SUMMARY OF PRODUCT CHARACTERISTICS

1. NAME OF THE MEDICINAL PRODUCT

Singulair® 5 mg chewable tablets

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

One chewable tablet contains montelukast sodium, which is equivalent to 5 mg montelukast.

Excipients with known effect: This medicinal product contains 1,5 mg aspartame (E 951) per tablet.

This medicinal product contains up to 0.45 mg benzyl alcohol (E 1519) per tablet.

For the full list of excipients, see section 6.1.

3. PHARMACEUTICAL FORM

Chewable tablet.

Pink, round, biconvex, diameter 9,5 mm with SINGULAIR engraved on one side and MSD 275 on the other.

4. CLINICAL PARTICULARS

4.1 Therapeutic indications

Singulair is indicated in the treatment of asthma as add-on therapy in those patients with mild to moderate persistent asthma who are inadequately controlled on inhaled corticosteroids and in whom “as-needed” short acting β-agonists provide inadequate clinical control of asthma.

Singulair may also be an alternative treatment option to low-dose inhaled corticosteroids for patients

with mild persistent asthma who do not have a recent history of serious asthma attacks that required oral corticosteroid use and who have demonstrated that they are not capable of using inhaled corticosteroids (see section 4.2).

Singulair is also indicated in the prophylaxis of asthma in which the predominant component is exercise-induced bronchoconstriction.

4.2 Posology and method of administration

Posology

The recommended dose for paediatric patients 6-14 years of age is one 5 mg chewable tablet daily to be taken in the evening. If taken in connection with food, Singulair should be taken 1 hour before or 2 hours after food. No dosage adjustment within this age group is necessary.

General recommendations

The therapeutic effect of Singulair on parameters of asthma control occurs within one day. Patients should be advised to continue taking Singulair even if their asthma is under control, as well as during periods of worsening asthma.

No dosage adjustment is necessary for patients with renal insufficiency or mild to moderate hepatic impairment. There are no data on patients with severe hepatic impairment. The dosage is the same for both male and female patients.

Singulair as an alternative treatment option to low-dose inhaled corticosteroids for mild persistent asthma

Montelukast is not recommended as monotherapy in patients with moderate persistent asthma. The use of montelukast as an alternative treatment option to low-dose inhaled corticosteroids for children with mild persistent asthma should only be considered for patients who do not have a recent history

of serious asthma attacks that required oral corticosteroid use and who have demonstrated that they are not capable of using inhaled corticosteroids (see section 4.1). Mild persistent asthma is defined as asthma symptoms more than once a week but less that once a day, nocturnal symptoms more than twice a month but less than once a week, normal lung function between episodes. If satisfactory control of asthma is not achieved at follow-up (usually within one month), the need for an additional or different anti-inflammatory therapy based on the step system for asthma therapy should be evaluated. Patients should be periodically evaluated for their asthma control.

Therapy with Singulair in relation to other treatments for asthma

When treatment with Singulair is used as add-on therapy to inhaled corticosteroids, Singulair should not be abruptly substituted for inhaled corticosteroids (see section 4.4).

10 mg tablets are available for adults and adolescents 15 years of age and older.

Paediatric population

Do not give Singulair 5 mg chewable tablets to children less than 6 years of age. The safety and efficacy of Singulair 5 mg chewable tablets in children less than 6 years of age has not been established.

4 mg chewable tablets are available for paediatric patients 2 to 5 years of age.

4 mg granules are available for paediatric patients 6 months to 5 years of age.

Method of administration

Oral use.

The tablets are to be chewed before swallowing.

4.3 Contraindications

Hypersensitivity to the active substance or to any of the excipients listed in section 6.1.

4.4 Special warnings and precautions for use

Patients should be advised never to use oral montelukast to treat acute asthma attacks and to keep their usual appropriate rescue medication for this purpose readily available. If an acute attack occurs, a short-acting inhaled β-agonist should be used. Patients should seek their doctors' advice as soon as possible if they need more inhalations of short-acting β-agonists than usual.

Montelukast should not be abruptly substituted for inhaled or oral corticosteroids.

There are no data demonstrating that oral corticosteroids can be reduced when montelukast is given concomitantly.

