BRIMOCOM Eye Drops (Brimonidine tartrate 0.2% + Timolol maleate 0.5%)

**Composition**

Each ml contains
- Brimonidine tartrate .................. 2 mg
- Timolol maleate equivalent to timolol... 5 mg
- Benzalkonium chloride as preservative...0.005% w/v
- Isotonic aqueous vehicle .................. q.s

**Dosage Form**

Eye drops

**Description**

BRIMOCOM is comprised of two components: brimonidine tartrate and timolol. Each of these two components decreases elevated intraocular pressure, whether or not associated with glaucoma. Elevated IOP is decreased by complementary mechanisms of action and the combined effect results in additional IOP reduction compared to either compound administered alone.

**Pharmacology**

**Pharmacodynamics**

Brimonidine tartrate/Timolol maleate ophthalmic solution is comprised of two components: brimonidine tartrate and timolol. Each of these two components decreases elevated intraocular pressure, whether or not associated with glaucoma. Elevated intraocular pressure is a major risk factor in the pathogenesis of optic nerve damage and glaucomatous visual field loss. The higher the level of intraocular pressure, the greater the likelihood of glaucomatous field loss and optic nerve damage.

Brimonidine tartrate/Timolol maleate ophthalmic solution is a selective alpha-2 adrenergic receptor agonist with a non-selective beta-adrenergic receptor inhibitor. Both brimonidine and timolol have a rapid onset of action, with peak ocular hypotensive effect seen at two hours post-dosing for brimonidine and one to two hours for timolol.

Brimonidine tartrate is an alpha-2 adrenergic receptor agonist that is 1000-fold more selective for the alpha-2 adrenoceptor than the alpha-1 adrenoreceptor. This selectivity results in no mydriasis and the absence of vasoconstriction in microvessels associated with human retinal xenografts.

Fluorophotometric studies in animals and humans suggest that brimonidine tartrate has a dual mechanism of action by reducing aqueous humor production and increasing uveoscleral outflow.

Timolol maleate is a beta₁ and beta₂ non-selective adrenergic receptor inhibitor that does not have significant intrinsic
sympathomimetic, direct myocardial depressant, or local anaesthetic (membrane-stabilizing) activity. Timolol lowers IOP by reducing aqueous humour formation. The precise mechanism of action is not clearly established, but inhibition of the increased cyclic AMP synthesis caused by endogenous beta-adrenergic stimulation is probable.

Clinical Effects
In three controlled, double-masked clinical studies, Brimonidine tartrate/Timolol maleate ophthalmic solution (twice daily) produced a clinically meaningful additive decrease in mean diurnal IOP compared with timolol (twice daily) and brimonidine (twice daily or three times a day) when administered as monotherapy.

In a study in patients whose IOP was insufficiently controlled following a minimal 3-week run-in on any monotherapy, additional decreases in mean diurnal IOP of 4.5, 3.3 and 3.5 mmHg were observed during 3 months of treatment for Brimonidine tartrate/Timolol maleate ophthalmic solution (twice daily), timolol (twice daily) and brimonidine (twice daily), respectively. In this study, at trough, a significant additional decrease in IOP could only be demonstrated on comparison with brimonidine but not with timolol, however a positive trend was seen with superiority at all other timepoints. In the pooled data of the other two trials statistical superiority versus timolol was seen throughout.

In addition, the IOP-lowering effect of Brimonidine tartrate/Timolol maleate ophthalmic solution was consistently non-inferior to that achieved by adjunctive therapy of brimonidine and timolol (all twice daily).

The IOP-lowering effect of Brimonidine tartrate/Timolol maleate ophthalmic solution has been shown to be maintained in double-masked studies of up to 12 months.

