APO-PRAVASTATIN
Pravastatin Sodium Tablets 20mg and 40mg
Lipid Metabolism Regulator

Clinical Pharmacology: Pravastatin sodium is one of a new class of lipid-lowering compounds known as HMG-CoA reductase inhibitors (statins) that reduce cholesterol biosynthesis. These agents are competitive inhibitors of 3-hydroxy-3-methylglutaryl-coenzyme A (HMG- CoA) reductase, the enzyme catalyzing the early rate-limiting step in cholesterol biosynthesis, conversion of HMG-CoA to mevalonate. Pravastatin is isolated from a strain of *Penicillium solitium.* The active drug substance is the hydroxyacid form.

Pravastatin produces its lipid-lowering effect in two ways. First, as a consequence of its reversible inhibition of HMG-CoA reductase activity, it effects modest reductions in intracellular pools of cholesterol. This results in an increase in the number of Low Density Lipoproteins (LDL) - receptors on cell surfaces and enhanced receptor-mediated catabolism and clearance of circulating LDL. Second, pravastatin inhibits LDL production by inhibiting hepatic synthesis of Very Low Density Lipoproteins (VLDL), the LDL precursor. Treatment with pravastatin has been shown to reduce circulating Total–C, LDL–C, and apolipoprotein B, modestly reduce VLDL–C and triglycerides (TG) while producing increases of variable magnitude in HDL–C and apolipoprotein A. Clinical trials suggest that pravastatin's effect on reducing clinical events appears to incorporate both cholesterol modification and some ancillary mechanism.

Human Pharmacology: In both normal volunteers and patients with hypercholesterolemia, treatment with pravastatin reduced total-C, LDL-C, apolipoprotein B, VLDL-C and TG while increasing HDL-C and apolipoprotein A. The mechanism of action of pravastatin is complex. Inhibition of hepatic VLDL synthesis and/or secretion occurs, leading to a decrease in LDL precursor formation. The reduction in hepatic cellular pools of cholesterol, resulting from the specific and reversible inhibition of HMG-CoA reductase activity, leads to an increase in the fractional catabolic rate of IDL and LDL via increased expression of LDL receptors on the surface of hepatic cells. Through a combination of these and possibly other unknown metabolic effects, a decline in the serum level of cholesterol results.

Pharmacokinetics: Pravastatin sodium is administered orally in the active form. Following oral ingestion, pravastatin is rapidly absorbed with peak plasma levels attained at about 1 to 1.5 hours. Average oral absorption of pravastatin, based on urinary recovery of radiolabelled drug after oral and intravenous dosing, is 34%; average absolute bioavailability of the parent drug is 17%. The therapeutic response to pravastatin is similar, whether taken with meals or one hour prior to meals, even though the presence of food in the gastrointestinal tract causes a reduction in systemic bioavailability.

	% Decrease in LDL-C	
Pravastatin	10 mg bid	20 mg bid
With meals	- 25%	- 37%
Before meals*	- 26%	- 36%

* administered one hour or more prior to eating.

Pravastatin undergoes extensive first pass extraction in the liver (estimated hepatic extraction ratio, 66%), its primary site of action, and is excreted in the bile. Therefore, plasma levels of the drug are probably of limited value in predicting therapeutic effectiveness. Nevertheless, measurement of plasma pravastatin concentrations by gas chromatography and mass spectrometry showed dose proportionality for area under the concentration-time curve (AUC) and maximum and steady-state plasma levels. Steady-state areas under the plasma concentration-time curves and maximum (Cmax) or minimum (Cmin) plasma concentrations showed no accumulation following once or twice daily administration of pravastatin tablets.

Protein binding of pravastatin is approximately 50%. The plasma elimination half-life of pravasatatin is between 1.5 and 2 hours (2.5 – 3 hours in hypercholesterolemic subjects). Approximately 20% of a radiolabelled oral dose is excreted in the urine and 70% in the feces. Pravastatin is extensively metabolized. The major metabolite is the 3-alpha hydroxy isomer, which has one-tenth to one-fortieth of the inhibitory activity of the parent compound on HMG-CoA reductase. After intravenous administration to healthy subjects, approximately 47% of the total drug clearance occurs via renal excretion of intact pravastatin, and about 53% is cleared by non-renal routes, i.e. biliary excretion and biotransformation. Studies of pravastatin administered as a single dose to healthy elderly male and female subjects (age 65 to 78 years) indicated a 30-50% increase in plasma levels. No studies have been carried out in patients with renal insufficiency.

