatric patients 11 years of age and older with HoFH [see *Clinical Studies (14)*].

The safety and effectiveness of ZETIA as an adjunct to diet for the reduction of elevated sitosterol and campesterol levels have been established in adults and pediatric patients 9 years of age and older with homozygous familial sitosterolemia. Use of ZETIA for this indication is based on an 8-week double-blind, placebo-controlled clinical trial in 4 patients 9 years of age and older with homozygous sitosterolemia with elevated plasma sitosterol levels (>5 mg/dL) [see *Clinical Studies (14)*].

The safety and effectiveness of ZETIA have not been established in pediatric patients younger than 10 years of age with HeFH or HoFH, in pediatric patients younger than 9 years of age with homozygous familial sitosterolemia, or in pediatric patients with other types of hyperlipidemia.

## **8.5 Geriatric Use**

Of the 2,396 patients who received ZETIA in clinical trials, 669 (28%) were 65 years of age and older, and 111 (5%) were 75 years of age and older. Of the 11,308 patients who received ZETIA in combination with a statin in clinical trials, 3587 (32%) were 65 years of age and older, and 924 (8%) were 75 years of age and older [see *Clinical Studies (14)*]. No overall differences in safety or effectiveness of ZETIA have been observed between patients 65 years of age and older and younger patients. No clinically meaningful differences in the pharmacokinetics of ezetimibe were observed in geriatric patients compared to younger adult patients [see *Clinical Pharmacology (12.3)*].

## 8.6 Renal Impairment

No dosage adjustment of ZETIA is necessary in patients with renal impairment.

## 8.7 Hepatic Impairment

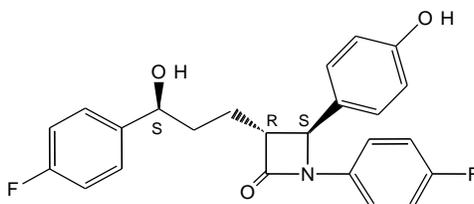
ZETIA is not recommended for use in patients with moderate to severe hepatic impairment (Child-Pugh B or C) due to the unknown effects of the increased exposure to ezetimibe [see *Clinical Pharmacology* (12.3)].

## 10 OVERDOSAGE

In the event of overdose, consider contacting the Poison Help line (1-800-222-1222) or a medical toxicologist for additional overdose management recommendations.

## 11 DESCRIPTION

ZETIA (ezetimibe) is a dietary cholesterol absorption inhibitor. The chemical name of ezetimibe is 1-(4-fluorophenyl)-3(R)-[3-(4-fluorophenyl)-3(S)-hydroxypropyl]-4(S)-(4-hydroxyphenyl)-2-azetidinone. The empirical formula is  $C_{24}H_{21}F_2NO_3$ . Its molecular weight is 409.4 and its structural formula is:



Ezetimibe is a white, crystalline powder that is freely to very soluble in ethanol, methanol, and acetone and practically insoluble in water. Ezetimibe has a melting point of about 163°C and is stable at ambient temperature. ZETIA is available as a tablet for oral use containing 10 mg of ezetimibe and the following inactive ingredients: croscarmellose sodium NF, lactose monohydrate NF, magnesium stearate NF, microcrystalline cellulose NF, povidone USP, and sodium lauryl sulfate NF.

## 12 CLINICAL PHARMACOLOGY

### 12.1 Mechanism of Action

Ezetimibe reduces blood cholesterol by inhibiting the absorption of cholesterol by the small intestine.

The molecular target of ezetimibe has been shown to be the sterol transporter, Niemann-Pick C1-Like 1 (NPC1L1), which is involved in the intestinal uptake of cholesterol and phytosterols. Ezetimibe localizes at the brush border of the small intestine and inhibits the absorption of cholesterol, leading to a decrease in the delivery of intestinal cholesterol to the liver. This causes a reduction of hepatic cholesterol stores and an increase in LDL receptors, resulting in clearance of cholesterol from the blood.

### 12.2 Pharmacodynamics

ZETIA reduces total cholesterol (total-C), LDL-C, apolipoprotein (Apo) B, and non-high-density lipoprotein cholesterol (non-HDL-C) in patients with hyperlipidemia.

