1. Name of the medicinal product

Ondansetron Tablets BP 4mg (ONSETT 4)

Ondansetron Tablets BP 8 mg (ONSETT 8)

2. Qualitative and Quantitative Composition

ONSETT 4:

Each Film-coated tablet contains:

Ondansetron HCL Dihydrate BP
Equivalent to Ondansetron…....4 mg
Excipients…… q.s.
Colour: Titanium Dioxide

ONSETT 8:

Each Film-coated tablet contains:

Ondansetron HCL Dihydrate BP
Equivalent to Ondansetron…....8 mg
Excipients…… q.s.
Colour: Yellow Iron Oxide and Titanium Dioxide

For a full list of excipients, see section 6.1.

3. Pharmaceutical Form

ONSETT 4:
White, oval shaped, film coated tablet, plain on both sides.

ONSETT 8:
Yellow, oval shaped film coated, plain on both sides.

4. Clinical Particulars

4.1 Therapeutic indications

Adults
Ondansetron hydrochloride is indicated for the management of nausea and vomiting induced by cytotoxic chemotherapy and radiotherapy, and for the prevention and treatment of post-operative nausea and vomiting.

Paediatric Population
Ondansetron hydrochloride is indicated for the management of chemotherapy-induced nausea and vomiting (CINV) in children aged ≥6 months, and for the prevention and treatment of PONV in children aged ≥1 month.

4.2 Posology and method of administration Chemotherapy and Radiotherapy

Adults: The emetogenic potential of cancer treatment varies according to the doses and combinations of chemotherapy and radiotherapy regimens used. The route of administration and dose of Ondansetron hydrochloride should be flexible in the range of 8-32mg a day and selected as shown below.

Emetogenic chemotherapy and radiotherapy: Ondansetron hydrochloride can be given either by rectal, oral (tablets or syrup), intravenous or intramuscular administration.
For most patients receiving emetogenic chemotherapy or radiotherapy, Ondansetron hydrochloride 8mg should be administered as a slow intravenous or intramuscular injection immediately before treatment, followed by 8 mg orally twelve hourly.
To protect against delayed or prolonged emesis after the first 24 hours, oral or rectal treatment with Ondansetron hydrochloride should be continued for up to five days after a course of treatment.

Highly emetogenic chemotherapy: For patients receiving highly emetogenic chemotherapy, e.g.. high-dose cisplatin, Ondansetron hydrochloride can be given either by rectal, intravenous or intramuscular administration.
Ondansetron hydrochloride has been shown to be equally effective in the following dose schedules over the first 24 hours of chemotherapy:

- A single dose of 8mg by slow intravenous or intramuscular injection immediately before chemotherapy.
- A dose of 8mg by slow intravenous or intramuscular injection immediately before chemotherapy, followed by two further intravenous or intramuscular doses of 8mg two to four hours apart, or by a constant infusion of 1mg/hour for up to 24 hours.
- A single dose of 32mg diluted in 50-l00ml of saline or other compatible infusion fluid and infused over not less than 15 minutes immediately before chemotherapy.

The selection of dose regimen should be determined by the severity of the emetogenic challenge.
The efficacy of ondansetron hydrochloride in highly emetogenic chemotherapy may be enhanced by the addition of a single intravenous dose of dexamethasone sodium phosphate, 20mg administered prior to chemotherapy.
To protect against delayed or prolonged emesis after the first 24 hours, oral or rectal treatment with ondansetron hydrochloride should be continued for up to five days after a course of treatment.

Pediatric Population

CINV in children aged ≥ 6 months and adolescents
The dose for CINV can be calculated based on body surface area (BSA) or weight – see below. Weight-based dosing results in higher total daily doses compared to BSA-based dosing.
Ondansetron hydrochloride should be diluted in 5% dextrose or 0.9% sodium chloride or other compatible infusion fluid and infused intravenously over not less than 15 minutes.
There are no data from controlled clinical trials on the use of ondansetron hydrochloride in the prevention of delayed or prolonged CINV. There are no data from controlled clinical trials on the use of ondansetron hydrochloride for radiotherapy-induced nausea and vomiting in children.

Dosing by BSA

Ondansetron hydrochloride should be administered immediately before chemotherapy as a single intravenous dose of 5 mg/m^2. The intravenous dose must not exceed 8 mg.
Oral dosing can commence twelve hours later and may be continued for up to 5 days The total daily dose must not exceed adult dose of 32 mg.