In rare cases, patients on therapy with anti-asthma agents including montelukast may present with systemic eosinophilia, sometimes presenting with clinical features of vasculitis consistent with Churg-Strauss syndrome, a condition which is often treated with systemic corticosteroid therapy. These cases have been sometimes associated with the reduction or withdrawal of oral corticosteroid therapy. Although a causal relationship with leukotriene receptor antagonism has not been established, physicians should be alert to eosinophilia, vasculitic rash, worsening pulmonary symptoms, cardiac complications and/or neuropathy presenting in their patients. Patients who develop these symptoms should be reassessed and their treatment regimens evaluated.

Treatment with montelukast does not alter the need for patients with aspirin-sensitive asthma to avoid taking aspirin and other non-steroidal anti-inflammatory drugs.

Neuropsychiatric events such as behavioural changes, depression and suicidality have been reported in all age groups taking montelukast (see section 4.8). The symptoms may be serious and

continue if the treatment is not withdrawn. Therefore, the treatment with montelukast should be discontinued if neuropsychiatric symptoms occur during treatment.

Advise patients and/or caregivers to be alert for neuropsychiatric events and instruct them to notify their physician if these changes in behaviour occur.

Aspartame

Singulair contains aspartame, a source of phenylalanine. Each 5 mg chewable tablet contains 1.5 mg aspartame, corresponding to 0.842 mg phenylalanine per dose. It may be harmful for patients with phenylketonuria.

Sodium

This medicinal product contains less than 1 mmol sodium (23 mg) per tablet, that is to say essentially ‘sodium-free’.

Benzyl alcohol

This medicinal product contains up to 0.45 mg benzyl alcohol per tablet. Benzyl alcohol may cause allergic reactions.

High volumes should be used with caution and only if necessary, especially in subjects with liver or kidney impairment, or those who are pregnant or breast-feeding, because of the risk of accumulation and toxicity (metabolic acidosis).

4.5 Interactions with other medicinal products and other forms of interaction

Montelukast may be administered with other therapies routinely used in the prophylaxis and chronic treatment of asthma. In drug-interactions studies, the recommended clinical dose of montelukast did not have clinically important effects on the pharmacokinetics of the following medicinal products: theophylline, prednisone, prednisolone, oral contraceptives (ethinylestradiol/norethindrone 35/1),

terfenadine, digoxin and warfarin.

The area under the plasma concentration curve (AUC) for montelukast was decreased approximately 40 % in subjects with co-administration of phenobarbital. Since montelukast is metabolised by CYP 3A4, 2C8 and 2C9, caution should be exercised, particularly in children, when montelukast is co-administered with inducers of CYP 3A4, 2C8 and 2C9, such as phenytoin, phenobarbital and rifampicin.

In vitro studies have shown that montelukast is a potent inhibitor of CYP 2C8. However, data from a clinical drug-drug interaction study involving montelukast and rosiglitazone (a probe substrate representative of medicinal products primarily metabolised by CYP 2C8) demonstrated that montelukast does not inhibit CYP 2C8 *in vivo*. Therefore, montelukast is not anticipated to markedly alter the metabolism of medicinal products metabolised by this enzyme (e.g. paclitaxel, rosiglitazone and repaglinide).

In vitro studies have shown that montelukast is a substrate of CYP 2C8 and to a less significant extent, of 2C9 and 3A4. In a clinical drug-drug interaction study involving montelukast and gemfibrozil (an inhibitor of both CYP 2C8 and 2C9) gemfibrozil increased the systemic exposure of montelukast by 4,4-fold. No routine dosage adjustment of montelukast is required upon co-administration with gemfibrozil or other potent inhibitors of CYP 2C8, but the physician should be aware of the potential for an increase in adverse reactions.

Based on *in vitro* data, clinically important drug interactions with less potent inhibitors of CYP 2C8 (e.g. trimethoprim) are not anticipated. Co-administration of montelukast with itraconazole, a strong inhibitor of CYP 3A4, resulted in no significant increase in the systemic exposure of montelukast.

4.6 Fertility, pregnancy and lactation

Pregnancy

Animal studies do not indicate harmful effects with respect to effects on pregnancy or embryonal/foetal development.