In a 2-week clinical trial in 18 hypercholesterolemic patients, ZETIA inhibited intestinal cholesterol absorption by 54%, compared with placebo. ZETIA had no clinically meaningful effect on the plasma concentrations of the fat-soluble vitamins A, D, and E (in a trial of 113 patients) and did not impair adrenocortical steroid hormone production (in a trial of 118 patients).

### 12.3 Pharmacokinetics

#### Absorption

After oral administration, ezetimibe is absorbed and extensively conjugated to a pharmacologically active phenolic glucuronide (ezetimibe-glucuronide). After a single 10-mg dose of ZETIA to fasted adults, mean ezetimibe peak plasma concentrations ( $C_{max}$ ) of 3.4 to 5.5 ng/mL were attained within 4 to 12 hours ( $T_{max}$ ).

Ezetimibe-glucuronide mean  $C_{max}$  values of 45 to 71 ng/mL were achieved between 1 and 2 hours ( $T_{max}$ ). There was no substantial deviation from dose proportionality between 5 and 20 mg. The absolute bioavailability of ezetimibe cannot be determined, as the compound is virtually insoluble in aqueous media suitable for injection.

#### *Effect of Food*

Concomitant food administration (high-fat or non-fat meals) had no effect on the extent of absorption of ezetimibe when administered as ZETIA 10-mg tablets. The  $C_{max}$  value of ezetimibe was increased by 38% with consumption of high-fat meals.

#### Distribution

Ezetimibe and ezetimibe-glucuronide are highly bound (>90%) to human plasma proteins.

#### Elimination

##### *Metabolism*

Ezetimibe is primarily metabolized in the small intestine and liver via glucuronide conjugation (a phase II reaction) with subsequent biliary and renal excretion. Minimal oxidative metabolism (a phase I reaction) has been observed in all species evaluated. In humans, ezetimibe is rapidly metabolized to ezetimibe-glucuronide. Ezetimibe and ezetimibe-glucuronide are the major drug-derived compounds detected in plasma, constituting approximately 10 to 20% and 80 to 90% of the total drug in plasma, respectively.

Both ezetimibe and ezetimibe-glucuronide are eliminated from plasma with a half-life of approximately 22 hours for both ezetimibe and ezetimibe-glucuronide. Plasma concentration-time profiles exhibit multiple peaks, suggesting enterohepatic recycling.

##### *Excretion*

Following oral administration of  $^{14}C$ -ezetimibe (20 mg) to human subjects, total ezetimibe (ezetimibe + ezetimibe-glucuronide) accounted for approximately 93% of the total radioactivity in plasma. After 48 hours, there were no detectable levels of radioactivity in the plasma.

Approximately 78% and 11% of the administered radioactivity were recovered in the feces and urine, respectively, over a 10-day collection period. Ezetimibe was the major component in feces and accounted for 69% of the administered dose, while ezetimibe-glucuronide was the major component in urine and accounted for 9% of the administered dose.

#### Specific Populations

##### *Geriatric Patients*

In a multiple-dose trial with ezetimibe given 10 mg once daily for 10 days, plasma concentrations for total ezetimibe were about 2-fold higher in older ( $\geq 65$  years) healthy subjects compared to younger subjects. However, the difference in plasma concentrations is not clinically meaningful.

##### *Gender*

In a multiple-dose trial with ezetimibe given 10 mg once daily for 10 days, plasma concentrations for total ezetimibe were slightly higher (<20%) in females than in males.

##### *Race*

Based on a meta-analysis of multiple-dose pharmacokinetic studies, there were no pharmacokinetic differences between Black and White subjects. Studies in Asian subjects indicated that the pharmacokinetics of ezetimibe were similar to those seen in White subjects.

##### *Renal Impairment*

After a single 10-mg dose of ezetimibe in patients with severe renal disease ( $n=8$ ; mean  $CrCl \leq 30$  mL/min/1.73 m<sup>2</sup>), the mean AUC values for total ezetimibe, ezetimibe-glucuronide, and ezetimibe were increased approximately 1.5-fold, compared to healthy subjects ( $n=9$ ).

