

HIGHLIGHTS OF PRESCRIBING INFORMATION These highlights do not include all the information needed to use AVANAFIL TABLETS safely and effectively. See full prescribing

Initial U.S. Approval: 2012

--INDICATIONS AND USAGE--Avanafil tablet is a phosphodiesterase 5 (PDE5) inhibitor indicated for the treatment of erectile dysfunction (1)

--DOSAGE AND ADMINISTRATION-The starting dose is 100 mg taken as early as approximately 15 minutes before sexual activity, on an as needed basis (2.1)

- Take avanafil tablet no more than once a day (2.1).

 Based on efficacy and/or tolerability, the dose may be increased to 200 mg taken as early as approximately 15 minutes before
- sexual activity or decreased to 50 mg taken approximately 30 minutes before sexual activity. Use the lowest dose that provides
- Avanafil tablet may be taken with or without food (2.2) Do not use avanafil tablet with strong CYP3A4 inhibitors (2.3)
- If taking a moderate CYP3A4 inhibitor, the dose should be no more than 50 mg in a 24-hour period (2.3). In patients on stable alpha-blocker therapy, the recommended starting dose of avanafil tablet is 50 mg (2.3).

--DOSAGE FORMS AND STRENGTHS-

Tablets: 50 mg, 100 mg, 200 mg (3)

-CONTRAINDICATIONS-Administration of avanafil tablet to patients using any form of organic nitrate is contraindicated (4.1) Hypersensitivity to any component of the avanafil tablet (4.2)
Administration with guanylate cyclase (GC) stimulators such as riociguat and vericiguat (4.3)

FILL PRESCRIBING INFORMATION: CONTENTS* INDICATIONS AND USAGE

- DOSAGE AND ADMINISTRATION Erectile Dysfunction
- 2.2 Use with Food 2.3 Concomitant Medications
- 3 DOSAGE FORM AND STRENGTHS CONTRAINDICATIONS
 - Nitrates 4.2 Hypersensitivity Reactions
- 4.3 Concomitant Guanylate Cyclase Stimulators WARNINGS AND PRECAUTIONS
- Cardiovascular Risks Concomitant Use of CYP3A4 Inhibitors
- Prolonged Erection
- Effects on Eye 5.5 Sudden Hearing Loss Alpha-Blockers and Other Antihypertensives
- Alcohol 5.8 Combination with Other PDE5 Inhibitors or Erectile Dysfunction Therapies
- 5.9 Effects on Bleeding
 5.10 Counseling Patients about Sexually Transmitted Diseases
- 6 ADVERSE REACTIONS
- 6.1 Clinical Trials Experience6.2 Postmarketing Experience
- DRUG INTERACTIONS
- 7.1 Potential for Pharmacodynamic Interactions with Avanafil
 7.2 Potential for Other Drugs to Affect Avanafil
- 8 USE IN SPECIFIC POPULATIONS
- 8.1 Pregnancy 8.2 Lactation

FULL PRESCRIBING INFORMATION

Avanafil tablets are a phosphodiesterase 5 (PDE5) inhibitor indicated for the treatment of erectile dysfunction in adult males

2.1 Erectile Dysfunction

The recommended starting dose is 100 mg. Avanafil tablet should be taken orally as needed as early as approximately 15 minutes

The maximum recommended dosing frequency is once per day. Sexual stimulation is required for a response to treatment

Avanafil tablet may be taken with or without food.

2.3 Concomitant Medications

mitant use of nitrates in any form is contraindicated [see Contraindications (4.1)].

If avanafil tablet is co-administered with an alpha-blocker, patients should be stable on alpha-blocker therapy prior to initiating treatment with avanafil tablet, and avanafil tablet should be initiated at the 50 mg dose [see Warnings and Precautions (5.6), Drug

For natients taking concomitant strong CYP3A4 inhibitors (including ketoconazole, ritonavir, atazanavir, clarithromycin indinavir, itraconazole, nefazodone, nelfinavir, saquinavir and telithromycin), do not use avanafil tablet [see Warnings and Precautions (5.2) and Drug Interactions (7.2)].

fluconazole, fosamprenavir, and verapamil), the maximum recommended dose of every 24 hours [see Warnings and Precautions (5.2) and Drug Interactions (7.2)]. nmended dose of avanafil tablet is 50 mg, not to exceed once

Avanafil tablets, 100 mg are white to off white, oval shape, biconvex tablets debossed with 'A Avanafil tablets, 200 mg are white to off white, oval shape, biconvex tablets debossed with 'A43' on one side and 'H' on the other side.

4 CONTRAINDICATIONS 4.1 Nitrates Administration of avanafil tablets with any form of organic nitrates, either regularly and/or intermittently, is contraindicated. Consistent

In a patient who has taken avanafil tablets, where nitrate administration is deemed medically necessary in a life-threatening situation, at least 12 hours should elapse after the last dose of avanafil tablets before nitrate administration is considered. In such circumstances, nitrates should only be administered under close medical supervision with appropriate hemodynamic monitoring [see

4.2 Hypersensitivity Reactions

Avanafil is contraindicated in patients with a known hypersensitivity to any component of the tablet. Hypersensitivity reactions have been reported, including pruritis and eyelid swelling

4.3 Concomitant Guanylate Cyclase (GC) Stimulators

Evaluation of erectile dysfunction (ED) should include an appropriate medical assessment to identify potential underlying causes, as

5.1 Cardiovascular Risk There is a potential for cardiac risk during sexual activity in patients with pre-existing cardiovascular disease. Therefore, treatments for ED. including avanafil, should not be used in men for whom sexual activity is inadvisable because of their underlying cardiovascular status. Patients with left ventricular outflow obstruction (e.g., aortic stenosis, idiopathic hypertrophic subaortic stenosis) and those with severely impaired autonomic control of blood pressure can be particularly sensitive to the actions of vasodilators, including avanafil. The following groups of patients were not included in clinical safety and efficacy trials for avanafil, and therefore until further

- Patients who have suffered a myocardial infarction, stroke, life-threatening arrhythmia, or coronary revascularization within the
- 170/100 mmHa):

As with other PDE5 inhibitors avanafil has systemic vasodilatory properties and may augment the blood pressure-lowering effect of other anti-hypertensive medications. Avanafil 200 mg resulted in transient decreases in sitting blood pressure in healthy volunteers of 8.0 mmHg systolic and 3.3 mmHg diastolic [see Clinical Pharmacology (12.2)], with the maximum decrease observed at 1 hour after dosing. While this normally would be expected to be of little consequence in most patients, prior to prescribing avanafil, physicians should carefully consider whether patients with underlying cardiovascular disease could be affected adversely by such vasodilatory effects, especially in combination with sexual activity.

5.2 Concomitant Use of CYP3A4 Inhibitors

Avanafil metabolism is principally mediated by the CYP450 isoform 3A4 (CYP3A4). Inhibitors of CYP3A4 may reduce avanafil clearance and increase plasma concentrations of avanafil.

itraconazole, nefazodone, nelfinavir, saquinavir and telithromycin), do not use avanafil [see Drug Interactions (7.2)].

5.3 Prolonged Erection

Prolonged erection greater than 4 hours and priapism (painful erections greater than 6 hours in duration) have been reported with other PDE5 inhibitors. In the event of an erection that persists longer than 4 hours, the patient should seek immediate medical

assistance. If not treated immediately, penile tissue damage and permanent loss of potency could result. Avanafil should be used with caution in patients with anatomical deformation of the penis (such as angulation, cavernosal fibrosis, or Peyronie's disease), or in patients who have conditions which may predispose them to priapism (such as sickle cell anemia, multiple

sudden loss of vision in one or both eyes. Such an event may be a sign of non-arteritic anterior ischemic optic neuropathy (NAION), a rare condition and a cause of decreased vision including permanent loss of vision that has been reported rarely postmarketing in temporal association with the use of all PDE5 inhibitors. Based on published literature, the annual incidence of NAION is 2.5 to 11.8

An observational case-crossover study evaluated the risk of NAION when PDE5 inhibitor use, as a class, occurred immediately before NAION onset (within 5 half-lives), compared to PDE5 inhibitor use in a prior time period. The results suggest an approximate 2-fold increase in the risk of NAION, with a risk estimate of 2.15 (95% CI 1.06, 4.34). A similar study reported a consistent result, with a

risk estimate of 2.27 (95% Cl 0.99, 5.20). Other risk factors for NAION, such as the presence of "crowded" optic disc, may have contributed to the occurrence of NAION in these studies.

a causal relationship between PDE5 inhibitor use and NAION [see Adverse Reactions (6.2)].

o drop suddenly to an unsafe o not take avanafil tablets if you ed to treat chest pain (angina). feel dizzy, faint, or have a heart

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lets can cause your blood pressure to taken with certain other medicines. Do dicines called nitrates. Nitrates are used op in blood pressure can cause you to fe

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know about avanafil tablets?

information I should

important

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Patient Information Avanafii (a VAN a fil)

Dimensions

Pantone Colours Version No.

Spec

tablets, for oral use

inhibitors. Individuals who have already experienced NAION are at increased risk of NAION recurrence. Therefore, PDE5 inhibitors. including avanafii should be used with caution in these patients and only when the anticipated benefits outweigh the risks. Individuals with "crowded" optic disc are also considered at greater risk for NAION compared to the general population; however, evidence is insufficient to support screening of prospective users of PDE5 inhibitors, including avanafil, for this uncommon condition.