Indications: Therapy with lipid-altering agents should be considered a component of multiple risk factor intervention in those individuals at increased risk for atherosclerotic vascular disease due to hypercholesterolemia. APO-PRAVASTATIN (pravastatin sodium) should be used in addition to a diet restricted in saturated fat and cholesterol when the response to diet and other non-pharmacological measures alone has been inadequate.

Hypercholesterolemia: Apo-Pravastatin is indicated as an adjunct to diet for the reduction of elevated Total and Low Density Lipoprotein Cholesterol (LDL–C) levels in patients with primary hypercholesterolemia (Types IIa and IIb), when the response to diet and other non- pharmacologic measures alone has been inadequate. Prior to initiating therapy with Apo-Pravastatin, secondary causes for hypercholesterolemia, such as obesity, poorly controlled diabetes mellitus, hypothyroidism, nephrotic syndrome, dysproteinemias, obstructive liver disease, other drug therapy or alcoholism, should be excluded and it should be determined that patients for whom treatment with APO-PRAVASTATIN is being considered have an elevated LDL–C level as the cause for an elevated total serum cholesterol. A lipid profile should be performed to measure Total Cholesterol, High Density Lipoprotein Cholesterol (HDL-C) and Triglycerides (TG).

For patients with total triglycerides less than 4.52 mmol/L (400mg/dl), LDL-C can be estimated using the following equation: LDL-C (mmol/L)
= Total Cholesterol – [(0.37 x triglycerides) + HDL-C]
LDL-C (mg/dL) = Total Cholesterol – [(0.16 x triglycerides) + HDL-C]
When total triglyceride levels exceed 4.5 mmol/L (400mg/dL), this equation is less accurate and LDL-C concentrations should be determined by ultracentrifugation.

As with other lipid-lowering therapy, Apo-Pravastatin is not indicated when hypercholesterolemia is due to hyperalphalipoproteinemia (elevated HDL-C). The efficacy of pravastatin has not been evaluated in conditions where the major abnormality is elevation of chylomicrons, VLDL or IDL (i.e. hyperlipoproteinemia or dyslipoproteinemia types I, III, IV or V).

Primary Prevention of Coronary Events: In hypercholesterolemic patients without clinically evident coronary heart disease, Apo- Pravastatin is indicated to:

- Reduce the risk of myocardial infarction;
- Reduce the risk for undergoing myocardial revascularization procedures;
- Reduce the risk of cardiovascular mortality with no increase in death from non-cardiovascular causes.

Secondary Prevention of Cardiovascular Events : In patients with total cholesterol in the normal to moderately elevated range who have clinically evident coronary heart disease, Apo-Pravastatin is indicated to:

- Reduce the risk of myocardial infarction;
- Reduce the risk of undergoing myocardial revascularization procedures;
- Reduce the risk of stroke and transient ischemic attack (TIA).

Pravastatin was also found to reduce the rate of progression of atherosclerosis in patients with coronary heart disease as part of a treatment strategy to lower Total and LDL–cholesterol to target levels. In two trials including this type of patient (i.e. in a secondary prevention intervention), pravastatin monotherapy was shown to reduce the rate of progression of atherosclerosis as evaluated by quantitative angiography and B-mode ultrasound. This effect may be associated with an improvement in the coronary endpoints (fatal or nonfatal myocardial infarction). In these trials, however, no effect was observed in all cause mortality.

Adverse Reactions: In seven randomized, double-blind, placebo-controlled trials involving over 21,500 patients treated with pravastatin (N=10,784) or placebo (N=10,719), the safety and tolerability in the pravastatin group was comparable to that of the placebo group. Over 19,000 patients were followed for a median of 4.8-5.9 years, while the remaining patients were followed two years or more.

