RHOPRESSA OPHTHALMIC SOLUTION, 0.02% W/V
FULL PRESCRIBING INFORMATION

1. INDICATIONS AND USAGE

RHOPRESSA (netarsudil ophthalmic solution) 0.02% is indicated for the reduction of elevated intraocular pressure (IOP) in patients with primary open-angle glaucoma or ocular hypertension *[see section 12 Clinical Studies].*

2. DOSAGE AND ADMINISTRATION

The recommended dosage is one drop in the affected eye(s) once daily in the evening.

If one dose is missed, treatment should continue with the next dose in the evening. Twice a day dosing is not well tolerated and is not recommended. If RHOPRESSA is to be used concomitantly with other topical ophthalmic drug products to lower IOP, administer each drug product at least 5 minutes apart.

Due to netarsudil's vasodilating properties, other eye drops should be administered before netarsudil. Eye ointments should be administered last.

3. DOSAGE FORMS AND STRENGTHS

Ophthalmic solution containing 0.2 mg/mL of netarsudil.

4. CONTRAINDICATIONS

Hypersensitivity to the active substance or to any of the excipients.

5. WARNINGS AND PRECAUTIONS

5.1 Bacterial Keratitis

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.

5.2 Use with Contact Lenses

Contact lenses should be removed prior to instillation of RHOPRESSA and may be reinserted 15 minutes following its administration.

5.3 Benzalkonium chloride content

This medicinal product contains benzalkonium chloride.
Benzalkonium chloride has been reported to cause eye irritation, symptoms of dry eyes and may affect the tear film and corneal surface and is known to discolour soft contact lenses. It should be used with caution in dry eye patients and in patients where the cornea may be compromised.
Patients should be monitored in case of prolonged use.

5.4 Long term use

The efficacy and safety of netarsudil has not been studied beyond 12 months.

6. ADVERSE REACTIONS

6.1 Clinical Trials Experience

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

The most common ocular adverse reaction observed in controlled clinical studies with RHOPRESSA dosed once daily was conjunctival hyperemia which was reported in 53% of patients. Six percent of patients discontinued therapy due to conjunctival hyperemia. Other common (approximately 20%) ocular adverse reactions reported were: corneal verticillata, instillation site pain, and conjunctival hemorrhage. Instillation site erythema, corneal staining, blurred vision, increased lacrimation, erythema of eyelid, and reduced visual acuity were reported in 5-10% of patients.

Corneal Verticillata

Corneal verticillata occurred in approximately 20% of the patients in controlled clinical studies. The corneal verticillata seen in RHOPRESSA-treated patients were first noted at 4 weeks of daily dosing. This reaction did not result in any apparent visual functional changes in patients. Most corneal verticillata resolved upon discontinuation of treatment. The incidence of cornea verticillata was higher in certain subpopulations: elderly (≥65 years) versus non-elderly (24.8 vs. 15.9%); males versus females (24.4 vs. 18.4%) and in white versus other races (25.6 vs. 7.0%).

Tabulated list of adverse reactions

The following adverse reactions have been reported with netarsudil, dosed once daily. Reactions are classified according to the convention: very common (≥1/10), common (≥1/100 to <1/10), uncommon (≥1/1,000 to <1/100), rare (≥1/10,000 to <1/1,000), very rare (<1/10,000) or not known (cannot be estimated from the available data).