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medicines

take

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avanafil tablets rhich include:

-WARNINGS AND PRECAUTIONS-Patients should not use avanafil if sexual activity is inadvisable due to cardiovascular status or any other reason (5.1)

2D Code

Use of avanafil with alpha-blockers, other antihypertensives, or substantial amounts of alcohol (greater than 3 units) may lead Patients should seek emergency treatment if an erection lasts greater than 4 hours (5.3)

Patients should stop avanafil and seek medical care if a sudden loss of vision occurs in one or both eyes, which could be a sign of Non Arteritic Ischemic Optic Neuropathy (NAION). Avanafil should be used with caution, and only when the anticipated benefits outweigh the risks, in patients with a history of NAION. Patients with a "crowded" optic disc may also be at an increased Patients should stop taking avanafil and seek prompt medical attention in the event of sudden decrease or loss of hearing (5.5)

----ADVERSE REACTIONS----Most common adverse reactions (greater than or equal to 2%) include headache, flushing, nasal congestion, nasopharyngitis, and

To report SUSPECTED ADVERSE REACTIONS, contact Hetero Labs Limited at 1-866-495-1995 or FDA at 1-800-FDA-1088 or www

--DRUG INTERACTIONS--

Avanafil can potentiate the hypotensive effect of nitrates, alpha-blockers, antihypertensives, and alcohol (7.1) CYP3A4 inhibitors (e.g., ketoconazole, ritonavir, erythromycin) increase avanafil exposure (7.2) ---USE IN SPECIFIC POPULATIONS

Do not use in patients with severe renal impairment (8.6) Do not use in patients with severe hepatic impairment (8.7)

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

Revised: 07/2024

Table 3: Adverse Reactions Reported by Greater than or Equal to 2% of Patients Treated with Avanafil in a Placebo-Controlled

Avanafil 100 mg

(N = 99)

8.1%

5.1%

3%

2%

3%

3%

1%

1%

Avanafil 100 mg

(N = 146)

1.4%

0.7%

0%

Avanafil 200 mg

(N = 99)

12.1%

10.1%

5.1%

3%

1%

2%

3%

Avanafil 200 mg

(N = 146)

8.9%

4.1%

2.1%

Clinical Trial Lasting 3 Months in Patients Who Underwent Bilateral Nerve-Sparing Radical Prostatectom

Adverse Reaction

Months to Determine the Time to Onset of Effect (Study 4)

of clear alternative causation, or a combination of these factors

Ophthalmologic: vitreous detachment, visual impairment

hyperlipidemia and smoking [see Warnings and Precautions (5.4)].

7.1 Potential for Pharmacodynamic Interactions with Avanafil

7.2 Potential for Other Drugs to Affect Avanafil

hours in healthy volunteers. Do not use avanafil in patients taking ritonavir.

No *in vivo* drug-drug interaction studies with weak CYP3A4 inhibitors were conducted.

avanafil exposure.

Weak CYP3A4 Inhibitors

8.1 Pregnancy

Animal Data

Risk Summary

8.5 Geriatric Use

Clinical Pharmacology (12.3)

8.7 Hepatic Impairment

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you t herbal

8 USE IN SPECIFIC POPULATIONS

Avanafil is not indicated for use in females.

Avanafil is not indicated for use in females.

8.3 Females and Males of Reproductive Potential

or the effects on milk production

Across all trials with any avanafil dose, 1 subject reported a change in color vision

Adverse Reaction

Headache

Nasopharyngitis

Nasal congestion

Back pain

Headache

Nasal congestion

Gastroenteritis viral

6.2 Postmarketing Experience

Nervous: transient global amnesia

Special senses:

Information (17.6)].

Nit<u>rates</u>

7 DRUG INTERACTIONS

Upper respiratory infection

Electrocardiogram abnormal

Flushina

Placebo

(N = 100)

1%

0%

0%

0%

1%

1%

0%

0%

for sexual intercourse. Table 4 presents the adverse reactions occurring in ≥ 2% of subjects treated with avanafil.

(N = 143)

0.7%

0%

0%

A randomized, double-blind, placebo-controlled 2 months study was conducted in 435 subjects with a mean age of 58.2 years (range

24 to 86 years) to determine the time to onset of effect of avanafil, defined as the time to the first occurrence of an erection sufficient

Table 4: Adverse Reactions Reported by $\geq 2\%$ of Patients Treated with Avanafil in a Placebo-Controlled Clinical Trial Lasting 2

The following adverse reactions have been identified during post approval use of avanafil. Because these reactions are reported voluntarily from a population of uncertain size, it is not always possible to reliably estimate their frequency or establish a causal

relationship to drug exposure. These events have been chosen for inclusion either due to their seriousness, reporting frequency, lack

Serious cardiovascular and cerebrovascular events, including myocardial infarction, sudden cardiac death, cerebrovascular accident

and subarachnoid hemorrhage, have been reported post-marketing in temporal association with the use of avanafil. All of these patients had preexisting cardiovascular risk factors. The occurrence of sexual activity was not stated in the majority of reports,

although events were reported to occur both with and without sexual activity. It is not possible to determine whether these events are related directly to avanafil, to sexual activity, to the patient's underlying cardiovascular disease, to a combination of these factors, or to other factors [see Warnings and Precautions (5.1) and Patient Counseling Information (17.2)].

Non-arteritic anterior ischemic optic neuropathy (NAION), a cause of decreased vision including permanent loss of vision, has

been reported rarely post-marketing in temporal association with the use of phosphodiesterase type 5 (PDE5) inhibitors, such as

avanafil. Most, but not all, of these patients had underlying anatomic or vascular risk factors for developing NAION, including but not necessarily limited to: low cup to disc ratio ("crowded disc"), age over 50, diabetes, hypertension, coronary artery disease,

Otologic: Cases of sudden decrease or loss of hearing have been reported postmarketing in temporal association with the use of

played a role in the otologic adverse events. In many cases, medical follow-up information was limited. It is not possible to determine

whether these reported events are related directly to the use of PDE5 inhibitors such as avanafii, to the patient's underlying risk factors for hearing loss, a combination of these factors, or to other factors [see Warnings and Precautions (5.5) and Patient Counseling

Administration of avanafil to patients who are using any form of organic nitrate, is contraindicated. In a clinical pharmacology trial,

avanafil was shown to potentiate the hypotensive effect of nitrates. In a patient who has taken avanafil, where nitrate administration is deemed medically necessary in a life-threatening situation, at least 12 hours should elapse after the last dose of avanafil before

nitrate administration is considered. In such circumstances, nitrates should only be administered under close medical supervision with appropriate hemodynamic monitoring [see Contraindications (4.1), Dosage and Administration (2.3), and Clinical Pha

Caution is advised when PDE5 inhibitors are co-administered with alpha-blockers. PDE5 inhibitors, including avanafil, and alphaadrenergic blocking agents are both vasodilators with blood pressure-lowering effects. When vasodilators are used in combination,

an additive effect on blood pressure may be anticipated. In some patients, concomitant use of these two drug classes can lower blood

pressure significantly leading to symptomatic hypotension (e.g., dizziness, lightheadedness, fainting) [see Warnings and Precautions (5.6), Dosage and Administration (2.3), and Clinical Pharmacology (12.2)].

PDE5 inhibitors, including avanafil, are mild systemic vasodilators. A clinical pharmacology trial was conducted to assess the effect of avanafil on the potentiation of the blood pressure-lowering effects of selected antihypertensive medications (amlodipine and enalapril). Additional reductions in blood pressure of 3 to 5 mmHg occurred following co-administration of a single 200 mg dose of

Both alcohol and PDE5 inhibitors, including avanafil, act as vasodilators. When vasodilators are taken in combination, blood pressurelowering effects of each individual compound may be increased. Substantial consumption of alcohol (e.g., greater than 3 units) in

combination with avanafil can increase the potential for orthostatic signs and symptoms, including increase in heart rate, decrease in standing blood pressure, dizziness, and headache [see Clinical Pharmacology (12.2)].

Avanafil is a substrate of and predominantly metabolized by CYP3A4. Studies have shown that drugs that inhibit CYP3A4 can increase

Ketoconazole (400 mg daily), a selective and strong inhibitor of CYP3A4, increased avanafil 50 mg single-dose systemic exposure (AUC) and maximum concentration (Cmmx) equal to 13-fold and 3-fold, respectively, and prolonged the half-life of avanafil to approximately 9 hours. Other potent inhibitors of CYP3A4 (e.g., itraconazole, clarithromycin, nefazadone, ritonavir, saquinavir,

nelfinavir, indinavir, atanazavir and telithromycin) would be expected to have similar effects. Do not use avanafil in patients taking strong CYP3A4 inhibitors [see Warnings and Precautions (5.2) and Dosage and Administration (2.3)].