Clinical adverse events probably or possibly related, or of uncertain relationship to therapy, occurring in at least 0.5% of patients treated with pravastatin or placebo in these long-term morbidity/mortality trials are shown in the table below:

	Pravastatin (N=10,784)%	Placebo (N=10,719)%
Cardiovascular		
Angina Pectoris	3.1	3.4
Disturb rhythm subj.	0.8	0.7
Hypertension	0.7	0.9
Edema	0.6	0.6
Myocardial Infarction	0.5	0.7
Distension abdomen	0.5	0.5
Gastrointestinal		
Dyspepsia/heartburn	3.5	3.7
Nausea/vomiting	1.4	1.6
Flatulence	1.2	1.1
Constipation	1.2	1.3
Diarrhea	0.9	1.1
Abdominal pain	0.9	1.0
Distension abdomen	0.5	0.5
Musculoskeletal		
Musculoskeletal pain	5.9	5.7
Muscle cramp	2.0	1.8
Myalgia	1.4	1.4
Musculoskeletal trauma	0.5	0.3
Nervous System		
Dizziness	2.2	2.1
Headache	1.9	1.8
Sleep disturbance	1.0	0.9
Depression	1.0	1.0
Anxiety/nervousness	1.0	1.2
Paresthesia	0.9	0.9
Numbness	0.5	0.4
General		
Fatigue	3.4	3.3
Chest pain	2.6	2.6
Weight gain	0.6	0.7
Influenza	0.6	0.5
Special Senses		
Vision disturbance	1.5	1.3
Disturbance eye	0.8	0.9
Hearing abnormality	0.6	0.5
Lens opacity	0.5	0.4
Dermatologic		
Rash	2.1	2.2
Pruritus	0.9	1.0
Renal/Genitourinary		
Urinary abnormality	1.0	0.8
Respiratory		
Dyspnea	1.6	1.6

Upper respiratory infection	1.3	1.3
Cough	1.0	1.0
Sinus abnormality	0.8	0.8
Pharyngitis	0.5	0.6

The following additional events were reported in either uncontrolled clinical trials or in marketed use: pruritus, scalp hair abnormalities, skin dryness, abnormal stool, appetite change, chest pain (non-cardiovascular), weakness, excess sweating, hot flashes, paresthesia, equilibrium disturbance, mood change, eye symptoms (including soreness, dryness, or itching), tinnitus and impotence (see Endocrine Function).
The following have also been reported with other statins: hepatitis, cholestatic jaundice, anorexia, psychic disturbances including anxiety, hypospermia and hypersensitivity (see Precautions).
Lens: Current data from clinical trials do not indicate an adverse effect of pravastatin on the human lens.
Laboratory Test Abnormalities: increases in serum transaminases and in creatine phosphokinase (CPK) in patients treated with pravastatin have been discussed (see Warnings).
There have been rare post-marketing reports of cognitive impairment (e.g. memory loss, forgetfulness, amnesia, memory impairment, confusion) associated with statin use. These cognitive issues have been reported for all statins. The reports are generally non-serious and reversible upon statin discontinuation, with variable times to symptom onset (1 day to years) and symptom resolution (median 3 weeks).
Increases in HbA1c and fasting blood glucose have been reported with statins. The risk of hyperglycemia, however, is outweighed by the reduction in vascular risk with statins.

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Musculoskeletal disorders
Frequency not known: Immune-mediated necrotizing myopathy