System Organ Classification	**Frequency**	**Adverse reactions**
Immune system disorders	Uncommon	hypersensitivity
Nervous system disorders	Common	headache
	Uncommon	dizziness, visual field defect
Eye disorders	Very common	conjunctival hyperaemia[1], cornea verticillata[1], instillation site pain
	Common	conjunctival haemorrhage, vision blurred, lacrimation increased, erythema of eyelid, eye pruritis, eye irritation, visual acuity reduced, eyelid oedema, punctate keratitis, conjunctival oedema, foreign body sensation in eyes, conjunctivitis, conjunctivitis allergic, photophobia, eyelid pruritus, eye pain, corneal opacity, dry eye, eye discharge, instillation site erythema, instillation site discomfort, instillation site pruritis, vital dye staining cornea present, intraocular pressure increased
	Uncommon	ocular hyperaemia, blepharitis, corneal disorder, eyelid margin crusting, eye allergy, conjunctival follicles, ocular discomfort, eye swelling, corneal deposits, eyelid disorder, meibomian gland dysfuntion, corneal pigmentation, diplopia, ectropion, lenticular opacities, noninfective conjunctivitis, abnormal sensation in the eye, asthenopia, episcleral hyperaemia, halo vision, keratitis, refraction disorder, anterior chamber flare, anterior chamber inflammation, blindness, conjunctival irritation, conjunctivochalasis, diabetic retinopathy, eczema eyelids, eyelid skin dryness, glaucoma, growth of eyelashes, iris adhesions, iris bombe, iritis, ocular hypertension, visual impairment, corneal dystrophy, instillation site foreign body sensation, instillation site irritation, glassy eyes, fatigue, instillation site dryness, instillation site oedema, instillation site paraesthesia, conjunctival staining, optic nerve cup/disc ratio increased, madarosis
Respiratory, thoracic and mediastinal disorders	Uncommon	nasal discomfort, rhinalgia
Skin and subcutaneous tissue disorders	Uncommon	dermatitis allergic, dermatitis contact, lichenification, petechiae
Musculoskeletal and connective tissue disorders	Uncommon	polychondritis
Injury, poisoning and procedural complications	Uncommon	excoriation

[1] See *ADVERSE REACTIONS, Clinical Trials Experience* for further information

8. USE IN SPECIFIC POPULATIONS

8.1 Pregnancy

Risk Summary

There are no available data on RHOPRESSA use in pregnant women to inform any drug associated risk; however, systemic exposure to netarsudil from ocular administration is low *[see Clinical Pharmacology]*. Intravenous administration of netarsudil to pregnant rats and rabbits during organogenesis did not produce adverse embryofetal effects at clinically relevant systemic exposures *[see Data]*.

Data

Animal Data

Netarsudil administered daily by intravenous injection to rats during organogenesis caused abortions and embryofetal lethality at doses ≥0.3 mg/kg/day (126-fold the plasma exposure at the recommended human ophthalmic dose [RHOD], based on C_{max}). The no-observed-adverse-effect-level (NOAEL) for embryofetal development toxicity was 0.1 mg/kg/day (40-fold the plasma exposure at the RHOD, based on C_{max}).

Netarsudil administered daily by intravenous injection to rabbits during organogenesis caused embryofetal lethality and decreased fetal weight at 5 mg/kg/day (1480-fold the plasma exposure at the RHOD, based on C_{max}). Malformations were observed at ≥3 mg/kg/day (1330-fold the plasma exposure at the RHOD, based on C_{max}), including thoracogastroschisis, umbilical hernia and absent intermediate lung lobe. The NOAEL for embryofetal development toxicity was 0.5 mg/kg/day (214-fold the plasma exposure at the RHOD, based on C_{max}).

Rhopressa should not be used during pregnancy unless the clinical condition of the woman requires treatment with netarsudil.

8.2 Lactation

Risk Summary

There are no data on the presence of RHOPRESSA in human milk, the effects on the breastfed infant, or the effects on milk production. However, systemic exposure to netarsudil following topical ocular administration is low *[see Clinical Pharmacology]*, and it is not known whether measurable levels of netarsudil would be present in maternal milk following topical ocular administration.

The developmental and health benefits of breastfeeding should be considered along with the mother's clinical need for RHOPRESSA and any potential adverse effects on the breast-fed child from RHOPRESSA.

A decision must be made whether to discontinue breast-feeding or to discontinue/abstain from Rhopressa therapy taking into account the benefit of breast feeding for the child and the benefit of therapy for the woman.