Pharmacokinetics
Absorption
Systemic absorption of brimonidine tartrate and timolol maleate was assessed in healthy volunteers and patients following topical dosing with Brimonidine tartrate/Timolol maleate ophthalmic solution. Normal volunteers dosed with one drop of Brimonidine tartrate/Timolol maleate ophthalmic solution twice daily in both eyes for seven days showed peak plasma brimonidine tartrate and timolol maleate concentrations of 30 pg/mL and 400 pg/mL, respectively. Plasma concentrations of brimonidine peaked at 1 to 4 hours after ocular dosing. Peak plasma concentrations of timolol occurred approximately 1 to 3 hours post-dose. In a crossover study of Brimonidine tartrate/Timolol maleate ophthalmic solution, brimonidine tartrate 0.2%, and timolol maleate 0.5% administered twice daily for 7 days in healthy volunteers, the mean brimonidine tartrate area-under-the-plasma-concentration-time curve (AUC) for Brimonidine tartrate/Timolol maleate ophthalmic solution was 128 ±61 pg-hr/mL versus 141 ±106 pg-hr/mL for the respective monotherapy treatments; mean C\text{max} values of brimonidine tartrate were comparable following Brimonidine tartrate/Timolol maleate ophthalmic solution treatment versus monotherapy (32.7 ±15.0 pg/mL versus 34.7 ±22.6 pg/mL, respectively). Mean timolol AUC for Brimonidine tartrate/Timolol maleate ophthalmic solution was similar to that of the respective monotherapy treatment (2919 ±1679 pg-hr/mL versus 2909 ±1231 pg-hr/mL, respectively); mean C\text{max} of timolol maleate was approximately 20% lower following Brimonidine tartrate/Timolol maleate ophthalmic solution treatment versus monotherapy.

In a parallel study in patients dosed twice daily with Brimonidine tartrate/Timolol maleate ophthalmic solution, twice daily with timolol maleate 0.5%, or three times daily with brimonidine tartrate 0.2%, one-hour post dose plasma concentrations of timolol maleate and brimonidine tartrate were approximately 30-40% lower with Brimonidine tartrate/Timolol maleate ophthalmic solution than their respective monotherapy values. The lower plasma brimonidine tartrate concentrations with Brimonidine tartrate/Timolol maleate ophthalmic solution appears to be due to twice-daily dosing for Brimonidine tartrate/Timolol maleate ophthalmic solution versus three-times dosing with brimonidine tartrate 0.2%.

Distribution
The protein binding of timolol maleate is approximately 60% and human plasma protein binding of brimonidine tartrate is approximately 29%. Brimonidine tartrate binds extensively and reversibly to melanin in ocular tissues without any
untoward effects. Accumulation does not occur in the absence of melanin.

**Metabolism**

Brimonidine tartrate is not metabolised to a great extent in human eyes. In humans, brimonidine tartrate is extensively metabolized by the liver. Timolol maleate is partially metabolized by the liver.

**Excretion**

In the crossover study in healthy volunteers, the plasma concentration of brimonidine tartrate declined with a systemic half-life of approximately 3 hours. The apparent systemic half-life of timolol maleate was about 7 hours after ocular administration.

Urinary excretion is the major route of elimination of brimonidine tartrate and its metabolites. Approximately 87% of an orally-administered radioactive dose of brimonidine tartrate was eliminated within 120 hours, with 74% found in the urine. Unchanged timolol maleate and its metabolites are excreted by the kidney.

### Indications

Brimonidine tartrate/timolol maleate ophthalmic solution is an alpha adrenergic receptor agonist with a beta adrenergic receptor inhibitor indicated for the reduction of elevated intraocular pressure (IOP) in patients with glaucoma or ocular hypertension who require adjunctive or replacement therapy due to inadequately controlled IOP; the IOP-lowering of Brimonidine tartrate/timolol maleate ophthalmic solution dosed twice a day was slightly less than that seen with the concomitant administration of 0.5% timolol maleate ophthalmic solution dosed twice a day and 0.2% brimonidine tartrate ophthalmic solution dosed three times per day.

### Dosage And Administration

The recommended dose in adults is one drop of Brimonidine tartrate/timolol maleate ophthalmic solution in the affected eye(s) twice daily, approximately 12 hours apart. If more than one topical ophthalmic product is to be used, the different products should be instilled at least 5 minutes apart.

As with any eye drops, to reduce possible systemic absorption, it is recommended that the lachrymal sac be compressed at the medial canthus (punctual occlusion) or eyelids are closed for two minutes. This should be performed immediately following the instillation of each drop. This may result in a decrease of systemic side effects and an increase in local activity.