### Hepatic Impairment

After a single 10-mg dose of ezetimibe, the mean AUC for total ezetimibe was increased approximately 1.7-fold in patients with mild hepatic impairment (Child-Pugh score 5 to 6), compared to healthy subjects. The mean AUC values for total ezetimibe and ezetimibe were increased approximately 3- to 4-fold and 5- to 6-fold, respectively, in patients with moderate (Child-Pugh score 7 to 9) or severe hepatic impairment (Child-Pugh score 10 to 15). In a 14-day, multiple-dose trial (10 mg daily) in patients with moderate hepatic impairment, the mean AUC values for total ezetimibe and ezetimibe were increased approximately 4-fold on Day 1 and Day 14 compared to healthy subjects [see Use in Specific Populations (8.7)].

### Drug Interactions

ZETIA had no significant effect on a series of probe drugs (caffeine, dextromethorphan, tolbutamide, and IV midazolam) known to be metabolized by cytochrome P450 (1A2, 2D6, 2C8/9 and 3A4) in a “cocktail” trial of twelve healthy adult males. This indicates that ezetimibe is neither an inhibitor nor an inducer of these cytochrome P450 isozymes, and it is unlikely that ezetimibe will affect the metabolism of drugs that are metabolized by these enzymes.

**TABLE 4: Effect of Coadministered Drugs on Total Ezetimibe**

Coadministered Drug and Dosing Regimen	Total Ezetimibe*	
	Change in AUC	Change in C <sub>max</sub>
Cyclosporine-stable dose required (75-150 mg BID) <sup>†, ‡</sup>	↑240%	↑290%
Fenofibrate, 200 mg QD, 14 days <sup>†</sup>	↑48%	↑64%
Gemfibrozil, 600 mg BID, 7 days <sup>†</sup>	↑64%	↑91%
Cholestyramine, 4 g BID, 14 days <sup>†</sup>	↓55%	↓4%
Aluminum & magnesium hydroxide combination antacid, single dose <sup>§</sup>	↓4%	↓30%
Cimetidine, 400 mg BID, 7 days	↑6%	↑22%
Glipizide, 10 mg, single dose	↑4%	↓8%
<b>Statins</b>		
Lovastatin 20 mg QD, 7 days	↑9%	↑3%
Pravastatin 20 mg QD, 14 days	↑7%	↑23%
Atorvastatin 10 mg QD, 14 days	↓2%	↑12%
Rosuvastatin 10 mg QD, 14 days	↑13%	↑18%
Fluvastatin 20 mg QD, 14 days	↓19%	↑7%

\* Based on 10-mg dose of ezetimibe.

<sup>†</sup> Post-renal transplant patients with mild impaired or normal renal function. In a different trial, a renal transplant patient with severe renal insufficiency (creatinine clearance of 13.2 mL/min/1.73 m<sup>2</sup>) who was receiving multiple medications, including cyclosporine, demonstrated a 12-fold greater exposure to total ezetimibe compared to healthy subjects.

<sup>‡</sup> See Drug Interactions (7).

<sup>§</sup> Supralox, 20 mL.

**TABLE 5: Effect of Ezetimibe Coadministration on Systemic Exposure to Other Drugs**

Coadministered Drug and its Dosage Regimen	Ezetimibe Dosage Regimen	Change in AUC of Coadministered Drug	Change in C <sub>max</sub> of Coadministered Drug
Warfarin, 25-mg single dose on Day 7	10 mg QD, 11 days	↓2% (R-warfarin)	↑3% (R-warfarin)
		↓4% (S-warfarin)	↑1% (S-warfarin)
Digoxin, 0.5-mg single dose	10 mg QD, 8 days	↑2%	↓7%
Gemfibrozil, 600 mg BID, 7 days*	10 mg QD, 7 days	↓1%	↓11%
Ethinyl estradiol & Levonorgestrel, QD, 21 days	10 mg QD, days 8-14 of 21d oral contraceptive cycle	Ethinyl estradiol	Ethinyl estradiol
		0%	↓9%
Glipizide, 10 mg on Days 1 and 9	10 mg QD, days 2-9	Levonorgestrel	Levonorgestrel
		0%	↓5%
Glipizide, 10 mg on Days 1 and 9	10 mg QD, days 2-9	↓3%	↓5%
Fenofibrate, 200 mg QD, 14 days*	10 mg QD, 14 days	↑11%	↑7%
Cyclosporine, 100-mg single dose Day 7*	20 mg QD, 8 days	↑15%	↑10%