8.4 Pediatric Use

Safety and effectiveness in pediatric patients below the age of 18 years have not been established.

8.5 Geriatric Use

With the exception of corneal verticillata *[see section 6.1]*, no overall differences in the safety or effectiveness profile for Rhopressa has been observed between subjects aged <65 or ≥65 years.

8.6 Compromised corneal epithelium or co-existing ocular pathologies

The efficacy and safety of netarsudil in subjects with compromised corneal epithelium or co-existing ocular pathologies e.g. pseudoexfoliation and pigment dispersion syndrome has not been established.

8.7 Effects on ability to drive and use machines

Rhopressa has negligible influence on the ability to drive and use machines.

If transient blurred vision occurs at instillation, the patient should wait until the vision clears before driving or using machines

8.8 Interaction with other medicinal products and other forms of interaction

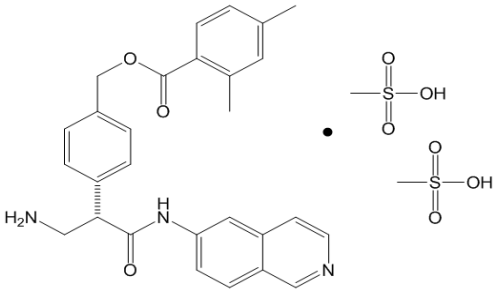
No interaction studies have been performed.

8.9 Overdose

Systemic exposure to netarsudil following topical ocular administration has been shown to be negligible. If topical overdose of netarsudil should occur, the eye(s) may be flushed with tap water. Treatment of an overdose would include supportive and symptomatic therapy.

9. DESCRIPTION

Netarsudil is a Rho kinase inhibitor. Its chemical name is (*S*)-4-(3-amino-1-(isoquinolin-6-yl-amino)-1-oxopropan-2-yl) benzyl 2,4-dimethylbenzoate dimesylate. The molecular formula of the free base is $C_{28}H_{27}N_3O_3$ and the molecular formula of the mesylate is $C_{30}H_{35}N_3O_9S_2$. The molecular weight of the free base is 453.54 and the molecular weight of the mesylate is 645.74. The chemical structure is:



Netarsudil mesylate is a light yellow to white powder that is freely soluble in water, soluble in methanol, sparingly soluble in dimethyl formamide, and practically insoluble in dichloromethane and heptane.

RHOPRESSA (netarsudil ophthalmic solution) 0.02% is supplied as a clear, sterile aqueous ophthalmic solution of netarsudil mesylate with pH 4.2-5.2 and osmolality 250-340 mOsm/kg. It is intended for topical application in the eye. Each mL of RHOPRESSA contains 0.2 mg of netarsudil (equivalent to 0.28 mg of netarsudil mesylate). Benzalkonium chloride, 0.015%, is added as a preservative. The inactive ingredients are: boric acid, mannitol, sodium hydroxide to adjust pH, and water for injection.

10. CLINICAL PHARMACOLOGY

ATC code: S01EX05

10.1 Mechanism of Action

Netarsudil is a rho kinase inhibitor, which is believed to reduce IOP by increasing the outflow of aqueous humor through the trabecular meshwork. The exact mechanism is unknown.

10.2 Pharmacokinetics

Absorption

The systemic exposures of netarsudil and its active metabolite, AR-13503, were evaluated in 18 healthy subjects after topical ocular administration of RHOPRESSA 0.02% once daily (one drop bilaterally in the morning) for 8 days. There were no quantifiable plasma concentrations of netarsudil (lower limit of quantitation (LLOQ) 0.100 ng/mL) post dose on Day 1 and Day 8. Only one plasma concentration at 0.11 ng/mL for the active metabolite was observed for one subject on Day 8 at 8 hours post-dose.

Metabolism

After topical ocular dosing, netarsudil is metabolized by esterases in the eye to AR-13503.