### Contraindications

**Asthma, COPD**

Contraindicated in patients with bronchial asthma; a history of bronchial asthma; severe chronic obstructive pulmonary disease, with sinus bradycardia, second or third degree atrioventricular block not controlled with a pace-maker, sick sinus syndrome sino-atrial block, overt cardiac failure; cardiogenic shock.

Local hypersensitivity reactions have occurred following the use of different components of Brimonidine tartrate/Timolol maleate ophthalmic solution. Contraindicated in patients who have exhibited a hypersensitivity reaction to any component of this medication in the past.

Contraindicated in neonates and infants (less than 2 years of age). Patients receiving monoamine oxidase (MAO) inhibitor therapy.

Patients on antidepressants which affect noradrenergic transmission (e.g. tricyclic antidepressants and mianserin)
Warnings And Precautions

General
Brimonidine tartrate/Timolol maleate ophthalmic solution must be used with caution in patients with metabolic acidosis and untreated phaeochromocytoma.

Corneal Diseases
Ophthalmic beta-blockers may induce dryness of eyes. Patients with corneal diseases should be treated with caution. Children of 2 years of age and above, especially those in the 2-7 age range and/or weighing ≤20 Kg, should be treated with caution and closely monitored due to the high incidence and severity of somnolence. The safety and effectiveness of Brimonidine tartrate/timolol maleate ophthalmic solution in children and adolescents (2 to 17 years of age) have not been established.

Some patients have experienced ocular allergic type reactions (allergic conjunctivitis and allergic blepharitis) with Brimonidine tartrate/Timolol maleate ophthalmic solution in clinical trials. Allergic conjunctivitis was seen in 5.2% of patients. Onset was typically between 3 and 9 months resulting in an overall discontinuation rate of 3.1%. Allergic blepharitis was uncommonly reported (<1%). If allergic reactions are observed, treatment with Brimonidine tartrate/timolol maleate ophthalmic solution should be discontinued.

Delayed ocular hypersensitivity reactions have been reported with brimonidine tartrate ophthalmic solution 0.2%, with some reported to be associated with an increase in IOP.

Like other topically applied ophthalmic agents, Brimonidine tartrate/timolol maleate ophthalmic solution may be absorbed systemically. No enhancement of the systemic absorption of the individual active substances has been observed. Due to beta-adrenergic component, timolol, the same types of cardiovascular, pulmonary and other adverse reactions seen with systemic beta-adrenergic blocking agents may occur. Incidence of systemic undesirable effects after topical ophthalmic administration is lower than for systemic administration.

Brimonidine tartrate/timolol maleate ophthalmic solution has not been studied in patients with closed-angle glaucoma.

Choroidal Detachment
Choroidal detachment has been reported with administration of aqueous suppressant therapy (e.g. timolol, acetazolamide) after filtration procedures.

Surgical anaesthesia
Beta-blocking ophthalmological preparations may block systemic beta-agonist effects e.g. of adrenaline. The anaesthetist must be informed if the patient is receiving timolol maleate.

In patients with severe renal impairment on dialysis, treatment with timolol maleate has been associated with pronounced hypotension.

Brimonidine tartrate/Timolol maleate ophthalmic solution has minor influence on the ability to drive and use machines. Brimonidine tartrate/Timolol maleate ophthalmic solution may cause transient blurring of vision, visual disturbance, fatigue and/or drowsiness which may impair the ability to drive or operate machines. The patient should wait until these symptoms have cleared before driving or using machinery.

Potentiation of Respiratory Reactions Including Asthma
Brimonidine tartrate/timolol maleate ophthalmic solution contains timolol maleate; and although administered topically can be absorbed systemically. Therefore, the same types of adverse reactions found with systemic administration of beta-adrenergic blocking agents may occur with topical administration. For example, severe respiratory reactions including death due to bronchospasm in patients with asthma have been reported following systemic or ophthalmic administration of timolol maleate.