Table 1: BSA-based dosing for Chemotherapy - Children aged ≥ 6 months and adolescents

BSA	Day 1 (a,b)	Days 2-6 (b)
<0.6m^2	5 mg/m^2 i.v. plus 2 mg syrup after 12 hrs	2 mg syrup every 12 hrs
0.6m^2	5 mg/m^2 i.v. plus 4 mg syrup or tablet after 12 hrs	4 mg syrup or tablet every 12 hrs

a The intravenous dose must not exceed 8mg.
b The total daily dose must not exceed adult dose of 32 mg Dosing by bodyweight
Weight-based dosing results in higher total daily doses compared to BSA-based dosing.

Ondansetron hydrochloride should be administered immediately before chemotherapy as a single intravenous dose of 0.15 mg/kg. The intravenous dose must not exceed 8 mg.
Two further intravenous doses may be given in 4-hourly intervals. The total daily dose must not exceed adult dose of 32 mg.
Oral dosing can commence twelve hours later and may be continued for up to 5 days (Table 2).

Table 2: Weight-based dosing for Chemotherapy - Children aged ≥ 6 months and adolescents

Weight	Day 1 (a,b)	Days 2-6 (b)
10 Kg	Up to 3 doses of 0.15mg/kg every 4 hrs	2 mg syrup every 12 hrs
>10 Kg	Up to 3 doses of 0.15mg/kg every 4 hrs	4 mg syrup or tablet every 12 hrs

a The intravenous dose must not exceed 8mg.
b The total daily dose must not exceed adult dose of 32 mg.

Elderly: Ondansetron hydrochloride is well tolerated by patients over 65 years and no alteration of dosage, dosing frequency or route of administration are required.

Patients with Renal Impairment: No alteration of daily dosage or frequency of dosing, or route of administration are required.

Patients with hepatic Impairment: Clearance of Ondansetron hydrochloride is significantly reduced and serum half-life significantly prolonged in subjects with moderate or severe impairment of hepatic function. In such patients a total daily dose of 8mg should not be exceeded.
Post-operative nausea and vomiting (PONV):

Adults: For the prevention of PONV ondansetron hydrochloride can be administered orally or by intravenous or intramuscular injection.
Ondansetron hydrochloride may be administered as a single dose of 4mg given by intramuscular or slow intravenous injection at induction of anaesthesia.
For treatment of established PONV a single dose of 4mg given by intramuscular or slow intravenous injection is recommended.
Paediatric population
PONV in children aged ≥ 1 month and adolescents

Oral formulation:
No studies have been conducted on the use of orally administered ondansetron in the prevention or treatment of post-operative nausea and vomiting; slow i.v. injection is recommended for this purpose.
For prevention of PONV in paediatric patients having surgery performed under general anaesthesia, a single dose of ondansetron may be administered by slow intravenous injection (not less than 30 seconds) at a dose of 0.1mg/kg up to a maximum of 4mg either prior to, at or after induction of anaesthesia.
For the treatment of PONV after surgery in paediatric patients having surgery performed under general anaesthesia, a single dose of ondansetron hydrochloride may be administered by slow intravenous injection (not less than 30 seconds) at a dose of 0.1mg/kg up to a maximum of 4mg.
There are no data on the use of ondansetron hydrochloride in the treatment of PONV in children below 2 years of age.

Elderly: There is limited experience in the use of ondansetron hydrochloride in the prevention and treatment of PONV in the elderly, however ondansetron hydrochloride is well tolerated in patients over 65 years receiving chemotherapy.

Patients with renal impairment: No alteration of daily dosage or frequency of dosing, or route of administration are required.

Patients with hepatic impairment: Clearance of ondansetron hydrochloride is significantly reduced and serum half life significantly prolonged in subjects with moderate or severe impairment of hepatic function. In such patients a total daily dose of 8mg should not be exceeded.

Patients with poor sparteine/debrisoquine metabolism: The elimination half-life of ondansetron hydrochloride is not altered in subjects classified as poor metabolisers ofsparteine and debrisoquine. Consequently in such patients repeat dosing will give drug exposure levels no different from those of the general population. No alteration of daily dosage or frequency of dosing are required.

4.3 Contraindications

Hypersensitivity to any component of the preparation.