11. NONCLINICAL TOXICOLOGY

11.1 Carcinogenesis, Mutagenesis, Impairment of Fertility

Long-term studies in animals have not been performed to evaluate the carcinogenic potential of netarsudil. Netarsudil was not mutagenic in the Ames test, in the mouse lymphoma test, or in the *in vivo* rat micronucleus test. Studies to evaluate the effects of netarsudil on male or female fertility in animals have not been performed.

Netarsudil and its active metabolite AR-13503 was found to have a possible phototoxic potential in a modified 3T3 NRU-PT *in vitro* assay, where the wavelength was extended to include UVB light.

12. CLINICAL STUDIES

RHOPRESSA 0.02% was evaluated in three randomized and controlled clinical trials, namely AR-13324-CS301 (NCT 02207491, referred to as Study 301), AR-13324-CS302 (NCT 02207621, referred to as Study 302), and AR-13324-CS304 (NCT 02558374, referred to as Study 304), in patients with open-angle glaucoma or ocular hypertension. Studies 301 and 302 enrolled subjects with baseline IOP lower than 27 mmHg and Study 304 enrolled subjects with baseline IOP lower than 30 mmHg. The treatment duration was 3 months in Study 301, 12 months in Study 302, and 6 months in Study 304.

Study CS301

A randomised, double-blind, multicentre Phase 3 clinical trial compared the efficacy and safety of netarsudil once daily with that of timolol maleate 0.5% twice daily in reducing IOP in a total of 411 patients with open-angle glaucoma or ocular hypertension. The median age of study participants was 65.0 years (range 20 to 96 years).

The study was designed to show non-inferiority of netarsudil when dosed once daily in the evening to timolol maleate 0.5% dosed twice daily in patients with a baseline IOP of >20 mmHg and <27 mmHg. The primary efficacy outcome measure was mean IOP at each of 9 timepoints measured at 08:00, 10:00 and 16:00 on day 15, day 43 and day 90. The non-inferiority margin applied was a difference in mean IOP ≤1.5 mmHg for all time points over all visits through 3 months and ≤1.0 mmHg at a majority of these time points. Noninferiority of netarsudil to timolol maleate 0.5% was not demonstrated in the overall PP population (baseline IOP < 27 mmHg). The IOP reduction with netarsudil dosed once daily was non-inferior to the effect of timolol 0.5% dosed twice daily in patients with baseline IOP of <25 mmHg (Table 1). Efficacy was also investigated in patients with baseline IOP ≥25 mmHg and <27 mmHg. Netarsudil demonstrated clinically relevant reductions in IOP at all timepoints, however non-inferiority to timolol was not demonstrated in this population with baseline IOP ≥25 mmHg and <30 mmHg (Table 2).

Table 1: Mean IOP by visit: PP population with baseline IOP <25 mmHg (Study CS301)

Study Visit and Time Point		Netarsudil 0.02% Once daily		Timolol 0.5% twice daily		Difference (95% CI) Netarsudil – Timolol
		N	IOP	N	IOP	
Baseline	08:00	113	22.39	124	22.50	
	10:00	113	21.28	124	21.07	
	16:00	113	20.62	124	20.52	
Day 15	08:00	108	17.34	123	17.78	-0.44 (-1.10, 0.22)
	10:00	107	16.18	122	16.98	-0.81 (-1.44, -0.17)
	16:00	107	16.22	122	17.14	-0.92 (-1.58, -0.26)
Day 43	08:00	105	17.85	121	17.81	0.05 (-0.68, 0.77)
	10:00	105	16.88	121	16.96	-0.08 (-0.74, 0.58)
	16:00	105	16.57	120	17.26	-0.69 (-1.40, 0.02)
Day 90	08:00	99	18.22	119	17.91	0.31 (-0.40, 1.02)
	10:00	99	17.34	119	17.43	-0.09 (-0.82, 0.63)

	16:00	99	17.02	119	17.37	-0.35 (-1.03, 0.34)