HIV Protease inhibitor — Ritonavir (600 mg twice daily), a strong CYP3A4 inhibitor, which also inhibits CYP2C9, increased avanafil

Erythromycin (500 mg twice daily) increased avanafil 200 mg single-dose Cmax and AUC equal to approximately 2-fold and 3-fold,

respectively, and prolonged the half-life of avanafil to approximately 8 hours in healthy volunteers. Moderate CYP3A4 inhibitors (e.g., erythromycin, amprenavir, aprepitant, diltiazem, fluconazole, fosamprenavir, and verapamil) would be expected to have similar

effects. Consequently, the maximum recommended dose of avanafil is 50 mg, not to exceed once every 24 hours for natients taking

Although specific interactions have not been studied, other CYP3A4 inhibitors, including grapefruit juice are likely to increase avanafil

When administered with avanafil 200 mg, amlodipine (5 mg daily) increased the Cmax and AUC of avanafil by approximately 22% and 70%, respectively. The half-life of avanafil was prolonged to approximately 10 hrs. The Cmax and AUC of amlodipine decreased by approximately 9% and 4%, respectively [see Dosage and Administration (2.3)].

The potential effect of CYP inducers on the pharmacokinetics of avanafil was not evaluated. The concomitant use of avanafil and CYP inducers is not recommended.

There are no data with the use of avanafil in pregnant women to inform any drug-associated risks for adverse developmental outcomes.

In animal reproduction studies conducted in pregnant rats and rabbits, no adverse developmental outcomes were observed with oral administration of avanafil during organogenesis at exposures for total avanafil at approximately 8 and 6 times, respectively, the Maximum Recommended Human Dose (MRHD) of 200 mg based on AUC (see Data).

In pregnant rats administered orally at 100, 300, or 1000 mg/kg/day from gestation days 6 to 17, no evidence of teratogenicity embryotoxicity, or fetotoxicity was observed at up to 300 mg/kg/day. This dose is equivalent to exposures of approximately 8 times the exposure at the Maximum Recommended Human Dose (MRHD) of 200 mg based on AUCs for total avanafil. At the maternally

toxic dose (1000 mg/kg/day), decreased fetal body weight occurred with no signs of teratogenicity. In pregnant rabbits administered orally at 30, 60, 120, or 240 mg/kg/day from gestation days 6 to 18, no teratogenicity was observed at exposures up to approximately 6 times the human exposure at the MRHD based on AUCs for total avanafil.

In a pre- and post-natal development study in rats given orally at 100, 300, or 600 mg/kg/day on gestation days 6 through lactation day 20, offspring growth and maturation were reduced when maternal rats were given avanafil doses greater than or equal to 300 mg/kg/day, resulting in exposures greater than or equal to 17 times the human exposure to total avanafil at the MRHD. There was no effect on reproductive performance of the maternal rats or offspring, or on the behavior of the offspring at up to the highest dose

tested. The no observed adverse effect level (NOAEL) for developmental toxicity (100 mg/kg/day) was observed at exposures to total avanafil approximately 2-fold greater than the systemic exposure in humans at the MRHD.

There is no information on the presence of avanafil and/or its metabolites in human or animal milk, the effects on the breastfed child,

Based on studies in animals, decreased fertility, abnormal sperm motility and morphology, and altered estrous cycles were observed

Avanafil is not indicated for use in pediatric patients. Safety and efficacy in patients below the age of 18 years has not been established.

Of the total number of subjects in clinical studies of avanafil, approximately 23% were 65 and over. No overall differences in efficacy

and safety were observed between subjects over 65 years of age compared to younger subjects; therefore, no dose adjustment is warranted based on age alone. However, a greater sensitivity to medication in some older individuals should be considered *[see*

In a clinical pharmacology trial using single 200 mg doses of avanafil avanafil exposure (AUC or Cmax) in normal subjects was

comparable to patients with mild (creatinine clearance greater than or equal to 60 to less than 90 mL/min) or moderate (creatinine clearance greater than or equal to 30 to less than 90 mL/min) or moderate (creatinine clearance greater than or equal to 30 to less than 90 mL/min) renal impairment. No dose adjustment is necessary for patients with

mild to moderate renal impairment (creatinine clearance greater than or equal to 30 to less than 90 mL/min). The pharmacokinetics of avanafil in patients with severe renal disease or on renal dialysis has not been studied; do not use avanafil in such patients [see

In a clinical pharmacology trial, avanafil AUC and C_{max} in patients with mild hepatic impairment (Child-Pugh Class A) was comparable to that in healthy subjects when a dose of 200 mg was administered. Avanafil C_{max} was approximately 51% lower and AUC was 11% higher in patients with moderate hepatic impairment (Child Pugh Class B) compared to subjects with normal hepatic function. No dose

adjustment is necessary for patients with mild to moderate hepatic impairment (Child Pugh Class A or B). The pharmacokinetics of avanafii in patients with severe hepatic disease has not been studied; do not use avanafil in such patients [see Clinical Pharmacology

in rats. The abnormal sperm findings were reversible at the end of a 9-week drug-free period [see Nonclinical Toxicology (13.1)].

There have been no studies evaluating the effect of avanafil on fertility in men [see Clinical Pharmacology (12.2)]

concomitant moderate CYP3A4 inhibitors [see Warnings and Precautions (5.2) and Drug Interactions (7.2)].

50 mg single-dose Cmax and AUC equal to approximately 2-fold and 13-fold, and prolonged the half-life of avanafil to approximately

avanafil with these agents compared with placebo [see Warnings and Precautions (5.6) and Clinical Pharmacology (12.2).

PDE5 inhibitors, such as avanafil. In some of the cases, medical conditions and other factors were reported that may have also

- 8.3 Females and Males of Reproductive Potential
- Pediatric Use Geriatric Use
- 8.6 Renal Impairment 8.7 Hepatic Impairment
- 10 OVERDOSAGE 11 DESCRIPTION
- 12 CLINICAL PHARMACOLOGY
- 12.2 Pharmacodynamics 12.3 Pharmacokinetics
- 13 NONCLINICAL TOXICOLOGY 13.1 Carcinogenesis, Mutagenesis and Impairment of Fertility
- 13.2 Animal Toxicology and/or Pharmacology
- 14 CLINICAL STUDIES HOW SUPPLIED/STORAGE AND HANDLING
- 17 PATIENT COUNSELING INFORMATION
 - 17.1 Nitrates17.2 Cardiovascular Considerations 17.3 Concomitant Use with Drugs Which Lower Blood Pressure
 - 17.4 Potential for Drug Interactions 17.5 Priapism
- 17.6 Vision 17.7 Sudden Hearing Loss 17.8 Alcohol
- 17.9 Sexually Transmitted Disease
- 17.11 Guanylate Cyclase (GC) Stimulators

*Sections or subsections omitted from the full prescribing information are not listed.

INDICATIONS AND USAGE

Based on individual efficacy and tolerability, the dose may be increased to 200 mg taken as early as approximately 15 minutes before sexual activity, or decreased to 50 mg taken approximately 30 minutes before sexual activity. The lowest dose that provides benefit

2.2 Use with Food

Interactions (7.1) and Clinical Pharmacology (12.2)].

For patients taking concomitant moderate CYP3A4 inhibitors (including erythromycin, amprenayir, aprepitant, diltiazem

DOSAGE FORMS AND STRENGTHS Avanafil tablets, 50 mg are white to off white, oval shape, biconvex tablets debossed with 'A41' on one side and 'H' on the other side

with its known effects on the nitric oxide/cyclic guanosine monophosphate (cGMP) pathway, avanafil has been shown to potentiate

Contraindications (4.1), Dosage and Administration (2.3), and Clinical Pharmacology (12.2)].

Do not use avanafil tablets in patients who are using a GC stimulator, such as riociguat or vericiguat. PDE5 inhibitors, including avanafil tablets may potentiate the hypotensive effects of GC stimulators.

Before prescribing avanafil, it is important to note the following:

information is available, avanafil is not recommended for the following groups

- Patients with resting hypotension (blood pressure less than 90/50 mmHg) or hypertension (blood pressure greater than
- Patients with unstable angina, angina with sexual intercourse, or New York Heart Association Class 2 or greater congestive heart

For patients taking concomitant strong CYP3A4 inhibitors (including ketoconazole, ritonavir, atazanavir, clarithromycin, indinavir, For patients taking concomitant moderate CYP3A4 inhibitors (including erythromycin, amprenavir, aprepitant, diltiazem, fluconazole, fosamprenavir, and verapamil), the maximum recommended dose of avanafil is 50 mg, not to exceed once every 24 hours [see Drug

5.4 Effects on Eye
Physicians should advise patients to stop use of all PDE5 inhibitors, including avanafil and seek medical attention in the event of a

cases per 100,000 in males aged ≥ 50 .

Neither the rare postmarketing reports, nor the association of PDE5 inhibitor use and NAION in the observational studies, substantiate Physicians should consider whether their patients with underlying NAION risk factors could be adversely affected by use of PDE5

Patients with known hereditary degenerative retinal disorders, including retinitis pigmentosa, were not included in the clinical trials for avanafil. and therefore, until further information is available, avanafil is not recommended for use in these patients.

arterial hypertensior

at and vericiguat, medicine that treat pulmonary onic-thromboembolic pulmonary hypertension.

Riocigua and chro

Ask your heal guanylate cyc

hcare provider or pharmacist if any of your medicines are nitrates ase stimulators.

you need healthcare

healthcare providers that you take avanafil tablets. If edical care for a heart problem, it will be important for your tow when you last took avanafil tablets.

healthcare

Tell all your

right away if you get symptoms such as . Sexual activity can put an extra strain on y weak from a heart attack or heart disease.

and get medical help riq s, or nausea during sex. 9 y if your heart is already v

zziness, oecially

and

sexual activity

M 0 0

5.5 Sudden Hearing Loss Use of PDE5 inhibitors has been associated with sudden decrease or loss of hearing, which may be accompanied by tinnitus or dizziness. It is not possible to determine whether these events are related directly to the use of PDE5 inhibitors or to other factors [see Adverse Reactions (6)]. Patients experiencing these symptoms should be advised to stop taking avanafil and seek prompt

5.6 Alpha-Blockers and Other Antihypertensives Physicians should discuss with patients the potential for avanafil to augment the blood pressure-lowering effect of alpha-blockers and other antihypertensive medications [see Drug Interactions (7.1) and Clinical Pharmacology (12.2)].