<b>Statins</b>				
Lovastatin 20 mg QD, 7 days	10 mg QD, 7 days		↑19%	↑3%
Pravastatin 20 mg QD, 14 days	10 mg QD, 14 days		↓20%	↓24%
Atorvastatin 10 mg QD, 14 days	10 mg QD, 14 days		↓4%	↑7%
Rosuvastatin 10 mg QD, 14 days	10 mg QD, 14 days		↑19%	↑17%
Fluvastatin 20 mg QD, 14 days	10 mg QD, 14 days		↓39%	↓27%

\* See Drug Interactions (7).

### 13 NONCLINICAL TOXICOLOGY

#### 13.1 Carcinogenesis, Mutagenesis, Impairment of Fertility

A 104-week dietary carcinogenicity study with ezetimibe was conducted in rats at doses up to 1,500 mg/kg/day (males) and 500 mg/kg/day (females) (~20 X the human exposure at 10 mg daily based on AUC<sub>0-24hr</sub> for total ezetimibe). A 104-week dietary carcinogenicity study with ezetimibe was also conducted in mice at doses up to 500 mg/kg/day (>150 X the human exposure at 10 mg daily based on AUC<sub>0-24hr</sub> for total ezetimibe). There were no statistically significant increases in tumor incidences in drug-treated rats or mice.

No evidence of mutagenicity was observed *in vitro* in a microbial mutagenicity (Ames) test with *Salmonella typhimurium* and *Escherichia coli* with or without metabolic activation. No evidence of clastogenicity was observed *in vitro* in a chromosomal aberration assay in human peripheral blood lymphocytes with or without metabolic activation. In addition, there was no evidence of genotoxicity in the *in vivo* mouse micronucleus test.

In oral (gavage) fertility studies of ezetimibe conducted in rats, there was no evidence of reproductive toxicity at doses up to 1,000 mg/kg/day in male or female rats (~7 X the human exposure at 10 mg daily based on AUC<sub>0-24hr</sub> for total ezetimibe).

### 14 CLINICAL STUDIES

#### Primary Hyperlipidemia in Adults

ZETIA reduces total-C, LDL-C, Apo B, and non-HDL-C in patients with hyperlipidemia. Maximal to near maximal response is generally achieved within 2 weeks and maintained during chronic therapy.

#### Monotherapy

In two multicenter, double-blind, placebo-controlled, 12-week trials in 1719 patients (age range 18 to 86 years, 52% females; 91% White, 5% Black or African American, 1% Asian, 3% other races mostly identified as Hispanic or Latino ethnicity) with primary hyperlipidemia, ZETIA significantly lowered total-C, LDL-C, Apo B, and non-HDL-C compared to placebo (see **Table 6**). Reduction in LDL-C was consistent across age, sex, and baseline LDL-C.

**TABLE 6: Response to ZETIA in Patients with Primary Hyperlipidemia (Mean % Change from Untreated Baseline\*)**

	Treatment Group	N	Total-C	LDL-C	Apo B	Non-HDL-C
<b>Trial 1<sup>†</sup></b>	Placebo	205	+1	+1	-1	+1
	Ezetimibe	622	-12	-18	-15	-16
<b>Trial 2<sup>†</sup></b>	Placebo	226	+1	+1	-1	+2
	Ezetimibe	666	-12	-18	-16	-16
	Placebo	431	0	+1	-2	+1

<b>Pooled Data<sup>†</sup> (Trials 1 &amp; 2)</b>	Ezetimibe	1288	-13	-18	-16	-16
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\* Baseline - on no lipid-lowering drug.

† ZETIA significantly reduced total-C, LDL-C, Apo B, and non-HDL-C compared to placebo.