Table 2: Mean IOP by visit: PP population with baseline IOP ≥25 and <27 mmHg (Study CS301)

Study Visit and Time Point		Netarsudil 0.02% Once daily		Timolol 0.5% twice daily		Difference (95% CI) Netarsudil – Timolol
		N	IOP	N	IOP	
Baseline	08:00	69	25.11	64	25.05	
	10:00	69	23.92	64	23.58	
	16:00	69	23.68	64	23.25	
Day 15	08:00	69	20.78	64	19.41	1.38 (0.36, 2.39)
	10:00	69	19.01	64	18.62	0.40 (-0.70, 1.49)
	16:00	69	18.82	64	18.75	0.07 (-1.04, 1.18)
Day 43	08:00	65	21.78	63	19.09	2.69 (1.53, 3.84)
	10:00	65	20.17	63	18.37	1.80 (0.60, 3.00)
	16:00	65	19.95	63	18.56	1.39 (0.18, 2.60)
Day 90	08:00	58	22.52	62	19.56	2.96 (1.83, 4.09)
	10:00	59	21.58	62	18.98	2.59 (1.48, 3.71)
	16:00	59	20.93	62	18.46	2.47 (1.32, 3.63)

Study CS302

A randomised, double-blind, multicentre Phase 3 clinical trial compared the efficacy and safety of netarsudil once daily and twice daily with that of timolol maleate 0.5% twice daily in reducing IOP in a total of 756 patients with open-angle glaucoma or ocular hypertension. The median age of study participants was 64.1 years (range 11 to 92 years).

The study was designed to show non-inferiority of netarsudil when dosed once daily in the evening and twice daily to timolol maleate 0.5% dosed twice daily in patients with a baseline IOP of >20 mmHg and <27 mmHg. The primary efficacy outcome measure was mean IOP at each of 9 timepoints measured at 08:00, 10:00 and 16:00 on day 15, day 43 and day 90 in patients with baseline IOP < 25 mmHg. The non-inferiority margin applied was a difference in mean IOP ≤1.5 mmHg for all time points over all visits through 3 months and ≤1.0 mmHg at a majority of these time points. The IOP reduction with netarsudil dosed once daily was non-inferior to the effect of timolol 0.5% dosed twice daily in patients with baseline IOP of <25 mmHg (Table 3). Efficacy was also investigated in patients with baseline IOP ≥25 mmHg and <27 mmHg. Netarsudil demonstrated clinically relevant reductions in IOP at all timepoints, however non-inferiority to timolol was not demonstrated in this population with baseline IOP ≥25 mmHg and <27 mmHg (Table 4).

Table 3: Mean IOP by visit: PP population with baseline IOP <25 mmHg (Study CS302)

Study Visit and Time Point		Netarsudil 0.02% Once daily		Timolol 0.5% twice daily		Difference (95% CI) Netarsudil – Timolol
		N	IOP	N	IOP	
Baseline	08:00	129	22.54	142	22.54	
	10:00	129	21.29	142	21.27	
	16:00	129	20.43	142	20.71	
Day 15	08:00	127	18.07	142	17.69	0.37 (-0.26, 0.99)
	10:00	126	16.72	141	16.93	-0.21 (-0.82, 0.41)
	16:00	126	16.68	141	16.83	-0.15 (-0.75, 0.46)
Day 43	08:00	122	17.95	141	17.46	0.49 (-0.13, 1.12)
	10:00	120	16.95	141	16.63	0.32 (-0.31, 0.95)
	16:00	120	17.00	141	16.60	0.40 (-0.22, 1.02)
Day 90	08:00	116	18.24	140	17.47	0.77 (0.03, 1.50)
	10:00	114	17.03	140	16.92	0.10 (-0.59, 0.80)
	16:00	114	17.13	139	16.95	0.18 (-0.55, 0.91)

Table 4: Mean IOP by visit: PP population with baseline IOP ≥25 and <27 mmHg (Study CS302)