Caution is advised when PDE5 inhibitors are co-administered with alpha-blockers. Phosphodiesterase type 5 inhibitors, including avanafil, and alpha-adrenergic blocking agents are both vasodilators with blood pressure-lowering effects. When vasodilators are used in combination, an additive effect on blood pressure may be anticipated. In some patients, concomitant use of these two drug classes can lower blood pressure significantly leading to symptomatic hypotension (e.g., dizziness, lightheadedness, fainting)

Consideration should be given to the following:

• Patients should be stable on alpha-blocker therapy prior to initiating treatment with a PDE5 inhibitor. Patients who demonstrate hemodynamic instability on alpha-blocker therapy alone are at increased risk of symptomatic hypotension with concomitant use

In those patients who are stable on alpha-blocker therapy, PDE5 inhibitors should be initiated at the lowest dose (Avanafil 50 mg). In those patients already taking an optimized dose of a PDE5 inhibitor, alpha-blocker therapy should be initiated at the lowest

dose. Stepwise increase in alpha-blocker dose may be associated with further lowering of blood pressure when taking a PDE5 Safety of combined use of PDE5 inhibitors and alpha-blockers may be affected by other variables, including intravascular volume

depletion and other anti-hypertensive drugs [see Dosage and Administration (2) and Drug Interactions (7.1)] Patients should be made aware that both alcohol and PDE5 inhibitors including avanafil act as vasodilators. When vasodilators are taken in combination, blood-pressure-lowering effects of each individual compound may be increased. Therefore, physicians should inform patients that substantial consumption of alcohol (e.g., greater than 3 units) in combination with avanafil may increase the

potential for orthostatic signs and symptoms, including increase in heart rate, decrease in standing blood pressure, dizziness, and headache [see Drug Interactions (7.1) and Clinical Pharmacology (12.2)]. 5.8 Combination with Other PDE5 Inhibitors or Erectile Dysfunction Therapies

The safety and efficacy of combinations of avanafil with other treatments for ED has not been studied. Therefore, the use of such

5.9 Effects on Bleeding

The safety of avanafil is unknown in patients with bleeding disorders and patients with active peptic ulceration. In vitro studies with human platelets indicate that avanafil potentiates the anti-aggregatory effect of sodium nitroprusside (a nitric oxide [NO] donor). 5 10 Counseling Patients about Sexually Transmitted Diseases

The use of avanafil offers no protection against sexually transmitted diseases. Counseling patients about the protective measures necessary to guard against sexually transmitted diseases, including Human Immunodeficiency Virus (HIV), should be considered. ADVERSE REACTIONS

Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in practice Avanafil was administered to 2215 men during clinical trials. In trials of avanafil for use as needed, a total of 493 natients were exposed for greater than or equal to 6 months, and 153 patients were treated for greater than or equal to 12 months

years (range from 23 to 88 years). 83.9% of patients were White, 13.8% were Black, 1.4% Asian, and <1% Hispanic. 41.1% were current or previous smokers, 30.6% had diabetes mellitus. The discontinuation rate due to adverse reactions for patients treated with avanafil 50 mg, 100 mg, or 200 mg was 1.4%, 2%, and 2%, respectively, compared to 1.7% for placebo-treated patients.

In three randomized, double-blind, placebo-controlled trials lasting up to 3 months in duration, the mean age of patients was 56.4

Table 1 presents the adverse reactions reported when avanafil was taken as recommended (on an as-needed basis) from these 3

Table 1: Adverse Reactions Reported by Greater Than or Equal to 2% of Patients Treated with Avanafil From 3 Placebo-Controlle Clinical Trials Lasting 3 Months for Avanafil Use as Needed				
Adverse Reaction	Placebo (N = 349)	Avanafil 50 mg (N = 217)	Avanafil 100 mg (N = 349)	Avanafil 200 mg (N = 352)
Headache	1.7%	5.1%	6.9%	10.5%
Flushing	0%	3.2%	4.3%	4%
Nasal congestion	1.1%	1.8%	2.9%	2%
Nasopharyngitis	2.9%	0.9%	2.6%	3.4%

1.1% 3.2% 1.1% Back pain 2% Adverse reactions reported by greater than or equal to 1%, but less than 2% of patients in any avanafil dose group, and greater

nausea, constipation, and rash. In an open-label, long-term extension study of two of these randomized, double-blind, placebo-controlled trials, the total duration of treatment was up to 52 weeks. Among the 712 patients who participated in this open-label extension study, the mean age of the population was 56.4 years (range from 23 to 88 years). The discontinuation rate due to adverse reactions for patients treated with

In this extension trial, all eligible patients were initially assigned to avanafil 100 mg. At any point during the trial, patients could request to have their dose of avanafil increased to 200 mg or decreased to 50 mg based on their individual response to treatment. In total, 536 (approximately 75%) patients increased their dose to 200 mg and 5 (less than 1%) patients reduced their dose to 50 mg. Table 2 presents the adverse reactions reported when avanafil was taken as recommended (on an as-needed basis) in this open-labe

Table 2: Adverse Reactions Reported by Greater Than or Equal to 2% of Patients Treated With Avanafil in an Open-Label

Extension Irial			
Adverse Reaction	Avanafil (N = 711)		
Headache	5.6%		
Flushing	3.5%		
Nasopharyngitis	3.4%		
	0.404		

Adverse reactions reported by greater than or equal to 1%, but less than 2% of patients in the open-label extension study included upper respiratory infection (URI), influenza, sinusitis, bronchitis, dizziness, back pain, arthralgia, hypertension, and diarrhea. The following events occurred in less than 1% of patients in the three placebo-controlled 3-month clinical trials and/or the open-label long-term extension study lasting 12 months. A causal relationship to avanafil is uncertain. Excluded from this list are those events that were minor, those with no plausible relation to drug use and reports too imprecise to be meaningful.

Body as a whole — edema peripheral, fatique Cardiovascular — angina, unstable angina, deep vein thrombosis, palpitations

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"poppers" such as amyl nitrite and butyl r any of the ingredients in avanafil tablet. te list of ingredients in avanafil tablet. ed guanylate cyclase stimulators.

drugs called "pol c to avanafil or an t for a complete li nedicines called g

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Nervous — depression, insomnia, somnolence, vertigo

the adverse reactions reported in this additional study.

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avanafil (50 mg, 100 mg, or 200 mg) was 2.8%.

Digestive — gastritis, gastroesophageal reflux disease, hypoglycemia, blood glucose increased, alanine aminotransferase increased, oropharyngeal pain, stomach discomfort, vomiting Musculoskeletal — muscle spasms, musculoskeletal pain, myalgia, pain in extremity

Respiratory - cough, dyspnea exertional, epistaxis, wheezing Skin and Appendages — pruritus Urogenital — balanitis, erection increased, hematuria, nephrolithiasis, pollakiuria, urinary tract infection In an additional, randomized, double-blind, placebo-controlled study lasting up to 3 months in 298 men who had undergone bilateral

nerve-sparing radical prostatectomy for prostate cancer, the mean age of patients was 58.4 years (range 40 to 70). Table 3 presents

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nes called nitrates (see What is the most important information I should about avanafil tablets?)

nes called guanylate cyclase stimulators, such a riociguat or vericiguat (see s the most important information I should know about avanafil tablets?)

nes called HIV protease inhibitors.

ypes of oral antifungal medicines, such as ketoconazole, and itraconozale. ypes of antibiotics, such as ketoconazole, and itraconozale. ypes of antibiotics, such as called alpha blockers. These include terazosin, tamsulosin HCl, sin, prazosin HCl, alfuzosin HCl, dutasteride and tamsulosin HCl, or sin. Alpha-blockers are sometimes prescribed for prostate problems or lood pressure. In some patients, the use of avanafil tablet with alpha-res can lead to a drop in blood pressure or to fainting.

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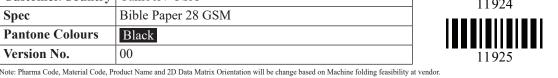
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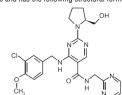


10 OVERDOSAGE Single doses up to 800 mg have been given to healthy subjects, and multiple doses up to 300 mg have been given to patients. In cases of overdose, standard supportive measures should be adopted as required. Renal dialysis is not expected to accelerate clearance because avanafil is highly bound to plasma proteins and is not significantly eliminated in the urine

11 DESCRIPTION

Avanafil is a selective inhibitor of cGMP-specific PDE5.