*Combination with Statins: ZETIA Added to On-going Statin Therapy*

In a multicenter, double-blind, placebo-controlled, 8-week trial, 769 patients (age range 22 to 85 years, 42% females; 90% White, 6% Black or African American, 1% Asian, 3% other races; and 2% identified as Hispanic or Latino ethnicity) with primary hyperlipidemia, known coronary heart disease or multiple cardiovascular risk factors who were already receiving statin monotherapy but who had not met their NCEP ATP II target LDL-C goal, were randomized to receive either ZETIA or placebo in addition to their on-going statin.

ZETIA, added to on-going statin therapy, significantly lowered total-C, LDL-C, Apo B, and non-HDL-C compared with a statin administered alone (see **Table 7**). LDL-C reductions induced by ZETIA were generally consistent across all statins.

**TABLE 7: Response to Addition of ZETIA to On-Going Statin Therapy\* in Patients with Hyperlipidemia (Mean % Change from Treated Baseline<sup>†</sup>)**

<b>Treatment (Daily Dose)</b>	<b>N</b>	<b>Total-C</b>	<b>LDL-C</b>	<b>Apo B</b>	<b>Non-HDL-C</b>
On-going Statin + Placebo <sup>‡</sup>	390	-2	-4	-3	-3
On-going Statin + ZETIA <sup>‡</sup>	379	-17	-25	-19	-23

\* Patients receiving each statin: 40% atorvastatin, 31% simvastatin, 29% others (pravastatin, fluvastatin, cerivastatin, lovastatin).

† Baseline - on a statin alone.

‡ ZETIA + statin significantly reduced total-C, LDL-C, Apo B, and non-HDL-C compared to statin alone.

*Combination with Statins: ZETIA Initiated Concurrently with a Statin*

In four multicenter, double-blind, placebo-controlled, 12-week trials, in 2,382 patients (age range 18 to 87 years, 57% female; 88% White, 5% Black or African American, 2% Asian, 5% other races mostly identified as Hispanic or Latino) with hyperlipidemia, ZETIA or placebo was administered alone or with various doses of atorvastatin, simvastatin, pravastatin, or lovastatin.

When all patients receiving ZETIA with a statin were compared to all those receiving the corresponding statin alone, ZETIA significantly lowered total-C, LDL-C, Apo B, and non-HDL-C compared to the statin administered alone. LDL-C reductions induced by ZETIA were generally consistent across all statins. (See footnote †, **Tables 8 to 11**.)

**TABLE 8: Response to ZETIA and Atorvastatin Initiated Concurrently in Patients with Primary Hyperlipidemia (Mean % Change from Untreated Baseline\*)**

<b>Treatment (Daily Dose)</b>	<b>N</b>	<b>Total-C</b>	<b>LDL-C</b>	<b>Apo B</b>	<b>Non-HDL-C</b>
Placebo	60	+4	+4	+3	+4
ZETIA	65	-14	-20	-15	-18
Atorvastatin 10 mg	60	-26	-37	-28	-34
ZETIA + Atorvastatin 10 mg	65	-38	-53	-43	-49
Atorvastatin 20 mg	60	-30	-42	-34	-39
ZETIA + Atorvastatin 20 mg	62	-39	-54	-44	-50
Atorvastatin 40 mg	66	-32	-45	-37	-41
ZETIA + Atorvastatin 40 mg	65	-42	-56	-45	-52
Atorvastatin 80 mg	62	-40	-54	-46	-51
ZETIA + Atorvastatin 80 mg	63	-46	-61	-50	-58
Pooled data (All Atorvastatin Doses) <sup>†</sup>	248	-32	-44	-36	-41
Pooled data (All ZETIA + Atorvastatin Doses) <sup>†</sup>	255	-41	-56	-45	-52

\* Baseline - on no lipid-lowering drug.

<sup>†</sup> ZETIA + all doses of atorvastatin pooled (10-80 mg) significantly reduced total-C, LDL-C, Apo B, and non-HDL-C compared to all doses of atorvastatin pooled (10-80 mg).