4.4 Special warnings and precautions for use

Hypersensitivity reactions have been reported in patients who have exhibited hypersensitivity to other selective 5HTs receptor antagonists. Respiratory events should be treated symptomatically and clinicians should pay particular attention to them as precursors of hypersensitivity reactions.

Very rarely and predominantly with intravenous ondansetron, transient ECG changes including QT interval prolongation have been reported.
As ondansetron is known to increase large bowel transit time, patients with signs of subacute intestinal obstruction should be monitored following administration.
In patients with adenotonsillar surgery prevention of nausea and vomiting with ondansetron may mask occult bleeding. Therefore, such patients should be followed carefully after ondansetron.

Patients with rare hereditary problems of galactose intolerance, the Lapp lactase deficiency or glucose-galactose malabsorption should not take this medicine.
Paediatric Population
Paediatric patients receiving ondansetron with hepatotoxic chemotherapeutic agents should be monitored closely for impaired hepatic function.
CINV

When calculating the dose on an mg/kg basis and administering three doses at 4-hourly intervals, the total daily dose will be higher than if one single dose of $5mg/m^2$ followed by an oral dose is given. The comparative efficacy of these two different dosing regimens has not been investigated in clinical trials. Cross-trial comparison indicates similar efficacy for both regimens.

4.5 Interaction with other medicinal products and other forms of interaction

There is no evidence that ondansetron either induces or inhibits the metabolism of other drugs commonly co-administered with it. Specific studies have shown that there are no pharmacokinetic interactions when ondansetron is administered with alcohol, temazepam, furosemide, alfentanil, tramadol, morphine, lidocaine, thiopental or propofol.
Ondansetron is metabolised by multiple hepatic cytochrome P-450 enzymes: CYP3A4, CYP2D6 and CYP1A2. Due to the multiplicity of metabolic enzymes capable of metabolising ondansetron, enzyme inhibition or reduced activity of one enzyme e.g. CYP2D6 genetic deficiency) is normally compensated by other enzymes and should result in little or no significant change in overall ondansetron clearance or dose requirement.
Phenytoin, Carbamazepine and Rifampicin: In patients treated with potent inducers of CYP3A4 (i.e. phenytoin, carbamazepine, and rifampicin), the oral clearance of ondansetron was increased and ondansetron blood concentrations were decreased.
Tramadol: Data from small studies indicate that ondansetron may reduce the analgesic effect of tramadol.
Use of ondansetron with QT prolonging drugs may result in additional QT prolongation. Concomitant use of ondansetron with cardiotoxic drugs (e.g. anthracyclines) may increase the risk of arrhythmias.

4.6 Pregnancy and lactation Pregnancy

The safety of ondansetron for use in human pregnancy has not been established.
Evaluation of experimental animal studies does not indicate direct or indirect harmful effects with respect to the development of the embryo, or foetus, the course of gestation and pre- and post-natal development. However as animal studies are not always predictive of human response the use of ondansetron in pregnancy is not recommended.

Lactation

Tests have shown that ondansetron passes into the milk of lactating animals. It is therefore recommended that mothers receiving ondansetron should not breast-feed their babies.

4.7 Effects on ability to drive and use machines

In psychomotor testing ondansetron does not impair performance nor cause sedation.

4.8 Undesirable effects

Adverse events are listed below by system organ class and frequency. Frequencies are defined as: very common (1/10), common (1/100 to ≤1/10), uncommon (1/1000 to<1/100), rare (1/10,000 to <1/1000) and very rare (<1/10,000). Very common, common and uncommon events were generally determined from clinical trial data. The incidence in placebo was taken into account. Rare and very rare events were generally determined from post-marketing spontaneous data.

The following frequencies are estimated at the standard recommended doses of ondansetron according to indication and formulation.