Study Visit and Time Point	Netarsudil 0.02% Once daily	Timolol 0.5% twice daily	Difference (95% CI) Netarsudil – Timolol

		N	IOP	N	IOP	
Baseline	08:00	77	25.14	75	25.18	
	10:00	77	24.02	75	23.89	
	16:00	77	23.46	75	23.33	
Day 15	08:00	74	20.66	75	19.31	1.35 (0.44, 2.26)
	10:00	73	19.49	74	18.56	0.93 (-0.08, 1.93)
	16:00	74	18.55	74	19.05	-0.50 (-1.48, 0.48)
Day 43	08:00	71	21.80	74	19.26	2.55 (1.41, 3.68)
	10:00	67	20.19	74	18.61	1.58 (0.51, 2.65)
	16:00	67	19.46	74	18.49	0.97 (0.01, 1.93)
Day 90	08:00	61	21.69	74	19.62	2.07 (0.95, 3.18)
	10:00	59	20.41	73	18.67	1.74 (0.60, 2.87)
	16:00	56	18.96	73	19.03	-0.08 (-1.23, 1.07)

Study CS304

A randomised, double-blind, multicentre Phase 3 clinical trial compared the efficacy and safety of netarsudil once daily with that of timolol maleate 0.5% twice daily in reducing IOP in a total of 708 patients with open-angle glaucoma or ocular hypertension. The median age of study participants was 65.5 years (range 18 to 91 years).

The study was designed to show non-inferiority of netarsudil when dosed once daily in the evening to timolol maleate 0.5% dosed twice daily in patients with a baseline IOP of >20 mmHg and <25 mmHg. The primary efficacy outcome measure was mean IOP at each of 9 timepoints measured at 08:00, 10:00 and 16:00 on day 15, day 43 and day 90 in patients with baseline IOP < 25 mmHg. The non-inferiority margin applied was a difference in mean IOP ≤1.5 mmHg for all time points over all visits through 3 months and ≤1.0 mmHg at a majority of these time points. The IOP reduction with netarsudil dosed once daily was non-inferior to the effect of timolol 0.5% dosed twice daily in patients with baseline IOP of <25 mmHg (Table 5). Efficacy was also investigated in patients with baseline IOP ≥25 mmHg and <30 mmHg. Netarsudil demonstrated clinically relevant reductions in IOP at all timepoints, however non-inferiority to timolol was not demonstrated in this population with baseline IOP ≥25 mmHg and <30 mmHg (Table 6).

Table 5: Mean IOP by visit: PP population with baseline IOP <25 mmHg (Study CS304)

Study Visit and Time Point		Netarsudil 0.02% Once daily		Timolol 0.5% twice daily		Difference (95% CI) Netarsudil – Timolol
		N	IOP	N	IOP	
Baseline	08:00	186	22.40	186	22.44	
	10:00	186	21.06	186	21.27	
	16:00	186	20.69	186	20.69	
Day 15	08:00	184	17.68	183	17.51	0.17 (-0.43, 0.77)
	10:00	181	16.55	183	16.71	-0.16 (-0.73, 0.41)
	16:00	181	16.32	183	16.92	-0.60 (-1.16, -0.04)
Day 43	08:00	177	17.84	183	17.60	0.25 (-0.34, 0.83)
	10:00	177	16.75	182	16.98	-0.22 (-0.82, 0.37)
	16:00	176	16.57	182	16.67	-0.10 (-0.66, 0.46)
Day 90	08:00	167	17.86	179	17.29	0.56 (-0.02, 1.15)
	10:00	166	16.90	179	16.69	0.21 (-0.37, 0.79)
	16:00	165	16.73	179	16.80	-0.07 (-0.68, 0.55)

Table 6: Mean IOP by visit: PP population with baseline IOP ≥25 and <30 mmHg (Study CS304)