**TABLE 9: Response to ZETIA and Simvastatin Initiated Concurrently  
in Patients with Primary Hyperlipidemia  
(Mean % Change from Untreated Baseline\*)**

<b>Treatment (Daily Dose)</b>	<b>N</b>	<b>Total-C</b>	<b>LDL-C</b>	<b>Apo B</b>	<b>Non-HDL-C</b>
Placebo	70	-1	-1	0	-1
ZETIA	61	-13	-19	-14	-17
Simvastatin 10 mg	70	-18	-27	-21	-25
ZETIA + Simvastatin 10 mg	67	-32	-46	-35	-42
Simvastatin 20 mg	61	-26	-36	-29	-33
ZETIA + Simvastatin 20 mg	69	-33	-46	-36	-42
Simvastatin 40 mg	65	-27	-38	-32	-35
ZETIA + Simvastatin 40 mg	73	-40	-56	-45	-51
Simvastatin 80 mg	67	-32	-45	-37	-41
ZETIA + Simvastatin 80 mg	65	-41	-58	-47	-53
Pooled data (All Simvastatin Doses) <sup>†</sup>	263	-26	-36	-30	-34
Pooled data (All ZETIA + Simvastatin Doses) <sup>†</sup>	274	-37	-51	-41	-47

\* Baseline - on no lipid-lowering drug.

<sup>†</sup> ZETIA + all doses of simvastatin pooled (10-80 mg) significantly reduced lipid total-C, LDL-C, Apo B, and non-HDL-C compared to all doses of simvastatin pooled (10-80 mg).

**TABLE 10: Response to ZETIA and Pravastatin Initiated Concurrently  
in Patients with Primary Hyperlipidemia  
(Mean % Change from Untreated Baseline\*)**

Treatment (Daily Dose)	N	Total-C	LDL-C	Apo B	Non-HDL-C
Placebo	65	0	-1	-2	0
ZETIA	64	-13	-20	-15	-17
Pravastatin 10 mg	66	-15	-21	-16	-20
ZETIA + Pravastatin 10 mg	71	-24	-34	-27	-32
Pravastatin 20 mg	69	-15	-23	-18	-20
ZETIA + Pravastatin 20 mg	66	-27	-40	-31	-36
Pravastatin 40 mg	70	-22	-31	-26	-28
ZETIA + Pravastatin 40 mg	67	-30	-42	-32	-39
Pooled data (All Pravastatin Doses) <sup>†</sup>	205	-17	-25	-20	-23
Pooled data (All ZETIA + Pravastatin Doses) <sup>†</sup>	204	-27	-39	-30	-36

\* Baseline - on no lipid-lowering drug.

<sup>†</sup> ZETIA + all doses of pravastatin pooled (10-40 mg) significantly reduced total-C, LDL-C, Apo B, and non-HDL-C compared to all doses of pravastatin pooled (10-40 mg).

**TABLE 11: Response to ZETIA and Lovastatin Initiated Concurrently in Patients with Primary Hyperlipidemia (Mean % Change from Untreated Baseline\*)**

Treatment (Daily Dose)	N	Total-C	LDL-C	Apo B	Non-HDL-C
Placebo	64	+1	0	+1	+1
ZETIA	72	-13	-19	-14	-16
Lovastatin 10 mg	73	-15	-20	-17	-19
ZETIA + Lovastatin 10 mg	65	-24	-34	-27	-31
Lovastatin 20 mg	74	-19	-26	-21	-24
ZETIA + Lovastatin 20 mg	62	-29	-41	-34	-39
Lovastatin 40 mg	73	-21	-30	-25	-27
ZETIA + Lovastatin 40 mg	65	-33	-46	-38	-43
Pooled data (All Lovastatin Doses) <sup>†</sup>	220	-18	-25	-21	-23
Pooled data (All ZETIA + Lovastatin Doses) <sup>†</sup>	192	-29	-40	-33	-38

\* Baseline - on no lipid-lowering drug.

<sup>†</sup> ZETIA + all doses of lovastatin pooled (10-40 mg) significantly reduced total-C, LDL-C, Apo B, and non-HDL-C compared to all doses of lovastatin pooled (10-40 mg).