Avanafil is designated chemically as (S)-4-[(3-Chloro-4-methoxybenzyl)amino]-2-[2-(hydroxymethyl)-1-pyrrolidinyl]-N-(2pyrimidinylmethyl)-5-pyrimidinecarboxamide and has the following structural formula:



Avanafil occurs as an off-white to white powder, molecular formula C₂₂H₂₆CIN₂O₃ and molecular weight of 483.95 and is slightly soluble in methanol, ethanol and insoluble in water. Avanafil tablets, for oral administration, is supplied as oval, white to off white tablets containing 50 mg, 100 mg, or 200 mg avanafil. In addition to the active ingredient, avanafil, each tablet contains the following inactive ingredients: fumaric acid, hydroxyl propyl cellulose, low- substituted hydroxyl propyl cellulose, magnesium stearate

12 CLINICAL PHARMACOLOGY

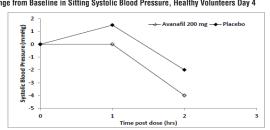
12.1 Mechanism of Action The physiologic mechanism of erection of the penis involves release of nitric oxide (NO) in the corpus cavernosum during sexual stimulation. NO then activates the enzyme guanylate cyclase, which results in increased levels of cGMP, producing smooth muscle relaxation in the corpus cavernosum and allowing inflow of blood. Avanafil has no direct relaxant effect on isolated human corpus relaxation in the corpus cavernosum and anyming inflow or broot. Available the leakant enter of instance inflored inflored course, or acavernosum, but enhances the effect of NO by inhibiting PDES, which is responsible for degradation of cGMP in the corpus cavernosum. Because sexual stimulation is required to initiate the local release of nitric oxide, the inhibition of PDE5 has no effect in the absence of sexual stimulation.

Studies *in vitro* have shown that avanafil is selective for PDE5. Its effect is more potent on PDE5 than on other known phosphodiesterases (greater than 100-fold for PDE6; greater than 1,000-fold for PDE4, PDE8 and PDE10; greater than 10,000-fold for PDE1, PDE3, PDE9, and PDE11). Avanafil is greater than 100-fold more potent for PDE5 than PDE6, which is found in the retina and is responsible for phototransduction. In addition to human corpus cavernosum smooth muscle, PDE5 is also found in other tissues including platelets, vascular and visceral smooth muscle, and skeletal muscle, brain, heart, liver, kidney, lung, pancreas, prostate, bladder, testis, and seminal vesicle. The inhibition of PDE5 in these tissues by avanafil may be the basis for the enhanced platelet anti-aggregatory activity of NO observed *in vitro* and peripheral vasodilatation *in vivo*.

Effects of Avanafil on Erectile Response In a single-blind, placebo-controlled, single-dose trial of 82 patients with either organic and/or psychogenic ED, visual sexual stimulation resulted in improved erections after avanafii administration compared to placebo, as assessed by an objective measurement of hardness and duration of erections (RigiScan®). Efficacy was assessed by RigiScan at discrete time intervals ranging from 20 to 40 minutes after dosing to 100 to 120 minutes after dosing.

Single oral doses of avanafil (200 mg) administered to healthy male volunteers resulted in mean changes from baseline in systolic/ diastolic blood pressure of -5.3/-3.7 mmHg at 1 hour after dosing, compared to mean changes from baseline in the placebo group of 2.7/-0.4 mmHg. The reductions in systolic/diastolic blood pressure at 1 hour after dosing of avanafil 200 mg compared to placebo

Figure 1: Median Change from Baseline in Sitting Systolic Blood Pressure. Healthy Volunteers Day 4



The effect of single 100 or 800 mg doses of avanafil on the QT interval were evaluated in a randomized, double-blind, placebo, and active (moxifloxacin) –controlled crossover study in 52 healthy male subjects aged 18 to 45 years. There were no significant effects of the 100 mg dose. The mean QTC (Fridericia QT correction) for avanafil 800 mg, relative to placebo was 9.4 milliseconds (two-sided 90% CI=7.2, 11.6). An 800 mg dose of avanafil (4 times the highest recommended dose) was chosen because this dose yields exposures greater than those observed upon co-administration of avanafil with strong CYP3A4 inhibitors. A double-blind, randomized, placebo- and active-controlled (moxifloxacin), thorough QT/QTc trial of avanafil (100 and 800 mg) in healthy male subjects demonstrated that avanafil (did not express any significant changes in QTC interval expression and proving the properties of the properties subjects demonstrated that avanafil did not cause any significant changes in QTc interval or ventricular repolarizations.

Effects of Avanafil on Blood Pressure When Administered with Nitrates In a clinical pharmacology trial, a single dose of avanafil 200 mg was shown to potentiate the hypotensive effect of nitrates. The use

of avanafil in patients taking any form of nitrates is contraindicated [see Contraindications (4.1)]. A trial was conducted to assess the degree of interaction between nitroglycerin and avanafil, should nitroglycerin be required in an emergency situation after avanafil was taken. This was a single-center, double-blind, randomized, 3-way crossover trial of healthy males from 30 to 60 years of age. Subjects were divided among 5 trial groups with the trial group being determined by the time interval between treatment with trial drug and glyceryl trinitrate administration. Subjects were assigned to trial groups sequentially and hemodynamic results from the previous group were reviewed for serious adverse events (SAEs) before the next group received treatment. Each subject was dosed with all 3 study drugs (avanafil 200 mg, sildenafil citrate 100 mg, and placebo) in random order. Subjects were administered a single dose of 0.4 mg sublingual nitroglycerin (NTG) at pre-specified time points, following their dose of trial drug (0.5, 1, 4, 8 or 12 hours). Overall, 14 (15%) subjects treated with placebo and 28 (28%) subjects treated with avanafil, had clinically significant decreases in standing SBP, defined as greater than or equal to 30 mmHg decrease in SBP, after glyceryl trinitrate tion. Mean maximum decreases are shown in Table 5.

Table 5: Mean Maximum Decreases from Baseline in Sitting and Standing Systolic Blood Pressure/Diastolic Blood Pressure

(IIIIIII) Tollowing Flacebo of 200 mg Avanam with 0.4 mg Submigual Introgrycerin		
Placebo with nitroglycerin Sitting Standing	13.4/11.8 21.1/16.5	
Avanafil with nitroglycerin Sitting Standing	21.6/18.2 28.0/23.5	

Like other PDE5 inhibitors, avanafil administration with nitrates is contraindicated. In a patient who has taken avanafil, where nitrate administration is deemed medically necessary in a life threatening situation, at least 12 hours should elapse after the last dose of avanafil before nitrate administration is considered. In such circumstances, nitrates should still only be administered under close with appropriate hemodynamic monitoring [see Contraindications (4.1)]

Effects of Avanafil on Blood Pressure When Administered with Alpha-Blockers

A single-center, randomized, double-blinded, placebo-controlled, two-period crossover trial was conducted to investigate the potential interaction of avanafil with alpha-blocker agents in healthy male subjects which consisted of two cohorts: Cohort A (N=24): Subjects received oral doses of doxazosin once daily in the morning at 1 mg for 1 day (Day 1), 2 mg for 2 days (Days 2 to 3), 4 mg for 4 days (Days 4 to 7), and 8 mg for 11 days (Days 8 to 18). On Days 15 and 18, the subjects also received a single 2 to 3), 4 fing for a days (eds) at 07), and only first days (eds) of 100. In 233 to and 10, the subjects also sub

(T_{max} ~2 hours) and avanafil (T_{max} ~0.7 hours) would reach their peak plasma concentrations at the same time Cohort B (N=24): Subjects received 0.4 mg daily oral doses of tamsulosin in the morning for 11 consecutive days (Days 1 to 11). On Days 8 and 11, the subjects also received a single oral dose of either 200 mg avanafil or placebo, according to the treatment mization code. The avanafil or placebo doses were administered 3.3 hours after the tamsulosin administration on Days 8 and 11. The co-administration was designed so that tamsulosin (Tmax ~4 hours) and avanafil (Tmax ~0.7 hours) would reach their peak

Supine and sitting BP and pulse rate measurements were recorded before and after avanafil or placebo dosing.

A total of seven subjects in Cohort A (doxazosin) experienced potentially clinically important absolute values or changes from baseline A total of seven supplieds in control in (doxazosin) experienced potentially clinically inflored absolute values of changes from baseline in standing SBP or DBP. Three subjects experienced standing SBP values less than 85 mmHg. One subject experienced a decrease from baseline in standing SBP greater than 30 mmHg following avanafil. Two subjects experienced standing DBP values less than 45 mmHg following avanafil. Four subjects experienced decreases from baseline in standing DBP greater than 20 mmHg following avanafil. One subject experienced such decreases following placebo. There were no severe adverse events related to hypotension

reported during the trial. There were no cases of syncope. A total of five subjects in Cohort B (tamsulosin) experienced potentially clinically important absolute values or changes from baseline in standing SBP or DBP. Two subjects experienced standing SBP values less than 85 mmHg following avanafil. One subject experienced a decrease from baseline in standing SBP greater than 30 mmHg following avanafil. Two subjects experienced standing SBP greater than 30 mmHg following avanafil. DBP values less than 45 mmHg following avanafil. Four subjects experienced decreases from baseline in standing DBP greater than 20 mmHg following avanafil; one subject experienced such decreases following placebo. There were no severe adverse events related to hypotension reported during the trial. There were no cases of syncope.

Table 6 presents the placebo-subtracted mean maximum decreases from baseline (95% CI) in systolic blood pressure results for the 24 subjects who received avanafil 200 mg and matching placebo.