Cardiac Failure
Sympathetic stimulation may be essential for support of the circulation in individuals with diminished myocardial
contractility, and its inhibition by beta-adrenergic receptor blockade may precipitate more severe failure. In patients without a history of cardiac failure, continued depression of the myocardium with beta-blocking agents over a period of time can, in some cases, lead to cardiac failure. At the first sign or symptom of cardiac failure, Brimonidine tartrate/timolol maleate ophthalmic solution should be discontinued. In patients with cardiovascular diseases (e.g. coronary heart disease, Prinzmetal's angina and cardiac failure) and hypotension therapy with beta-blockers should be critically assessed and the therapy with other active substances should be considered. Patients with cardiovascular diseases should be watched for signs of deterioration of these diseases and of adverse reactions. Due to its negative effect on conduction time, beta-blockers should only be given with caution to patients with first degree heart block. As with systemic beta-blockers, if discontinuation of treatment is needed in patients with coronary heart disease, therapy should be withdrawn gradually to avoid rhythm disorders, myocardial infarct or sudden death.

Obstructive Pulmonary Disease
Patients with chronic obstructive pulmonary disease (e.g., chronic bronchitis, emphysema) of mild or moderate severity, bronchospastic disease, or a history of bronchospastic disease (other than bronchial asthma or a history of bronchial asthma, in which brimonidine tartrate/Timolol maleate ophthalmic solution is contraindicated should, in general, not receive beta-blocking agents, including brimonidine tartrate/timolol maleate ophthalmic solution. Potentiation of Vascular Insufficiency
Brimonidine tartrate/ timolol maleate ophthalmic solution may potentiate syndromes associated with vascular insufficiency. Brimonidine tartrate/ timolol maleate ophthalmic solution should be used with caution in patients with depression, cerebral or coronary insufficiency, severe peripheral circulatory disturbance/disorder s (severe form of Raynaud's disease or Raynaud's syndrome), orthostatic hypotension, or thromboangiitis obliterans.

Increased Reactivity to Allergens
While taking beta-blockers, patients with a history of atopy or a history of severe anaphylactic reactions to a variety of allergens may be more reactive to repeated accidental, diagnostic, or therapeutic challenge with such allergens. Such patients may be unresponsive to the usual doses of epinephrine used to treat anaphylactic reactions.

Potentiation of Muscle Weakness
Beta-adrenergic blockade has been reported to potentiate muscle weakness consistent with certain myasthenic symptoms (e.g., diplopia, ptosis, and generalized weakness). Timolol has been reported rarely to increase muscle weakness in some patients with myasthenia gravis or myasthenic symptoms.

Masking of Hypoglycemic Symptoms in Patients with Diabetes Mellitus
Beta-adrenergic blocking agents should be administered with caution in patients subject to spontaneous hypoglycemia or to diabetic patients (especially those with labile diabetes) who are receiving insulin or oral hypoglycemic agents. Beta-adrenergic receptor blocking agents may mask the signs and symptoms of acute hypoglycemia.

Masking of Thyrotoxicosis
Beta-adrenergic blocking agents may mask certain clinical signs (e.g., tachycardia) of hyperthyroidism. Patients suspected of developing thyrotoxicosis should be managed carefully to avoid abrupt withdrawal of beta-adrenergic blocking agents that might precipitate a thyroid storm.

Ocular Hypersensitivity
Ocular hypersensitivity reactions have been reported with brimonidine tartrate ophthalmic solutions 0.2%, with some reported to be associated with an increase in intraocular pressure.

Anaphylactic Reactions
While taking beta-blockers, patients with a history of atopy or a history of severe anaphylactic reaction to a variety of allergens may be more reactive to repeated challenge with such allergens and unresponsive to the usual dose of adrenaline used to treat anaphylactic reactions.
Contamination of Topical Ophthalmic Products After Use
There have been reports of bacterial keratitis associated with the use of multiple dose containers of topical ophthalmic products. These containers had been inadvertently contaminated by patients who, in most cases, had a concurrent corneal disease or a disruption of the ocular epithelial surface.

Impairment of Beta-adrenergically Mediated Reflexes During Surgery
The necessity or desirability of withdrawal of beta-adrenergic blocking agents prior to major surgery is controversial. Beta-adrenergic receptor blockade impairs the ability of the heart to respond to beta-adrenergically mediated reflex stimuli. This may augment the risk of general anesthesia in surgical procedures. Some patients receiving beta-adrenergic receptor blocking agents have experienced protracted severe hypotension during anesthesia. Difficulty in restarting and maintaining the heartbeat has also been reported. For these reasons, in patients undergoing elective surgery, some authorities recommend gradual withdrawal of beta-adrenergic receptor blocking agents. If necessary during surgery, the effects of beta-adrenergic blocking agents may be reversed by sufficient doses of adrenergic agonists.