#### *Combination with Fenofibrate*

In a multicenter, double-blind, placebo-controlled, clinical trial in patients with mixed hyperlipidemia, 625 patients (age range 20 to 76 years, 44% female; 79% White, 1% Black or African American, 20% other races; and 11% identified as Hispanic or Latino ethnicity) were treated for up to 12 weeks and 576 for up to an additional 48 weeks. Patients were randomized to receive placebo, ZETIA alone, 160 mg fenofibrate alone, or ZETIA and 160 mg fenofibrate in the 12-week trial. After completing the 12-week trial, eligible patients were assigned to ZETIA coadministered with fenofibrate or fenofibrate monotherapy for an additional 48 weeks.

ZETIA coadministered with fenofibrate significantly lowered total-C, LDL-C, Apo B, and non-HDL-C compared to fenofibrate administered alone (see **Table 12**).

**TABLE 12: Response to ZETIA and Fenofibrate Initiated Concurrently in Patients with Mixed Hyperlipidemia (Mean % Change from Untreated Baseline\* at 12 weeks)**

Treatment (Daily Dose)	N	Total-C	LDL-C	Apo B	Non-HDL-C
Placebo	63	0	0	-1	0
ZETIA	185	-12	-13	-11	-15
Fenofibrate 160 mg	188	-11	-6	-15	-16
ZETIA + Fenofibrate 160 mg	183	-22	-20	-26	-30

\* Baseline - on no lipid-lowering drug.

The changes in lipid endpoints after an additional 48 weeks of treatment with ZETIA coadministered with fenofibrate or with fenofibrate alone were consistent with the 12-week data displayed above.

#### HeFH in Pediatric Patients

The effects of ZETIA coadministered with simvastatin (n=126) compared to simvastatin monotherapy (n=122) have been evaluated in males and females with HeFH. In a multicenter, double-blind, controlled trial followed by an open-label phase, 142 males and 106 postmenarchal females, 10 to 17 years of age (mean age 14.2 years, 43% females, 82% White, 4% Asian, 2% Black or African American, 13% multi-racial; 14% identified as Hispanic or Latino ethnicity) with HeFH were randomized to receive either ZETIA coadministered with simvastatin or simvastatin monotherapy. Inclusion in the trial required 1) a baseline LDL-C level between 160 and 400 mg/dL and 2) a medical history and clinical presentation consistent with HeFH. The mean baseline LDL-C value was 225 mg/dL (range: 161 to 351 mg/dL) in the ZETIA coadministered with simvastatin group compared to 219 mg/dL (range: 149 to 336 mg/dL) in the simvastatin monotherapy group. The patients received coadministered ZETIA and simvastatin (10 mg, 20 mg, or 40 mg) or simvastatin monotherapy (10 mg, 20 mg, or 40 mg) for 6 weeks, coadministered ZETIA and 40-mg simvastatin or 40-mg simvastatin monotherapy for the next 27 weeks, and open-label coadministered ZETIA and simvastatin (10 mg, 20 mg, or 40 mg) for 20 weeks thereafter.

The results of the trial at Week 6 are summarized in **Table 13**. Results at Week 33 were consistent with those at Week 6.

**TABLE 13: Mean Percent Difference at Week 6 Between the Pooled ZETIA Coadministered with Simvastatin Group and the Pooled Simvastatin Monotherapy Group in Adolescent Patients with HeFH**

	Total-C	LDL-C	Apo B	Non-HDL-C
Mean percent difference between treatment groups	-12%	-15%	-12%	-14%
95% Confidence Interval	(-15%, -9%)	(-18%, -12%)	(-15%, -9%)	(-17%, -11%)