Nervous system disorders
Frequency 'not known': myasthenia gravis

Eye disorders
Frequency 'not known': ocular myasthenia

Warnings
Liver Dysfunction: HMG-CoA reductase inhibitors have been associated with biochemical abnormalities of liver function. As with other lipid-lowering agents, including non-absorbable bile acid-binding resins, increases in liver enzymes to less than three times the upper limit of normal have occurred during therapy with pravastatin. The significance of these changes, which usually appear during the first few months of treatment initiation, is not known. In the majority of patients treated with pravastatin in clinical trials, these increased values declined to pretreatment levels despite continuation of therapy at the same dose.
Marked persistent increases (greater than three times the upper limit of normal) in serum transaminases were seen in 6 out of 1142 (0.5%) patients treated with pravastatin in clinical trials. The increases usually appeared 3 to 12 months after the start of therapy with pravastatin. These elevations were not associated with clinical signs and symptoms of liver disease and usually declined to pretreatment levels upon discontinuation of therapy. Patients rarely had persistent marked abnormalities possibly attributable to therapy.
Liver function tests should be performed at baseline and at 12 weeks following initiation of therapy or the elevation of dose. Special attention should be given to patients who develop increased transaminase levels. Liver function tests should be repeated to confirm an elevation and subsequently monitored at more frequent intervals. If increases in alanine aminotransferase (ALT) and aspartate aminotransferase (AST) equal or exceed three times the upper limit of normal and persist, therapy should be discontinued.
Cautions should be exercised when pravastatin is administered to patients with a history of liver disease or heavy alcohol ingestion. Muscle Effects: Elevation of creatinine phosphokinase levels (CPK[MM fraction]), myalgia (muscle pain, muscle strains, tears, ruptures), myopathy and rhabdomyolysis have been reported with the use of HMG-CoA reductase inhibitors, including pravastatin. Muscle weakness and rhabdomyolysis have been reported in patients receiving other HMG-CoA reductase inhibitors concomitantly with itraconazole and cyclosporine. The benefits and risks of using HMG-CoA Reductase Inhibitors concomitantly with immunosuppressive drugs, fibrates, erythromycin, systemic azole derivative antifungal agents or lipid-lowering doses of niacin should be carefully considered. Myalgia has been associated with pravastatin therapy. Rare cases of rhabdomyolysis associated with pravastatin (and macrocreatine kinase in one case) have been reported.
Myopathy was very rarely reported in pravastatin treated patients in clinical trials. Rhabdomyolysis with renal dysfunction secondary to myoglobinuria has also very rarely reported been with pravastatin. However, myopathy should be considered in any patients with diffuse myalgia, muscle tenderness or weakness, and/or marked elevation of CPK. As with other statins, the risk of myopathy including rhabdomyolysis may be substantially increased by concomitant immunosuppressive therapy including cyclosporine, and by concomitant therapy with gemfibrozil, erythromycin or niacin. Myopathy has not been observed in clinical trials involving small numbers of patients who were treated with pravastatin together with immunosuppressants, fibric acid derivatives or niacin. The use of fibrates alone is occasionally associated with myopathy. In a limited size clinical trial of combined therapy with pravastatin (40mg/day) and gemfibrozil (1200mg/day), myopathy was not reported, although a trend towards CPK elevations and musculoskeletal symptoms was seen. The combined use of pravastatin and fibrates should generally be avoided. No information is available on the combined therapy of pravastatin with erythromycin. Apo-Pravastatin therapy should be discontinued if marked elevation of CPK levels occurs or if myopathy is diagnosed or suspected. Interruption of therapy with Apo-Pravastatin should be considered in any patient with an acute, serious condition, suggestive of a myopathy or having a risk factor predisposing to the development of renal failure or rhabdomyolysis, such as severe acute infection, hypotension, major surgery, trauma, severe metabolic, endocrine or electrolyte disorders and uncontrolled seizures.
Skeletal Muscle Effects
The use of fibrates alone may occasionally be associated with myopathy. The benefit of further alterations in lipid levels by the combined use of pravastatin with fibrates should be carefully weighed against the potential risks of this combination.
Cases of myopathy, including rhabdomyolysis, have been reported with pravastatin co-administered with colchicine, and caution should be exercised

when prescribing pravastatin with colchicine.

Pravastatin must not be co-administered with systemic fusidic acid. There have been reports of rhabdomyolysis (including some fatalities) in patients receiving this combination. In patients where the use of systemic fusidic acid is considered essential, statin treatment should be discontinued throughout the duration of fusidic acid treatment. The patient should be advised to seek medical advice immediately if they experience any symptoms of muscle weakness, pain or tenderness. Pravastatin therapy may be re-introduced seven days after the last dose of fusidic acid.

There have been very rare reports of an immune-mediated necrotizing myopathy (IMNM) during or after treatment with some statins. IMNM is clinically characterized by:
• persistent proximal muscle weakness and elevated serum creatine kinase, which persist despite discontinuation of statin treatment;
• muscle biopsy showing necrotizing myopathy without significant inflammation;
• improvement with immunosuppressive agents.

Myasthenia Gravis/Ocular Myasthenia

In few cases, statins have been reported to induce de novo or aggravate pre-existing myasthenia gravis or ocular myasthenia. Apo-Pravastatin should be discontinued in case of aggravation of symptoms. Recurrences when the same or a different statin was (re-)administered have been reported.