Table 6: Placebo-Subtracted Mean (95% CI) Maximum Decreases from Baseline in Standing and Supine Systolic Blood Pressure

nmHg) with 200 mg Avanatii				
Doxazosin Supine Standing	-6 (-9.1, -2.9) -2.5 (-6.5, 1.5)			
Tamsulosin				
Supine Standing	-3.1 (-6.4, 0.1) -3.6 (-8.1, 0.9)			

Blood pressure effects (standing SBP) in normotensive men on stable dose doxazosin (8 mg) following administration of avanafil 200 mg or placebo, are shown in Figure 2. Blood pressure effects (standing SBP) in normotensive men on stable dose tamsulosin (0.4 mg) following administration of avanafil 200 mg or placebo are shown in Figure 3.

Figure 2: Mean (SD) Change From Baseline in Standing Systolic Blood Pressure Over Time Following Administration of a Single

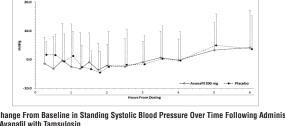
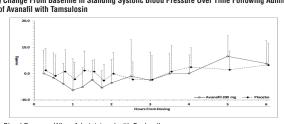


Figure 3: Mean (SD) Change From Baseline in Standing Systolic Blood Pressure Over Time Following Administration of a Single Dose 200 mg Dose of Avanafil with Tamsulosin



Effects of Avanafil on Blood Pressure When Administered with Enalapril
A trial was conducted to assess the interaction of enalapril (20 mg daily) and avanafil 200 mg. Single doses of 200 mg avanafil co-administered with enalapril caused a mean maximum decrease in supine systolic/diastolic blood pressure of 1.8/3.5 mmHg (compared to placebo), accompanied by a mean maximum increase in pulse rate of 1.0 bpm.

Effects of Avanafil on Blood Pressure When Administered with Amlodipine A trial was conducted to assess the interaction of amlodipine (5 mg daily) and avanafil 200 mg. Single doses of 200 mg avanafil co-administered with amlodipine caused a mean maximum decrease in supine systolic blood pressure of 1.2 mmHg (compared

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What should I avoid while taking avanafil tablets?
 Do not drink too much alcohol when taking avanafil tablets (for example, 3 glasses of wine, or 3 shots of whiskey). Drinking too much alcohol when taking avanafil tablets can increase your chances of increasing your heart rate, lowering your blood pressure, dizziness or getting a headache.

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icare provider may change your dose if needed. take the lowest dose of avanafil tablets that works for you. Yocare provider should decide about the lowest dose of avanafil for you.

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Take avanafil tablets exactly as your healthcare provider tells your healthcare provider will tell you how much avanafil table when to take it.
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Take avanafil tablets 50 mg as early as 30 minutes before sexu. Do not take avanafil tablets more than 1 time a day.
Some form of sexual stimulation is needed for an erection taking avanafil tablets.
Your healthcare provider may change your dose if needed.
You should take the lowest dose of avanafil tablets that works for you.
Avanafil tablets may be taken with or without food.
If you take too much avanafil, call your healthcare provider or ghospital emergency room right away.

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to placebo), accompanied by a mean maximum increase in pulse rate of 1.0 bpm; the mean maximum decrease in diastolic blood pressure was less than that observed in the placebo group. There was no effect of avanafil on amlodipine plasma concentrations. Concomitant amlodipine was associated with 22% and 70% increases in avanafil C_{max} and AUC, respectively.

Effects of Avanafil on Blood Pressure When Administered with Alcohol

Alcohol and PDE5 inhibitors, including avanafil, are mild systemic vasodilators. The interaction of avanafil with alcohol was evaluated in a clinical pharmacology trial. Alcohol was administered at a dose of 0.5 g/kg, which is equivalent to approximately 3 ounces of 80-proof vodka in a 70-kg male, and avanafil was administered at a dose of 200 mg. All patients consumed the entire alcohol dose within 15 minutes of starting. Blood alcohol levels of 0.057% were confirmed. There were no reports of orthostatic hypotension or dizziness. Additional maximum supine systolic/diastolic blood pressure decreases of 3.5/4.5 mmHg and additional maximum pulse rate increase of 9.3 bpm were observed when avanafil was taken with alcohol compared to alcohol alone. Avanafil did not affect alcohol plasma concentrations.

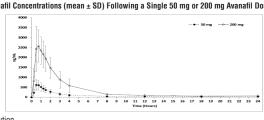
Effects of Avanafil on Spermatogenesis

The effect of avanafil on spermatogenesis was assessed in 181 healthy male volunteers who received avanafil 100 mg or placebo daily for 26 weeks. The results of this randomized, double-blind, placebo-controlled study in 137 subjects who completed the study through Week 26 and provided 2 semen samples at baseline and at Week 26 showed no adverse effects of avanafil on sperm concentration, total sperm count, sperm motility, sperm normal morphology, and semen volume.

Single oral doses of Type 5 phosphodiesterase inhibitors have demonstrated transient dose-related impairment of color discrimination (blue/green), using the Farnsworth-Munsell 100-hue test, with peak effects near the time of peak plasma levels. This finding is consistent with the inhibition of PDE6, which is involved in phototransduction in the retina.

Mean avanafil plasma concentrations measured after the administration of a single oral dose of 50 or 200 mg to healthy male volunteers are depicted in Figure 4. The pharmacokinetics of avanafil are dose proportional from 12.5 to 600 mg.

Figure 4: Plasma Avanafil Concentrations (mean ± SD) Following a Single 50 mg or 200 mg Avanafil Dose



Absorption and Distribution

Avanafil is rapidly absorbed after oral administration, with a median T_{max} of 30 to 45 minutes in the fasted state. When avanafil (200 mg) is taken with a high fat meal, the rate of absorption is reduced, with a mean delay in Tmax of 1.12 to 1.25 hours and a mean reduction in C_{max} of 39% (200 mg). There was an approximate 3.8% decrease in AUC. The small changes in avanafil C_{max} and AUC are considered of minimal clinical significance; therefore, avanafil may be administered with or without food. The mean accumulation ratio is approximately 1.2. Avanafil is approximately 99% bound to plasma proteins. Protein binding is independent of total drug concentrations, age, renal and hepatic function.

Based upon measurements of avanafil in semen of healthy volunteers 45 to 90 minutes after dosing, less than 0.0002% of the administered dose appeared in the semen of patients.

Avanafil is cleared predominantly by hepatic metabolism, mainly by the CYP3A4 enzyme and to a minor extent by CYP2C isoform. The plasma concentrations of the major circulating metabolites, M4 and M16, are approximately 23% and 29% that of the parent compound, respectively. The M4 metabolite has an *in vitro* inhibitory potency for PDE5 18% of that of avanafil and M4 accounts for approximately 4% of the pharmacologic activity of avanafil. The M16 metabolite was inactive against PDE5.

Avanafil was extensively metabolized in humans. After oral administration, avanafil is excreted as metabolites predominantly in the feces (approximately 62% of administered oral dose) and to a lesser extent in the urine (approximately 21% of the administered oral dose). Avanafil has a terminal elimination half-life of approximately 5 hours.

The pharmacokinetics of a single 200 mg avanafii administered to fourteen healthy elderly male volunteers (65 to 80 years) and eighteen healthy younger male volunteers (18 to 43 years of age) were compared. AUCo to lift increased by 6.8% and Cmax decreased by 2.1% in the elderly group, compared to the younger group. However, greater sensitivity to medications in some older individuals

Renal Impairment

The pharmacokinetics of a single 200 mg avanafil administered to nine patients with mild (creatinine clearance greater than or equal to 60 and less than 90 mL/min) and to ten patients with moderate (creatinine clearance greater than or equal to 30 to less than 60 mL/ min) renal impairment were evaluated. AUC $_{0.00}$ in decreased by 2.9% and C_{max} increased by 2.8% in patients with mild renal impairment. compared to healthy volunteers with normal renal function. AUCo to limit increased by 9.1% and Cmax decreased by 2.8% in patients with moderate renal impairment, compared to healthy volunteers with normal renal function. There is no data available for subjects with severe renal insufficiency or end-stage renal disease on hemodialysis [see Use in Specific Populations (8.6)].

The pharmacokinetics of a single 200 mg avanafil administered to eight patients with mild hepatic impairment (Child-Pugh A) and

eight patients with moderate hepatic impairment (Child-Pugh B) were evaluated. AUCo to inf increased by 3.8% and Cmax decreased by 2.7% in patients with mild hepatic impairment, compared to healthy volunteers with normal hepatic function. AUC_{0 to inf} increased by 11.2% and C_{max} decreased by 51% in patients with moderate hepatic impairment, compared to healthy volunteers with normal hepatic function. There is no data available for subjects with severe hepatic impairment (Child-Pugh Class C) [see Use in Specific Populations (8.7)].

Drug Interaction Studies

Clinical Studies Effect of CYP3A4 Inhibitors on Avanafil: Strong and moderate CYP3A4 inhibitors increase plasma concentrations of avanafil. The effect of strong CYP3A4 inhibitors, ketoconazole and ritonavir, and moderate CYP3A4 inhibitor, erythromycin, on avanafil pharmacokinetics was studied in an open-label, randomized, one-sequence crossover, three-way parallel study

Moderate CYP3A4 Inhibitors

Fifteen healthy male volunteers received 400 mg ketoconazole (2 tablets containing 200 mg ketoconazole) once daily for 5 days (Days 2 to 6) and a single 50 mg avanafil on Days 1 and 6. Twenty-four hour pharmacokinetics of avanafil on Days 1 and 6 were compared Co-administration with the strong CYP3A4 inhibitor ketoconazole resulted in an approximate 13-fold increase in AUC to inf and 3.1-fold increase in C_{max}. Fourteen healthy male volunteers received 300 mg ritonavir (3 tablets containing 100 mg ritonavir) twice daily for 1 day (Day 2), 400 mg twice daily for 1 day (Day 3), 600 mg twice daily for 5 days (Days 4 to 8), and a single 50 mg avanafil on Days 1 and 8. Twenty-four hour pharmacokinetics of avanafil on Days 1 and 8 were compared. Co-administration with the strong CYP3A4 inhibitor ritonavir resulted in an approximate 13-fold increase in AUCo to lim and 2.4-fold increase in C_{max} of avanafil.