Immune system disorders	
Rare:	Immediate hypersensitivity reactions, sometimes severe including anaphylaxis.
Nervous system disorders	
Very common:	Headache.
Uncommon:	Seizures, movement disorders (including extrapyramidal reactions such as dystonic reactions, oculogyric crisis and dyskinesia), observed without definitive evidence of persistent clinical sequelae.
Rare:	Dizziness during rapid intravenous administration.
Eye disorders	
Rare:	Transient visual disturbances (e.g. blurred vision), predominantly during intravenous administration.
Very rare:	Transient blindness, predominantly during intravenous administration. The majority of the blindness cases reported resolved within 20 minutes. Most patients had received chemotherapeutic agents, which included cisplatin. Some cases of transient blindness were reported as cortical in origin.
Cardiac disorders	
Uncommon:	Arrhythmias, chest pain with or without ST segment depression, bradycardia.
Very rare:	Transient ECG changes including QT interval prolongation, predominantly with intravenous administration of ondansetron.
Vascular disorders	
Common:	Sensation of warmth or flushing.
Uncommon:	Hypotension.
Respiratory, thoracic and mediastinal disorders	
Uncommon:	Hiccups.
Gastrointestinal disorders	
Common:	Constipation.
Hepatobiliary disorders	
Uncommon:	Asymptomatic increases in liver function tests. These events were observed commonly in patients receiving chemotherapy with cisplatin.
Paediatric population	
The adverse event profiles in children and adolescents were comparable to that seen in adults.	

1.1 Overdose Symptoms and Signs

There is limited experience of ondansetron overdose. In the majority of cases, symptoms were similar to those already reported in patients receiving recommended doses. Manifestations that have been reported include visual disturbances, severe constipation, hypotension and a vasovagal episode with transient second degree AV block.

Treatment

There is no specific antidote for ondansetron, therefore in all cases of suspected overdose, symptomatic and supportive therapy should be given as appropriate.

The use of ipecacuanha to treat overdose with ondansetron is not recommended, as patients are unlikely to respond due to the anti-emetic action of ondansetron itself.

5. Pharmacological Properties

5.1 Pharmacodynamic properties

ATC code:- A04 Antiemetics and antinauseants

ATC group:- A04AA0 1 Serotonin ($5HT_3$) antagonist

Ondansetron is a potent, highly selective 5HTs receptor-antagonist. Its precise mode of action in the control of nausea and vomiting is not known. Chemotherapeutic agents and radiotherapy may cause release of 5HT in the small intestine initiating a vomoting reflex by activating vagal afferents via 5HTs receptors. Ondansetron blocks the initiation of this reflex. Activation of vagal afferents may also cause a release of 5HT in the area postrema, located on the floor of the fourth ventricle, and this may also promote emesis through a central mechanism. Thus, the effect of ondansetron in the management of the nausea and vomiting induced by cytotoxic chemotherapy and radiotherapy is probably due to antagonism of 5HT3 receptors on neurons located both in the peripheral and central nervous system. The mechanisms of action in post-operative nausea and vomiting are not known but there may be common pathways with cytotoxic induced nausea and vomiting.

Ondansetron does not alter plasma prolactin concentrations. The role of ondansetron in opiate-induced emesis is not yet established.

Paediatric population

CINV

The efficacy of ondansetron in the control of emesis and nausea induced by cancer chemotherapy was assessed in a double-blind randomised trial in 415 patients aged 1 to 18 years (S3AB3006). On the days of chemotherapy, patients received either ondansetron 5 mg/m^2 intravenous + ondansetron 4 mg orally after 8-12 hrs or ondansetron 0.45 mg/kg intravenous + placebo orally after 8-12 hrs. Post- chemotherapy both groups received 4 mg ondansetron syrup twice daily for 3 days. Complete control of emesis on worst day of chemotherapy was 49% (5 mg/m^2 intravenous + ondansetron 4 mg orally) and 41% (0.45 mg/kg intravenous + placebo orally). Post-chemotherapy both groups received 4 mg ondansetron syrup twice daily for 3 days.

A double-blind randomised placebo-controlled trial (S3AB4003) in 438 patients aged 1 to 17 years demonstrated complete control of emesis on worst day of chemotherapy in:

- 73% of patients when ondansetron was administered intravenously at a dose of 5 mg/m^2 intravenous together with 2-4 mg dexamethasone orally

- 71% of patients when ondansetron was administered as syrup at a dose of 8 mg + 2-4 mg dexamethasone orally on the days of chemotherapy.