Precautions

General: Before instituting therapy with Apo-Pravastatin (pravastatin sodium), an attempt should be made to control hypercholesterolemia with appropriate diet, exercise, weight reduction in overweight and obese patients, and to treat other underlying medical problems. The patient should be advised to inform subsequent physicians of the prior use of pravastatin. Pravastatin may elevate creatine phosphokinase and transaminase levels. This should be considered in the differential diagnosis of chest pain in a patient on therapy with pravastatin.
Homozygous Familial Hypercholesterolemia: Pravastatin has not been evaluated in patients with rare homozygous familial hypercholesterolemia. Most HMG-CoA reductase inhibitors are less or not effective in this subgroup of hypercholesterolemic patients.
Carcinogenesis: A 21-month oral study in mice, with doses of 10 to 100mg/kg daily of pravastatin did not demonstrate any carcinogenic potential. In a 2-year oral study in rats, a statistically significant increase in the incidence of hepatocellular carcinoma was observed in male rats given 100 mg/kg daily (125 times the maximum human dose) of pravastatin. This change was not seen in male rats given 40 mg/kg daily *(*50 times the recommended human dose) or less, or in female rats at any dose level.
Use in Pregnancy: Apo-Pravastatin is contraindicated during pregnancy (see Contraindications). Safety in pregnant women has not been established.
Nursing Mothers: A negligible amount of pravastatin is excreted in human breast milk. Because of the potential for adverse reactions in nursing infants, if the mother is being treated with APO-PRAVASTATIN, nursing should be discontinued or treatment with APO- PRAVASTATIN stopped.
Pediatric Use: Safety and effectiveness in individuals under 18 years have not been established. Hence, treatment in patients under 18 years is not recommended of this time.
Elderly: Pharmacokinetic evaluation of pravastatin in patients over the age of 65 years indicates an increase AUC. There were no reported increases in the incidence of adverse effects in these or other studies involving patients in that age group. As a precautionary measure, the lowest dose should be administered initially.
Use in Patients with Impaired Renal Function: There have been no studies on the use of pravastatin in patients with renal failure. As a precautionary measure, the lowest dose should be used in these patients.
Endocrine Function: Caution should be exercised if an HMG-CoA reductase inhibitor or other agent used to lower cholesterol levels is administered to patients receiving other drugs (e.g. ketoconazole, spironolactone, or cimetidine) that may decrease the levels of endogenous steroid hormones.

Contraindications

Hypersensitivity to any component of this medication.
Pregnancy: Atherosclerosis is a chronic process and discontinuation of lipid-lowering drugs during pregnancy should have little impact on the outcome of long-term therapy of primary hypercholesterolemia. Cholesterol and other products of cholesterol biosynthesis are essential components for fetal development (including synthesis of steroids and cell membranes). Since HMG-CoA reductase inhibitors such as pravastatin sodium decrease cholesterol synthesis and possibly the synthesis of other biologically active substances derived from cholesterol, they may cause fetal harm when administered to pregnant women. Therefore, APO-PRAVASTATIN is contraindicated during pregnancy. Lactation and Nursing (see under Precautions).

Drug Interactions

Concomitant Therapy with Other Lipid Metabolism Regulators: Based on post-marketing surveillance, gemfibrozil, fenofibrate, other fibrates and lipid lowering doses of niacin (nicotinic acid) may increase the risk of myopathy when given concomitantly with HMG CoA reductase inhibitors, probably because they can produce myopathy when given alone. Therefore, combined drug therapy should be approached with caution.
Concurrent use of fibrates may cause severe myositis and myoglobinuria.
Bile Acid Sequestrants: Preliminary evidence suggests that the cholesterol-lowering effects of pravastatin and the bile acid sequestrants, cholestyramine/colestipol are additive. When pravastatin was administered one hour before or four hours after cholestyramine or one hour before colestipol and a standard meal, there was no clinically significant decrease in bioavailability or therapeutic effect. Concomitant administration resulted in an approximately 40 to 50% decrease in the mean AUC of pravastatin.
Gemfibrozil and nicotinic acid: Gemfibrozil and nicotinic acid do not statistically significantly affect the bioavailability of pravastatin. However, in a limited size clinical trial, a trend toward CK elevations and musculoskeletal symptoms was seen in patients treated concurrently with pravastatin and gemfibrozil. Myopathy, including rhabdomyolysis, has occurred in patients who were receiving coadministration of HMG-CoA reductase inhibitors with fibric acid derivatives and niacin, particularly in subjects with pre-existing renal insufficiency.
Digoxin: Coadministration of digoxin and other HMG-CoA reductase inhibitors has been shown to increase the steady state digoxin concentrations. The potential effects of coadministration of digoxin and pravastatin are not known. As a precautionary measure, patients taking digoxin should be closely monitored.
Antipyrine: Antipyrine was used as a model for drugs metabolized by the microsomal hepatic enzyme system (cytochrome P450 system). Pravastatin had no effect on the pharmacokinetics of antipyrine.
Coumarin Anticoagulants: Bioavailability parameters at steady state for pravastatin were not altered following concomitant administration with

warfarin. Dosing of the two drugs did not produce any changes in the anticoagulant action of warfarin (i.e. no increase was seen in mean prothrombin time after six days of concomitant therapy). However, until further clinical experience is gained, careful monitoring of prothrombin time is recommended in patients taking coumarin anticoagulants concomitantly with pravastatin.