Fifteen healthy male volunteers received 500 mg erythromycin (2 tablets containing 250 mg erythromycin) every 12 hrs for 5 days (Days 2 to 6) and a single 200 mg avanafil (2 tablets containing 100 mg avanafil) on Days 1 and 6. Twenty-four hour pharmacokinetics of avanafil on Days 1 and 6 were compared. Co-administration with the moderate CYP3A4 inhibitor erythromycin resulted in an approximate 3.6-fold increase in AUCo to an and 2-fold increase in C_{max} of avanafil.

Effect of Avanafil on Other Drugs.

The effect of avanafil on warfarin pharmacokinetics and pharmacodynamics was evaluated in a double-blind, randomized, placebo controlled, two-way crossover study. Twenty-four healthy male volunteers were randomized to receive either 200 mg avanafil or matching placebo for 9 days. On Day 3 of each period, volunteers received a single 25 mg warfarin. Pharmacokinetics of R- and S-warfarin, PT, and INR prior to warfarin dosing and up to 168 hrs after warfarin administration were compared. Platelet aggregation prior to warfarin dosing and up to 24 hrs after warfarin administration were compared. PT, INR, and platelet aggregation did not change with avanafil administration; 23.1 sec. 2.2, and 75.5%, respectively. Co-administration with avanafil resulted in an approximate increase in AUCo to inf and 5.2% decrease in Cmax of S-warfarin

Omeprazole, Rosiglitazone, and Desipramine

The effect of avanafil on the pharmacokinetics of omeprazole (a CYP2C19 substrate), rosiglitazone (a CYP2C8 substrate), and desipramine (a CYP2D6 substrate) was evaluated in an open-label, three cohort, crossover study. Nineteen healthy male volunteers received a single 40 mg omeprazole delaved-release capsule once daily for 8 days (Days 1 to 8), and a single 200 mg ayanafil on Day 8. Twelve hour pharmacokinetics of omeprazole on Days 7 and 8 were compared. Co-administration with avanafil resulted in an approximate 5.9% increase in AUC_{10 bit} and 8.6% increase in C_{max} of omeprazole. Twenty healthy male volunteers received a single 8 mg rosiglitazone tablet then a single 200 mg avanafil. Twenty-four hour pharmacokinetics of rosiglitazone with and without avanafil were compared. Co-administration with avanafil resulted in an approximate 2% increase in AUCo to mf and 14% decrease in C_{max} of rosiglitazone. Twenty healthy male volunteers received a single 50 mg desipramine tablet then a single 200 mg avanafil tablet 2 hours after desipramine. Ninety-six hour pharmacokinetics of desipramine with and without avanafil were compared. Co-administration with avanafil resulted in an approximate 5.7% increase in ALICo to int and 5.2% increase in Come of designamine

Avanafil had no effect on CYP1A1/2, 2A6, 2B6 and 2E1 (IC50 greater than 100 micromolar) and weak inhibitory effects toward other isoforms (CYP2C8, 2C9, 2C19, 2D6, 3A4). Major circulating metabolites of avanafii (M4 and M16) had no effect on CYPs 1A, 2A6, 2B6, 2C8, 2C9, 2C19, 2D6, 2E1 and 3A4. Avanafii and its metabolites (M4 and M16) are unlikely to cause clinically significant

inhibition of CYPs 1A, 2A6, 2B6, 2C8, 2C9, 2C19, 2D6, 2E1 or 3A4.

13 NONCLINICAL TOXICOLOGY 13.1 Carcinogenesis, Mutagenesis and Impairment of Fertility

Carcinogenesis

Avanafil was not carcinogenic to CD-1 mice when administered daily at doses of 100, 200, or 600 mg/kg/day orally by gavage for at least 98 weeks (approximately 11 times the MRHD on an AUC basis) or to Sprague Dawley rats when administered daily at doses of 100, 300, or 1000 mg/kg/day orally by gavage for at least 100 weeks (approximately 8 times for males and 34 times for females above the MRHD on an AUC basis)

Avanafil was not genotoxic in a series of tests. Avanafil was not mutagenic in Ames assays. Avanafil was not clastogenic in chromosome aberration assays using Chinese hamster ovary and lung cells, or *in vivo* in the mouse micronucleus assay. Avanafil did not affect DNA repair when tested in the rat unscheduled DNA synthesis assay.

In a rat fertility and early embryonic development study administered 100, 300, or 1000 mg/kg/day for 28 days prior to pairing and continued until euthanasia for males, and 14 days prior to pairing to gestation day 7 for females, a decrease in fertility, no or reduced sperm motility, altered estrous cycles, and an increased percentage of abnormal sperm (broken sperm with detached heads) occurred at exposures in males approximately 11 times the human exposure at a dose of 200 mg. The altered sperm effects were reversible at the end of a 9-week drug-free period. Systemic exposure at the NOAEL (300 mg/kg/day) was comparable to the human AUC at

13.2 Animal Toxicology and/or Pharmacology Repeated oral administration of avanafil in multiple species resulted in signs of centrally-mediated toxicity including ataxia, tremor, convulsion, hypoactivity, recumbency, and/or prostration at doses resulting in exposures approximately 5 to 8 times the MRHD based

an erection that will not go away (priapism). If you have an erection that lasts more than 4 hours, get medical help right away. If it is not treated right away, priapism can permanently damage your penis.
sudden vision loss in 1 or both eyes. Sudden vision loss in 1 or both eyes can be a sign of a serious eye problem called non-arteritic anterior ischemic optic neuropathy (NAION). It is uncertain whether PDE5 inhibitors such as avanafil tablets, directly cause vision loss. Stop taking avanafil tablets and call your healthcare provider right away if you have sudden vision loss in 1 or both eyes.
sudden hearing decrease or hearing loss. Some people may also have ringing in their ears (tinnitus) or dizziness.

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on C_{max} and 8 to 30 times the MRHD based on AUC.

14 CLINICAL STUDIES Avanafil was evaluated in four randomized, double-blind, placebo-controlled, parallel trials of 2 to 3 months in duration. Avanafil was taken as needed at doses of 50 mg, 100 mg, and 200 mg (Study 1) and 100 mg and 200 mg (Study 2 and Study 4). Patients were instructed to take 1 dose of study drug approximately 30 minutes (Study 1 and Study 2) or approximately 15 minutes (Study 4) prior to initiation of sexual activity. Food and alcohol intake was not restricted

In addition, a subset of patients from 2 of these trials were enrolled into an open-label extension trial. In the open-label extension trial, all eligible patients were initially assigned to avanafil 100 mg. At any point during the trial, patients could request to have their dose of afil increased to 200 mg or decreased to 50 mg based on their individual response to treat The 3 primary outcome measures in Studies 1, 2 and 3 were the erectile function domain of the International Index of Erectile Function (IIEF) and Questions 2 and 3 from Sexual Encounter Profile (SEP). The IIEF is a 4-week recall questionnaire that was administered

at baseline and at 4-week intervals during treatment. The IIEF erectile function domain has a 30-point total score, where the higher scores reflect better erectile function. The SEP included diary-based measures of erectile function. Patients recorded information regarding each sexual attempt made throughout the trial. Question 2 of the SEP asks "Were you able to insert your penis into your partner's vagina?" Question 3 of the SEP asks "Did your erection last long enough for you to have successful intercourse In Study 4, the primary efficacy variable was the per-subject proportion of sexual attempts that had an erectogenic effect within approximately 15 minutes following dosing, where an erectogenic effect was defined as an erection sufficient for vaginal penetration

and that enabled satisfactory completion of sexual intercourse Results are shown from the two, Phase 3, randomized, double-blind, placebo-controlled, parallel studies, one in the general ED population (Study 1), another in the diabetic population with ED (Study 2).