Drug Interactions

Antihypertensives/Cardiac Glycosides
Because brimonidine tartrate/timolol maleate ophthalmic may reduce blood pressure, caution in using drugs such as antihypertensives and/or cardiac glycosides with brimonidine tartrate/timolol maleate ophthalmic solution is advised.

Beta-adrenergic Blocking Agents
Patients who are receiving a beta-adrenergic blocking agent orally and brimonidine tartrate/timolol maleate ophthalmic solution should be observed for potential additive effects of beta-blockade, both systemic and on intraocular pressure. The concomitant use of two topical beta-adrenergic blocking agents is not recommended.

Calcium Antagonists
Caution should be used in the co-administration of beta-adrenergic blocking agents, such as brimonidine tartrate/timolol maleate ophthalmic solution, and oral or intravenous calcium antagonists because of possible atrioventricular conduction disturbances, left ventricular failure, and hypotension. In patients with impaired cardiac function, co-administration should be avoided.

Catecholamine-depleting Drugs
Close observation of the patient is recommended when a beta blocker is administered to patients receiving catecholamine-depleting drugs such as chlorpromazine, methylphenidate and reserpine, because of possible additive effects and the production of hypotension and/or marked bradycardia, which may result in vertigo, syncope, or postural hypotension.

CNS Depressants
Although specific drug interaction studies have not been conducted with Brimonidine tartrate/timolol maleate ophthalmic solution, the possibility of an additive or potentiating effect with CNS depressants (alcohol, barbiturates, opiates, sedatives, or anesthetics) should be considered.

Digitalis and Calcium Antagonists
The concomitant use of beta-adrenergic blocking agents with digitalis and calcium antagonists may have additive effects in prolonging atrioventricular conduction time.

CYP2D6 Inhibitors
Potentiated systemic beta-blockade (e.g., decreased heart rate, depression) has been reported during combined treatment with CYP2D6 inhibitors (e.g., quinidine, fluoxetine, paroxetine, SSRIs) and timolol.

Tricyclic Antidepressants
Tricyclic antidepressants have been reported to blunt the hypotensive effect of systemic clonidine. It is not known
whether the concurrent use of these agents with Brimonidine tartrate/Timolol maleate ophthalmic solution in humans can lead to resulting interference with the IOP lowering effect. Caution, however, is advised in patients taking tricyclic antidepressants which can affect the metabolism and uptake of circulating amines.

Monoamine Oxidase Inhibitors
Monoamine oxidase (MAO) inhibitors may theoretically interfere with the metabolism of brimonidine tartrate and potentially result in an increased systemic side-effect such as hypotension. Caution is advised in patients taking MAO inhibitors which can affect the metabolism and uptake of circulating amines. There is a potential for additive effects resulting in hypotension, and/or marked bradycardia when ophthalmic beta-blockers solution is administered concomitantly with oral calcium channel blockers, , beta-adrenergic blocking agents, anti-arrhythmics (including amiodarone), digitalis glycosides, parasympathomimetics or guanethidine. Also, after the application of brimonidine, very rare (Mydriasis resulting from concomitant use of ophthalmic beta-blockers and adrenaline (epinephrine) has been reported occasionally. Beta-blockers may increase the hypoglycaemic effect of antidiabetic agents. Beta-blockers can mask the signs and symptoms of hypoglycaemia.
The hypertensive reaction to sudden withdrawal of clonidine can be potentiated when taking beta-blockers. Brimonidine tartrate is contraindicated in patients receiving monoamine oxidase (MAO) inhibitor therapy and patients on antidepressants which affect noradrenagic transmission (e.g. tricyclic antidepressants and miaserin). Patients who have been receiving MAOI therapy should wait 14 days after discontinuation before commencing treatment with Brimonidine tartrate/timolol maleate ophthalmic solution.
Concomitant use of a beta-blocker with anaesthetic drugs may attenuate compensatory tachycardia and increase the risk of hypotension and therefore the anaesthetist must be informed if the patient is using Brimonidine tartrate/timolol maleate ophthalmic solution.
Caution must be exercised if Brimonidine tartrate/timolol maleate ophthalmic solution is used concomitantly with iodine contrast products or intravenously administered lidocain.
Cimetidine, hydralazine and alcohol may increase the plasma concentrations of timolol.
Caution is advised when initiating (or changing the dose of) a concomitant systemic agent (irrespective of pharmaceutical form) which may interact with ß-adrenergic agonists or interfere with their activity i.e. agonists or antagonists of the adrenergic receptor e.g. (isoprenaline, prazosin).
Although specific drug interactions studies have not been conducted with Brimonidine tartrate/timolol maleate ophthalmic solution, the theoretical possibility of an additive IOP lowering effect with prostamides, prostaglandins, carbonic anhydrase inhibitors and pilocarpine should be considered.