Antacids and Cimetidine: On the average (one hour prior to pravastatin) reduce and cimetidine increases the bioavailability of pravastatin. These changes were not statistically significant. The clinical significance of these interactions is not known but is probably minimal as judged from the interaction with food.

No information is available regarding interactions with erythromycin. Although specific interaction studies were not performed during clinical trials, no noticeable drug interactions were reported when pravastatin was added to diuretics, antihypertensives, angiotensin converting-enzyme (ACE) inhibitors, calcium channel blockers, or nitroglycerin.

Propranolol: Co-administration of propranolol and pravastatin reduced the AUC values by 23% and 16% respectively.

Cyclosporine: In a multicentre study, the AUC values of pravastatin were shown to be five-fold higher in the presence of cyclosporine. There was no accumulation of pravastatin after multiple doses.

Clarithromycin, colchicine: The risk of myopathy/rhabdomyolysis is increased with concomitant administration of clarithromycin or colchicine with pravastatin.

Fusidic acid: The risk of myopathy including rhabdomyolysis may be increased by the concomitant administration of pravastatin with systemic fusidic acid. Co-administration of this combination may cause increased plasma concentrations of both agents. The mechanism of this interaction (whether it is pharmacodynamics or pharmacokinetic, or both) is yet unknown. There have been reports of rhabdomyolysis (including some fatalities) in patients receiving this combination. If treatment with fusidic acid is necessary, pravastatin treatment should be discontinued throughout the duration of the fusidic acid treatment.

Recommended Dosage and Route of Administration

Hypercholesterolemia and Coronary Heart Disease: The recommended starting dose is 10 to 20mg once daily at bedtime. If serum cholesterol is markedly elevated [e.g. total cholesterol greater than 7.75mmol/L (300mg/dL)] dosage may be initiated at 40mg per day. APO-PRAVASTATIN may be taken without regard to meals. Since the maximal effect of a given dose is seen within four weeks, periodic lipid determinations should be performed and dosage adjusted according to the patient's response to therapy. The recommended dosage range is 10 to 40mg administered once a day at bedtime. In patients taking cyclosporine, with or without other immunosuppressive drugs, concomitantly with pravastatin, therapy should be initiated with 10mg/day and titration to higher doses should be performed with caution. Most patients treated with this combination received a maximum pravastatin dose of 20mg/day.

Concomitant Therapy: Some patients may require combination therapy with one or more lipid-lowering agents. Pharmacokinetic interaction with pravastatin administered concurrently with nicotinic acid, probucol, or gemfibrozil did not statistically affect the bioavailablity of pravastatin. The combined use of pravastatin and fibrates should however generally be avoided (see Warnings, Muscle Effects).

The lipid-lowering effects of pravastatin on Total and Low Density Lipoprotein Cholesterol are additive when combined with a bile acid- binding resin. However, when administering a bile acid-binding resin (e.g. cholestyramine, colestipol) and pravastatin, APO- PRAVASTATIN should be given either one hour or more, before or at least four hours following the resin.

Mode of administration: For Oral Use

Symptoms and Treatment of Overdosage: There have been two reports of overdosage with pravastatin, both of which were asymptomatic and not associated with clinical laboratory abnormalities. In the event of overdosage, treatment should be symptomatic and supportive, and appropriate therapy instituted. Until further experience is obtained, no specific therapy of overdosage can be recommended. The dialyzability of pravastatin and its metabolites is not known.

Availability of Dosage Forms

Apo-Pravastatin 20mg: each round, yellow, biconvex, rectangular-shaped tablet, engraved 'PRA' over '20' on one side, 'APO' on the other contains 20mg of pravastatin as pravastatin sodium. Available in cold formable foil blisters of 30's.

Apo-Pravastatin 40mg: each rounded rectangular-shaped, green, biconvex tablet engraved "PRA" over "40" on one side and "APO" on the other contains 40 mg of pravastatin sodium. Available in cold formable foil blisters of 30's.

Storage Conditions:

Store below 30°C.

Manufacturer: Apotex Inc., 150 Signet Drive, Weston Ontario, Canada M9L 1T9.

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