Post-chemotherapy both groups received 4 mg ondansetron syrup twice daily for 2 days.
The efficacy of ondansetron in 75 children aged 6 to 48 months was investigated in an openlabel, non-comparative, single-arm study (S3A40320). All children received three 0.15 mg/kg doses of intravenous ondansetron, administered 30 minutes before the start of chemotherapy and then at four and eight hours after the first dose. Complete control of emesis was achieved in 56% of patients.
Another open-label, non-comparative, single-arm study (S3A239) investigated the efficacy of one intravenous dose of 0.15 mg/kg ondansetron followed by two oral ondansetron doses of 4 mg for children aged < 12 yrs and 8 mg for children aged ≥ 12 yrs (total no. of children n= 28). Complete control of emesis was achieved in 42% of patients.
PONV
The efficacy of a single dose of ondansetron in the prevention of post-operative nausea and vomiting was investigated in a randomised, double-blind, placebo-controlled study in 670 children aged 1 to 24 months (post-conceptual age ≥ 44 weeks, weight ≥ 3 kg). Included subjects were scheduled to undergo elective surgery under general anaesthesia and had an ASA status III. A single dose of ondansetron 0.1 mg/kg was administered within five minutes following induction of anaesthesia. The proportion of subjects who experienced at least one emetic episode during the 24-hour assessment period (ITT) was greater for patients on placebo than those receiving ondansetron ((28% vs. 11%, p <0.0001).

Four double-blind, placebo-controlled studies have been performed in 1469 male and female patients (2 to 12 years of age) undergoing general anaesthesia. Patients were randomised to either single intravenous doses of ondansetron (0.1 mg/kg for paediatric patients weighing 40 kg or less, 4 mg for paediatric patients weighing more than 40 kg; number of patients = 735)) or placebo (number of patients = 734). Study drug was administered over at least 30 seconds, immediately prior to or following anaesthesia induction. Ondansetron was significantly more effective than placebo in preventing nausea and vomiting. The results of these studies are summarised in Table 3.

Table 3 Prevention and treatment of PONV in Paediatric Patients – Treatment response over 24 hours

Study	Endpoint	Ondansetron %	Placebo	% p value
S3A380	CR	68	39	≤ 0.001
S3GT09	CR	61	35	≤ 0.001
S3A381	CR	53	17	≤ 0.001
S3GT11	no nausea	64	51	0.004
S3GT11	no emesis	60	47	0.004

CR = no emetic episodes, rescue or withdrawal

5.2 Pharmacokinetic properties
Following oral administration, ondansetron is passively and completely absorbed from the gastrointestinal tract and undergoes first pass metabolism. Peak plasma concentrations of about 30ng/ml are attained approximately 1.5 hours after an 8mg dose. For doses above 8mg the increase in ondansetron systemic exposure with dose is greater than proportional; this may reflect some reduction in first pass metabolism at higher oral doses. Bioavailability, following oral administration, is slightly enhanced by the presence of food but unaffected by antacids. Studies in healthy elderly volunteers have shown slight, but clinically insignificant, age-related increases in both oral bioavailability (65%) and half-life (five hours) of ondansetron.

Gender differences were shown in the disposition of ondansetron, with females having a greater rate and extent of absorption following an oral dose and reduced systemic clearance and volume of distribution (adjusted for weight). The disposition of ondansetron following oral, intramuscular (IM) and intravenous (IV) dosing is similar with a terminal half life of about three hours and steady state volume of distribution of about 140L. Equivalent systemic exposure is achieved after IM and IV administration of ondansetron.

A 4mg intravenous infusion of ondansetron given over five minutes results in peak plasma concentrations of about 65ng/ml. Following intramuscular administration of ondansetron, peak plasma concentrations of about 25ng/ml are attained within 10 minutes of injection.
Following administration of ondansetron suppository, plasma ondansetron concentrations become detectable between 15 and 60 minutes after dosing.
Concentrations rise in an essentially linear fashion, until peak concentrations of 20-30ng/ml are attained, typically six hours after dosing. Plasma concentrations then fall, but at a slower rate than observed following oral dosing due to continued absorption of ondansetron. The absolute bioavailability ofondansetron from the suppository is approximately 60% and is not affected by gender. The half life of the elimination phase following suppository administration is determined by the rate ofondansetron absorption, not systemic clearance and is approximately six hours. Females show a small, clinically insignificant, increase in half- life in comparison with males.

Ondansetron is not highly protein bound (70-76%). Ondansetron is cleared from the systemic circulation predominantly by hepatic metabolism through multiple enzymatic pathways. Less than 5% of the absorbed dose is excreted unchanged in the urine. The absence of the enzyme CYP2D6 (the debrisoquine polymorphism) has no effect on ondansetron's pharmacokinetics. The pharmacokinetic properties ofondansetron are unchanged on repeat dosing.
Special Patient Populations

Children and Adolescents (aged 1 month to 17 years)
In paediatric patients aged 1 to 4 months (n=19) undergoing surgery, weight normalised clearance was approximately 30% slower than in patients aged 5 to 24 months (n=22) but comparable to the patients aged 3 to 12 years. The half-life in the patient population aged 1 to 4 month was reported to average 6.7 hours compared to 2.9 hours for patients in the 5 to 24 month and 3 to 12 year age range. The differences in pharmacokinetic parameters in the 1 to 4 month patient population can be explained in part by the higher percentage of total body water in neonates and infants and a higher volume of distribution for water soluble drugs like ondansetron.