Renal and Hepatic Impairment
Brimonidine tartrate/timolol maleate ophthalmic solution has not been studied in patients with hepatic or renal impairment. Therefore, caution should be used in treating such patients. A study of patients with renal failure showed that timolol maleate was not readily removed by dialysis. The effect of dialysis on brimonidine tartrate pharmacokinetics in patients with renal failure is not known.
Following oral administration of timolol maleate, the plasma half-life of timolol maleate is essentially unchanged in patients with moderate renal insufficiency.

Pregnancy
Pregnancy Category C
Since there are no adequate and well-controlled studies in pregnant women, Brimonidine tartrate/timolol maleate ophthalmic solution should be used during pregnancy only if the potential benefit to the mother justifies the potential
risk to the fetus.

Lactation

Timolol maleate is excreted in human milk. It is not known if brimonidine tartrate is excreted in human milk but is excreted in the milk of the lactating rat. Because of the potential for serious adverse reactions from Brimonidine tartrate/timolol maleate ophthalmic solution in nursing infants, a decision should be made whether to discontinue lactation or to discontinue the drug, taking into account the importance of the drug to the mother.

Pediatric Use

Brimonidine tartrate/timolol maleate ophthalmic solution is not recommended for use in children under the age of 2 years. During post-marketing surveillance, apnea, bradycardia, coma, hypotension, hypothermia, hypotonia, lethargy, pallor, respiratory depression, and somnolence have been reported in infants receiving brimonidine tartrate. The safety and effectiveness of Brimonidine tartrate/timolol maleate ophthalmic solution have been established in the age groups 2-16 years of age. Use of Brimonidine tartrate/timolol maleate ophthalmic solution in this age group is supported by evidence from adequate and well-controlled studies of Brimonidine tartrate/timolol maleate ophthalmic solution in adults with additional data from a study of the concomitant use of brimonidine tartrate ophthalmic solution 0.2% and timolol maleate ophthalmic solution in pediatric glaucoma patients (ages 2 to 7 years). In this study, brimonidine tartrate ophthalmic solution 0.2% was dosed three times a day as adjunctive therapy to beta-blockers. The most commonly observed adverse reactions were somnolence (50%-83% in patients 2 to 6 years) and decreased alertness. In pediatric patients 7 years of age or older (>20 kg), somnolence appears to occur less frequently (25%). Approximately 16% of patients on brimonidine tartrate ophthalmic solution discontinued from the study due to somnolence.

The safety and effectiveness of Brimonidine tartrate/timolol maleate ophthalmic solution in children and adolescents (2 to 17 years of age) have not been established and therefore, its use is not recommended in children or adolescents.

Geriatric Use

No overall differences in safety and effectiveness have been observed between elderly and adult patients.

Undesirable Effects

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

Brimonidine Tartrate/Timolol Maleate Ophthalmic Solution

In clinical trials of 12 months duration with Brimonidine tartrate/timolol maleate ophthalmic solution, the most frequent reactions associated with its use occurring in approximately 5% to 15% of the patients included: allergic conjunctivitis, conjunctival folliculosis, conjunctival hyperemia, eye pruritus, ocular burning, and stinging. The following adverse reactions were reported in 1% to 5% of patients: asthenia, blepharitis, corneal erosion, conjunctival oedema, asthenopia, papillary hypertrophy, conjunctival blanching, corneal oedema, corneal infiltrates depression, epiphora, eye discharge, eye dryness, eye irritation, eye pain, eyelid edema, eyelid erythema, eyelid pruritus, foreign body sensation, diarrhoea, headache, hypertension, oral dryness, somnolence, allergic contact dermatitis, superficial punctate keratitis, and visual disturbance.