#### HoFH in Adults and Pediatric Patients

A trial was conducted to assess the efficacy of ZETIA in the treatment of HoFH. This double-blind, randomized, 12-week trial enrolled 50 patients (age range 11 to 74 years, 58% female; 90% White, 2% Black or African American, 8% other races identified as Hispanic or Latino) with a clinical and/or genotypic diagnosis of HoFH, with or without concomitant LDL apheresis, already receiving atorvastatin or simvastatin (40 mg). Patients were randomized to one of three treatment groups, atorvastatin or simvastatin (80 mg), ZETIA administered with atorvastatin or simvastatin (40 mg), or ZETIA administered with atorvastatin or simvastatin (80 mg). Due to decreased bioavailability of ezetimibe in patients concomitantly receiving cholestyramine [see *Drug Interactions (7)*], ezetimibe was dosed at least 4 hours before or after administration of resins. Mean baseline LDL-C was 341 mg/dL in those patients randomized to atorvastatin 80 mg or simvastatin 80 mg alone and 316 mg/dL in the group randomized to ZETIA plus atorvastatin 40 or 80 mg or simvastatin 40 or 80 mg. ZETIA, administered with atorvastatin or simvastatin (40- and 80-mg statin groups, pooled), significantly reduced LDL-C (21%) compared with increasing the dose of simvastatin or atorvastatin monotherapy from 40 to 80 mg (7%). In those treated with ZETIA plus 80-mg atorvastatin or with ZETIA plus 80-mg simvastatin, LDL-C was reduced by 27%.

### Homozygous Sitosterolemia (Phytosterolemia) in Adults and Pediatric Patients

A trial was conducted to assess the efficacy of ZETIA in the treatment of homozygous sitosterolemia. In this multicenter, double-blind, placebo-controlled, 8-week trial, 37 patients (age range 9 to 72 years, 65% females; 89% White, 3% Asian, 8% other races identified as Hispanic or Latino) with homozygous sitosterolemia with elevated plasma sitosterol levels (>5 mg/dL) on their current therapeutic regimen (diet, bile-acid-binding resins, statins, ileal bypass surgery and/or LDL apheresis), were randomized to receive ZETIA (n=30) or placebo (n=7). Due to decreased bioavailability of ezetimibe in patients concomitantly receiving cholestyramine [see *Drug Interactions (7)*], ZETIA was dosed at least 2 hours before or 4 hours after resins were administered. Excluding the one subject receiving LDL apheresis, ZETIA significantly lowered plasma sitosterol and campesterol, by 21% and 24% from baseline, respectively. In contrast, patients who received placebo had increases in sitosterol and campesterol of 4% and 3% from baseline, respectively. For patients treated with ZETIA, mean plasma levels of plant sterols were reduced progressively over the course of the trial. Reductions in sitosterol and campesterol were consistent between patients taking ZETIA concomitantly with bile acid sequestrants (n=8) and patients not on concomitant bile acid sequestrant therapy (n=21).

## **16 HOW SUPPLIED/STORAGE AND HANDLING**

ZETIA 10 mg tablets are white to off-white, capsule-shaped, and debossed with “414” on one side and are supplied as follows:

<b>Package Size</b>	<b>NDC</b>
Bottle of 30 tablets	78206-178-01

Store ZETIA at room temperature between 68°F to 77°F (20°C to 25°C). Protect from moisture.

## **17 PATIENT COUNSELING INFORMATION**

Advise the patient to read the FDA-Approved Patient Labeling (Patient Information).

Inform patients that ZETIA may cause liver enzyme elevations [see *Warnings and Precautions (5.2)*].

### **Muscle Pain**

Advise patients that ZETIA may cause myopathy and rhabdomyolysis. Inform patients that the risk is also increased when taking certain types of medication and they should discuss all medication, both prescription and over the counter, with their healthcare provider. Instruct patients to promptly report any unexplained muscle pain, tenderness or weakness particularly if accompanied by malaise or fever [see *Warnings and Precautions (5.3)*, and *Drug Interactions (7)*].

### **Pregnancy**

Advise patients to inform their healthcare provider of a known or suspected pregnancy to discuss if ZETIA should be discontinued [see *Use in Specific Populations (8.1)*].

### **Breastfeeding**

Advise patients who have a lipid disorder and are breastfeeding to discuss the options with their healthcare provider [see *Use in Specific Populations (8.2)*].

### **Missed Dose**

Instruct patients to take ZETIA only as prescribed. If a dose is missed, it should be taken as soon as possible. Advise patients not to double their next dose.

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