Study Visit and Time Point		Netarsudil 0.02% Once daily		Timolol 0.5% twice daily		Difference (95% CI) Netarsudil – Timolol
		N	IOP	N	IOP	
Baseline	08:00	120	26.30	130	25.96	
	10:00	120	25.18	130	24.91	
	16:00	120	24.48	130	23.99	
Day 15	08:00	118	21.57	129	20.15	1.42 (0.51, 2.34)
	10:00	116	20.09	129	19.34	0.75 (-0.15, 1.64)

	16:00	116	20.01	129	19.17	0.83 (0.00, 1.67)
Day 43	08:00	112	21.99	127	19.84	2.14 (1.16, 3.13)
	10:00	109	20.33	127	19.19	1.15 (0.30, 1.99)
	16:00	109	20.03	127	19.63	0.41 (-0.47, 1.29)
Day 90	08:00	94	21.71	121	19.91	1.79 (0.74, 2.85)
	10:00	93	20.80	120	18.95	1.85 (0.89, 2.81)
	16:00	93	20.31	120	18.94	1.37 (0.46, 2.28)

The safety of netarsudil has been evaluated in clinical studies, including four well-controlled Phase 3 studies.

Approximately 75% of subjects included in the netarsudil treatment groups of Phase 3 studies were Caucasian and 24% Black or African American. Over half were aged ≥ 65 years. With the exception of the incidence of cornea verticillata, no other difference in safety profile was observed between races or age groups (see section 6.1).

Completion rates in Phase 3 studies were lower in the netarsudil treatment group when compared with the timolol maleate group. Subjects with known contraindications or hypersensitivity to timolol were excluded from the studies. Discontinuation rates due to adverse reactions were 19.3% for the netarsudil treatment group versus 1.7% for the timolol maleate group. The majority of discontinuations in the netarsudil group were associated with ocular adverse reactions, whereas the majority of discontinuations in the timolol group were associated with non-ocular adverse reactions. The most frequently reported adverse reactions associated with discontinuation in the netarsudil groups were conjunctival hyperemia (5.8%), cornea verticillata (3.7%) and vision blurred (1.4%). The incidences of hyperemia and vision blurred were sporadic in nature.

The efficacy and safety of netarsudil in subjects with compromised corneal epithelium or co-existing ocular pathologies e.g. pseudoexfoliation and dispersion pigment syndrome has not been established.

13. HOW SUPPLIED/STORAGE AND HANDLING

RHOPRESSA® (netarsudil ophthalmic solution) 0.02% (0.2 mg per mL) is supplied sterile in opaque white low density polyethylene bottles and tips with white polypropylene caps.

2.5 mL fill in a 4 mL container

Storage: Store at 2°C to 8°C until opened. After opening, do not store above 30°C and use within one month.

14. PATIENT COUNSELING INFORMATION

Handling the Container

Instruct patients to avoid allowing the tip of the dispensing container to contact the eye, surrounding structures, fingers, or any other surface in order to minimize contamination of the solution. Serious damage to the eye and subsequent loss of vision may result from using contaminated solutions *[see Warnings and Precautions].*

When to Seek Physician Advice

Advise patients that if they develop an intercurrent ocular condition (e.g., trauma or infection), have ocular surgery, or develop any ocular reactions, particularly conjunctivitis and eyelid reactions, they should immediately seek their physician's advice concerning the continued use of RHOPRESSA.

Use with Contact Lenses

Advise patients that RHOPRESSA contains benzalkonium chloride, which may be absorbed by soft contact lenses. Contact lenses should be removed prior to instillation of RHOPRESSA and may be reinserted 15 minutes following its administration.

Use with Other Ophthalmic Drugs

Advise patients that if more than one topical ophthalmic drug is being used, the drugs should be administered at least 5 minutes between applications.

Missed Dose

Advise patients that if one dose is missed, treatment should continue with the next dose in the evening.

15. Manufactured by

Aerie Pharmaceuticals Ireland, Limited

Athlone Business and Technology Park, Garrycastle, Dublin Road,

Athlone, Westmeath Ireland