In paediatric patients aged 3 to 12 years undergoing elective surgery with general anaesthesia, the absolute values for both the clearance and volume of distribution of ondansetron were reduced in comparison to values with adult patients. Both parameters increased in a linear fashion with weight and by 12 years of age, the values were approaching those of young adults. When clearance and volume of distribution values were normalised by body weight, the values for these parameters were similar between the different age group populations. Use of weight-based dosing compensates for age-related changes and is effective in normalising systemic exposure in paediatric patients.

Population pharmacokinetic analysis was performed on 428 subjects (cancer patients, surgery patients and healthy volunteers) aged 1 month to 44 years following intravenous administration of ondansetron. Based on this analysis, systemic exposure (AUC) of

ondansetron following oral or IV dosing in children and adolescents was comparable to adults, with the exception of infants aged 1 to 4 months. Volume was related to age and was lower in adults than in infants and children. Clearance was related to weight but not to age with the exception of infants aged 1 to 4 months. It is difficult to conclude whether there was an additional reduction in clearance related to age in infants 1 to 4 months or simply inherent variability due to the low number of subjects studied in this age group. Since patients less than 6 months of age will only receive a single dose in PONV a decreased clearance is not likely to be clinically relevant.
In patients with renal impairment (creatinine clearance 15-60 ml/min), both systemic clearance and volume of distribution are reduced following IV administration of ondansetron, resulting in a slight, but clinically insignificant, increase in elimination half-life (5.4h). A study in patients with severe renal impairment who required regular haemodialysis (studied between dialyses) showed ondansetron's pharmacokinetics to be essentially unchanged following IV administration.

Specific studies in the elderly or patients with renal impairment have been limited to IV and oral administration. However, it is anticipated that the half-life of ondansetron after rectal administration in these populations will be similar to that seen in healthy volunteers, since the rate of elimination of ondansetron following rectal administration is not determined by systemic clearance.

Following oral, intravenous or intramuscular dosing in patients with severe hepatic impairment, ondansetron's systemic clearance is markedly reduced with prolonged elimination half-lives (15-32 h) and an oral bioavailability approaching 100% due to reduced pre-systemic metabolism. The pharmacokinetics of ondansetron following administration as a suppository have not been evaluated in patients with hepatic impairment.

5.3 Preclinical safety data
No additional data of relevance.

6. Pharmaceutical Particulars

6.1 List of Excipients: Lactose, Micro Crystalline Cellulose, Pre Gelatinised Starch Sodium Starch Glycolate, Colloidal Anhydrous Silica, Magnesium Stearate & Purified Water

Film Coating material for Onsett 4
Opadry White 05K580001 contains Titanium Dioxide, HPMC 2910/Hypromellose 3cP, HPMC 2910/Hypromellose 6cP & Triacetin.

Film Coating material for Onsett 8

Opadry Yellow 05K520001 contains HPMC 2910/Hypromellose 3cP, HPMC 2910/Hypromellose 6cP, Titanium Dioxide, Triacetin, Iron Oxide Yellow.

6.2 Incompatibilities
None reported.

6.3 Shelf life
24 Months

6.4 Special precautions for storage

Store below 30°C.
Keep all medicines out of reach and sight of children.

6.5 Nature and contents of container

Onsett 4 mg and 8 mg tablets are packed in Alu/Alu printed blister foil containing 10 tablets.
Keep 10 blisters in a carton along with pack insert.

6.6 Special precautions for disposal and other handling

None stated.

7. Marketing Authorisation Holder

Cadila Pharmaceuticals Limited
1389, Trasad Road, Dholka – 382 225,
Dist: Ahmedabad, Gujarat State, India.

8. Marketing Authorisation Number(s)

Not applicable

9. Date of first authorisation/renewal of the authorisation

Renewal

10. DATE OF REVISION OF THE TEXT

23/06/2018