Avanafil was evaluated in 646 men with ED of various etiologies (organic, psychogenic, mixed), in a randomized, double-blinded

parallel, placebo controlled fixed dose trial of 3 months duration. The mean age was 55.7 years (range 23 to 88 years). The population was 85.6% White, 13.2% Black, 0.9% Asian, and 0.3% of other races. The mean duration of ED was approximately 6.5 years. Avanafil at doses of 50 mg, 100 mg, and 200 mg demonstrated statistically significant improvement in all 3 primary efficacy variables relative

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Table 7: Mean Change From Baseline for Primary Efficacy Variables in General ED Population (Study 1)

	Placebo (N=155)	Avanafil 50 mg (N=154)	Avanafil 100 mg (N=157)	Avanafil 200 mg (N=156)
IIEF EF Domain Score				
Endpoint	15.3	18.1	20.9	22.2
Change from baseline [†]	2.9	5.4	8.3	9.5
p-value*		0.0014	<0.0001	<0.0001
Vaginal Penetration (SEP2)				
Endpoint	53.8%	64.3%	73.9%	77.3%
Change from baseline [†]	7.1%	18.2%	27.2%	29.8%
p-value*	-	0.0009	<0.0001	<0.0001
Successful Intercourse (SEP3)				
Endpoint	27%	41.3%	57.1%	57%
Change from baseline [†]	14.1%	27.8%	43.4%	44.2%
p-value*	-	0.0002	<0.0001	<0.0001

† least-squares estimate from ANCOVA model * comparison to placebo for change from baseline

Results in the ED Population with Diabetes Mellitus (Study 2)

Avanafil was evaluated in ED patients (n=390) with type 1 or type 2 diabetes mellitus in a randomized, double-blind, parallel, placebo controlled fixed dose trial of 3 months in duration. The mean age was 58 years (range 30 to 78 years). The population was 80.5% White, 17.2% Black, 1.5% Asian, and 0.8% of other races. The mean duration of ED was approximately 6 years. In this trial, avanafil at doses of 100 mg and 200 mg demonstrated statistically significant improvement in all 3 primary efficacy variables as measured by the erectile function domain of the IIEF questionnaire; SEP2 and SEP3 (see Table 8).

Table 8: Mean Change From Baseline for Primary Efficacy Variables in ED Population with Diabetes Mellitus (Study 2)

	(N=127)	Avanatil 100 mg (N=126)	Avanatil 200 mg (N=126)
IIEF EF Domain Score			
Endpoint	13.2	15.8	17.3
Change from baseline [†]	1.8	4.5	5.4
p-value*	-	0.0017	<0.0001
Vaginal Penetration (SEP2)			
Endpoint	42%	54%	63.5%
Change from baseline [†]	7.5%	21.5%	25.9%
p-value*	-	0.0004	<0.0001
Successful Intercourse (SEP3)			
Endpoint	20.5%	34.4%	40%
Change from baseline [†]	13.6%	28.7%	34%
p-value*	-	<0.0001	<0.0001

† least-squares estimate from ANCOVA model * comparison to placebo for change from baselin

Time to Onset of Effect (Study 4) Avanafil was evaluated in 440 subjects with ED including diabetics (16.4%) and subjects with severe ED (41.4%) in a randomized double-blind, parallel, placebo-controlled study of 2 months duration. The mean age was 58.2 years (range 24 to 86 years). The population was 75.7% White, 21.4% Black, 1.6% Asian, and 1.4% of other races. Subjects were encouraged to attempt intercourse approximately 15 minutes after dosing and used a stopwatch for measurement of time to onset of effect, defined as the time to the first occurrence of an erection sufficient for sexual intercourse.

Avanafil 100 mg and 200 mg demonstrated statistically significant improvements relative to placebo in the primary efficacy variable percentage of all attempts resulting in an erection sufficient for penetration at approximately 15 minutes after dosing followed by successful intercourse (SEP3) (see Table 10

Table 10: Percentage of All Attempts Resulting in an Erection Sufficient for Penetration at Approximately 15 minutes After Dosing

ronowed by Successial intercourse (SEFS) During the o-week freathlent Feriod in the Time to Oliset of Effect (Study 4)				
	Placebo (N=136)	Avanafil 100 mg (N=139)	Avanafil 200 mg (N=139)	
Percentage of Successful Intercourse (SEP3)				
Mean	14.9	25.9	29.1	
Median	0	11.1	13.3	
p-value*	-	0.001	<0.001	

* comparison to placebo using rank-ANCOVA model HOW SUPPLIED/STORAGE AND HANDLING Avanafil tablets, 50 mg are white to off white, oval shape, biconvex tablets debossed with 'A41' on one side and 'H' on the other side. They are supplied as

Bottle of 100 tablets NDC 31722-440-01

Avanafil tablets, 100 mg are white to off white, oval shape, biconvex tablets debossed with 'A42' on one side and 'H' on the other side. They are supplied as

NDC 31722-441-30 Bottle of 30 tablets Bottle of 100 tablets NDC 31722-441-01

Avanafil tablets, 200 mg are white to off white, oval shape, biconvex tablets debossed with 'A43' on one side and 'H' on the other side. They are supplied as

Bottle of 30 tablets NDC 31722-442-30

Store at controlled room temperature 25°C (77°F); excursions permitted to 15° to 30°C (59° to 86°F). Protect from light [see USP Controlled Room Temperature].

17 PATIENT COUNSELING INFORMATION Advise the patient to read the FDA-approved patient labeling (Patient Information).

Physicians should discuss with patients the contraindication of avanafil tablets with regular and/or intermittent use of organic nitrates

unsafe level, resulting in dizziness, syncope, or even heart attack or stroke. Physicians should discuss with patients the appropriate action in the event that they experience anginal chest pain requiring nitroglycerin following intake of avanafil tablets. In such a patient, who has taken avanafil tablets, where nitrate administration is deemed medically necessary in a life-threatening situation, at least 12 hours should elapse after the last dose of avanafil tablets before nitrate administration is considered. In such circumstances, nitrates should still only be administered under close medical supervision

with appropriate hemodynamic monitoring. Patients who experience anginal chest pain after taking avanafil tablets should seek immediate medical attention [see Contraindications (4.1) and Warnings and Precautions (5.1)].

Physicians should discuss with patients the potential cardiac risk of sexual activity in patients with preexisting cardiovascular risk factors. Patients who experience symptoms upon initiation of sexual activity should be advised to refrain from further sexual activity and should seek immediate medical attention [see Warnings and Precautions (5.1)].

17.3 Concomitant Use with Drugs Which Lower Blood Pressure

Physicians should advise patients of the potential for avanafil tablets to augment the blood pressure-lowering effect of alpha-blockers and other antihypertensive medications [see Warnings and Precautions (5.6), Drug Interactions (7.1), and Clinical Pharmacology

17.4 Potential for Drug Interactions
Patients should be advised to contact the prescribing physician if new medications that may interact with avanafil are prescribed by another healthcare provider.

There have been rare reports of prolonged erections greater than 4 hours and priapism (painful erections greater than 6 hours in duration) for this class of compounds. Priapism, if not treated promptly, can result in irreversible damage to the erectile tissue. Physicians should advise patients who have an erection lasting greater than 4 hours, whether painful or not, to seek emergency

Physicians should advise patients to stop use of all PDE5 inhibitors, including avanafil tablets, and seek medical attention in the event of a sudden loss of vision in one or both eyes. Such an event may be a sign of non-arteritic anterior ischemic optic neuropathy (NAION), a cause of decreased vision including permanent loss of vision that has been reported rarely in temporal association with the use of PDE5 inhibitors. Physicians should discuss with patients the increased risk of NAION in individuals who have already experienced NAION in one eye. Physicians should also discuss with patients the increased risk of NAION among the general population in patients with a "crowded" optic disc, although evidence is insufficient to support screening of prospective users of PDE5 inhibitor, including avanafil tablets, for these uncommon conditions [see Warnings and Precautions (5.4) and Adverse Reactions (6.2)]

Physicians should advise patients to stop taking PDE5 inhibitors, including avanafil tablets, and seek prompt medical attention in the event of sudden decrease or loss of hearing. Use of PDE5 inhibitors has been associated with sudden decrease or loss of hearing, which may be accompanied by tinnitus and dizziness. It is not possible to determine whether these events are related directly to the use of PDE5 inhibitors or to other factors [see Adverse Reactions (6)].

Patients should be made aware that both alcohol and PDE5 inhibitors including avanafil tablets act as mild vasodilators. When mild vasodilators are taken in combination, blood pressure-lowering effects of each individual compound may be increased. Therefore, physicians should inform patients that substantial consumption of alcohol (e.g., greater than 3 units) in combination with avanafil tablets can increase the potential for orthostatic signs and symptoms, including increase in heart rate, decrease in standing blood pressure, dizziness, and headache [see Warnings and Precautions (5.7) and Clinical Pharmacology (12.2)]. 17.9 Sexually Transmitted Disease

The use of avanafil tablets offers no protection against sexually transmitted diseases. Counseling of patients about the protective

measures necessary to guard against sexually transmitted diseases, including Human Immunodet Physicians should discuss with patients the appropriate use of avanafil tablets and its anticipated benefits. It should be explained that sexual stimulation is required for an erection to occur after taking avanafil tablets. Patients should be counseled regarding

the dosing of avanafil tablets. Inform patients that the recommended starting dose of avanafil tablets is 100 mg, taken as early as approximately 15 minutes before initiation of sexual activity. Based on efficacy and tolerability, the dose may be increased to 200 mg taken as early as approximately 15 minutes before sexual activity, or decreased to 50 mg taken approximately 30 minutes before sexual activity. The lowest dose that provides benefit should be used. Patients should be advised to contact their healthcare provider 17.11 Guanylate Cyclase (GC) Stimulators
Physicians should discuss with patients the contraindication of avanafil tablets with use of guanylate cyclase stimulators such as

riociguat or vericiguat [see Contraindications (4.3)]



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General information about the safe and effective use of avanafil tablets.

Medicines are sometimes prescribed for purposes other than those listed in a Patient Information leaflet. Do not use avanafil tablets for a condition for which it was not prescribed. Do not give avanafil tablets to other people, even if they have the same symptoms that you have. It may harm them. You can ask your healthcare provider or pharmacist for information about avanafil tablets that is written for health professionals.

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