Other adverse reactions that have been reported with the individual components are listed below-
Brimonidine Tartrate (0.1%-0.2%)

Abnormal taste, allergic reaction, blepharoconjunctivitis, blurred vision, bronchitis, cataract, conjunctival edema, conjunctival hemorrhage, conjunctivitis, cough, dizziness, dyspepsia, dyspnea, fatigue, flu syndrome, follicular conjunctivitis, erythema facial, gastrointestinal disorder, hypercholesterolemia, hypotension, infection (primarily colds and respiratory infections), iritis, iridocyclitis (anterior uveitis), miosis, hordeolum, insomnia, keratitis, lid disorder, nasal dryness, ocular allergic reaction, pharyngitis, photophobia, rash, rhinitis, sinus infection, sinusitis, taste perversion, tearing, visual field defect, vitreous detachment, vitreous disorder, vitreous floaters, and worsened visual acuity.

Timolol (Ocular Administration) (0.1%-0.2%)

Body as a whole: chest pain; Cardiovascular: Arrhythmia, bradycardia, cardiac arrest, cardiac failure, cerebral ischemia, congestive heart failure, cerebral vascular accident, claudication, cold hands and feet, edema, heart block, palpitation, pulmonary edema, chest pain, Raynaud's phenomenon, syncope, and worsening of angina pectoris; Digestive: Anorexia, diarrhea, nausea; Immunologic: Systemic lupus erythematosus; Nervous System/Psychiatric: Increase in signs and symptoms of myasthenia gravis, insomnia, nightmares, paresthesia, behavioral changes and psychic disturbances including confusion, hallucinations, anxiety, disorientation, nervousness, and memory loss; Skin: Alopecia, psoriasiform rash or exacerbation of psoriasis; Hypersensitivity: Signs and symptoms of systemic allergic reactions, including anaphylaxis, angioedema, urticaria, and generalized and localized rash; Respiratory: Bronchospasm (predominantly in patients with pre-existing bronchospastic disease), dyspnea, nasal congestion, cough, respiratory failure; Endocrine: Masked symptoms of hypoglycemia in diabetes; Special Senses: Diplopia, choroidal detachment following filtration surgery, cystoid macular edema, decreased corneal sensitivity, pseudopemphigoid, ptosis, refractive changes, tinnitus; Urogenital: Decreased libido, sexual dysfunction, impotence, Peyronie's disease, retroperitoneal fibrosis.

Postmarketing Experience

Brimonidine

The following reactions have been identified during post-marketing use of brimonidine tartrate ophthalmic solutions in clinical practice. Because they are reported voluntarily from a population of unknown size, estimates of frequency cannot be made. The reactions, which have been chosen for inclusion due to either their seriousness, frequency of reporting, possible causal connection to brimonidine tartrate ophthalmic solutions, or a combination of these factors, include: bradycardia, depression, iritis, keratoconjunctivitis sicca, miosis, nausea, skin reactions (including erythema, eyelid pruritus, rash, and vasodilation), and tachycardia. Apnea, bradycardia, cyanosis, hypotension, hypothermia, hypotonia, and somnolence have been reported in infants receiving brimonidine tartrate ophthalmic solutions. Oral Timolol/Oral Beta-blockers

The following additional adverse reactions have been reported in clinical experience with oral timolol maleate or other oral beta-blocking agents and may be considered potential effects of ophthalmic timolol maleate: Allergic: Erythematous rash, fever combined with aching and sore throat, laryngospasm with respiratory distress; Body as a whole: Decreased exercise tolerance, extremity pain, weight loss; Cardiovascular: Vasodilatation, worsening of arterial insufficiency; Digestive: Gastrointestinal pain, abdominal pain, hepatomegaly, ischemic colitis, mesenteric arterial thrombosis, vomiting; Hematologic: Agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura; Endocrine: Hyperglycemia, hypoglycemia; Skin: Increased pigmentation, pruritus, skin irritation, sweating; Musculoskeletal: Arthralgia, myalgia; Nervous System/Psychiatric: An acute reversible syndrome characterized by disorientation for time and place, decreased performance on neuropsychometrics, diminished concentration, emotional lability, local weakness, reversible mental depression progressing to catatonia, slightly clouded sensorium, vertigo, fatigue; Respiratory: Bronchial obstruction, rales; Urogenital: Urination difficulties.
**Overdosage**

There have been reports of inadvertent overdosage with timolol ophthalmic solution resulting in systemic effects similar to those seen with systemic beta-adrenergic blocking agents such as dizziness, headache, shortness of breath, bradycardia, bronchospasm, and cardiac arrest. Very limited information exists on accidental ingestion of brimonidine in adults alone or in combination. Symptoms of brimonidine overdose have been reported in neonates, infants, and children receiving brimonidine ophthalmic solution as part of medical treatment of congenital glaucoma or by accidental oral ingestion. Treatment of an oral overdose includes supportive and symptomatic therapy; a patient's airway should be maintained.

**Brimonidine Tartrate**

**Ophthalmic Overdose (Adults)**

In those cases received, the events reported have generally been those already listed as adverse reactions.

**Systemic Overdose Resulting From Accidental Ingestion (Adults)**

There is very limited information regarding accidental ingestion of brimonidine tartrate in adults. The only adverse event reported to date was hypotension. It was reported that the hypotensive episode was followed by rebound hypertension. Oral overdoses of other alpha-2-agonists have been reported to cause symptoms such as hypotension, asthenia, vomiting, lethargy, sedation, bradycardia, arrhythmias, miosis, apnoea, hypotonia, hypothermia, respiratory depression and seizure.

**Paediatric Population**

Reports of serious adverse effects following inadvertent ingestion of Brimonidine tartrate 0.2% ophthalmic solution by paediatric subjects have been reported. The subjects experienced symptoms of CNS depression, typically temporary coma or low level of consciousness, lethargy, somnolence, hypotonia, bradycardia, hypothermia, pallor, respiratory depression and apnoea, and required admission to intensive care with intubation if indicated. All subjects were reported to have made a full recovery, usually within 6-24 hours.

**Timolol**

Symptoms of systemic timolol maleate overdose include: bradycardia, hypotension, bronchospasm, headache, dizziness and cardiac arrest. A study of patients showed that timolol did not dialyse readily.

**Incompatibility**

Not applicable

**Shelf-Life**

18 months

**Storage And Handling Instructions**

Store in a cool place.

**Packaging Information**

BRIMOCOM Eye Drops: Vial of 5 ml

**Information For Patients**
Patients with bronchial asthma, a history of bronchial asthma, severe chronic obstructive pulmonary disease, sinus bradycardia, second or third degree atrioventricular block, or cardiac failure should be advised not to take this product. Patients should be instructed that ocular solutions, if handled improperly or if the tip of the dispensing container contacts the eye or surrounding structures, can become contaminated by common bacteria known to cause ocular infections. Serious damage to the eye and subsequent loss of vision may result from using contaminated solutions. Always replace the cap after using. If solution changes color or becomes cloudy, do not use. Do not use the product after the expiration date marked on the bottle.

Patients also should be advised that if they have ocular surgery or develop an intercurrent ocular condition (e.g., trauma or infection), they should immediately seek their physician's advice concerning the continued use of the present multidose container.

If more than one topical ophthalmic drug is being used, the drugs should be administered at least five minutes apart. Patients should be advised that Brimonidine tartrate/timolol maleate ophthalmic solution contains benzalkonium chloride which may be absorbed by soft contact lenses. Contact lenses should be removed prior to administration of the solution. Lenses may be reinserted 15 minutes following administration of Brimonidine tartrate/timolol maleate ophthalmic solution.

As with other similar medications, Brimonidine tartrate/timolol maleate ophthalmic solution may cause fatigue and/or drowsiness in some patients. Patients who engage in hazardous activities should be cautioned of the potential for a decrease in mental alertness.

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