Available data from published prospective and retrospective cohort studies with montelukast use in pregnant women evaluating major birth defects have not established a drug-associated risk. Available studies have methodologic limitations, including small sample size, in some cases retrospective data collection, and inconsistent comparator groups.

Singulair may be used during pregnancy only if it is considered to be clearly essential.

Breastfeeding

Studies in rats have shown that montelukast is excreted in milk (see section 5.3). It is unknown whether montelukast/metabolites are excreted in human milk.

Singulair may be used in breastfeeding mothers only if it is considered to be clearly essential.

4.7 Effects on ability to drive and use machines

Singulair has no or negligible influence on the ability to drive and use machines. However, individuals have reported drowsiness or dizziness.

4.8 Undesirable effects

Montelukast has been evaluated in clinical studies as follows:

- 10 mg film-coated tablets in approximately 4 000 adult and adolescent patients 15 years of age and older, and
- 5 mg chewable tablets in approximately 1 750 paediatric patients 6 to 14 years of age.

The following drug-related adverse reactions in clinical studies were reported commonly (≥ 1/100 to < 1/10) in patients treated with montelukast and at a greater incidence than in patients treated with placebo:

Body System Class	**Adult and Adolescent Patients 15 years and older (two 12-week studies; n=795)**	**Paediatric Patients 6 to 14 years old (one 8-week study; n=201) (two 56-week studies; n=615)**
Nervous system disorders	headache	headache
Gastrointestinal disorders	abdominal pain	

With prolonged treatment in clinical trials with a limited number of patients for up to 2 years for adults and up to 12 months for paediatric patients 6 to 14 years of age, the safety profile did not change.

Tabulated list of Adverse Reactions

Adverse reactions reported in post-marketing use are listed, by System Organ Class and specific Adverse Reactions, in the table below. Frequency Categories were estimated based on relevant clinical trials.

System Organ Class	**Adverse Reactions**	**Frequency Category***
Infections and infestations	upper respiratory infection†	Very Common
Blood and lymphatic system disorders	increased bleeding tendency	Rare
	thrombocytopenia	Very Rare
Immune system disorders	hypersensitivity reactions including anaphylaxis	Uncommon
	hepatic eosinophilic infiltration	Very Rare
Psychiatric disorders	dream abnormalities including nightmares, insomnia,	Uncommon

	somnambulism, anxiety, agitation including aggressive behaviour or hostility, depression, psychomotor hyperactivity (including irritability, restlessness, tremor§)	
	disturbance in attention, memory impairment, tic	Rare
	hallucinations, disorientation, suicidal thinking and behaviour (suicidality), obsessive-compulsive symptoms, dysphemia	Very Rare
Nervous system disorders	dizziness, drowsiness, paraesthesia/hypoesthesia, seizure	Uncommon
Cardiac disorders	palpitations	Rare
Respiratory, thoracic and mediastinal disorders	epistaxis	Uncommon
	Churg-Strauss Syndrome (CSS) (see section 4.4)	Very Rare
	pulmonary eosinophilia	Very Rare
Gastrointestinal disorders	diarrhoea‡, nausea‡, vomiting‡	Common
	dry mouth, dyspepsia	Uncommon
Hepatobiliary disorders	elevated levels of serum transaminases (ALT, AST)	Common
	hepatitis (including cholestatic, hepatocellular and mixed-pattern liver injury).	Very Rare
Skin and subcutaneous tissue	rash‡	Common

disorders	bruising, urticaria, pruritus	Uncommon
	angioedema	Rare
	erythema nodosum, erythema multiforme	Very Rare
Musculoskeletal and connective tissue disorders	arthralgia, myalgia including muscle cramps	Uncommon
Renal and urinary disorders	enuresis in children	Uncommon
General disorders and administration site conditions	pyrexia‡	Common
	asthenia/fatigue, malaise, oedema	Uncommon

*Frequency Category: Defined for each Adverse Reaction by the incidence reported in the clinical trials data base: 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).

†This adverse experience, reported as Very Common in the patients who received montelukast, was also reported as Very Common in the patients who received placebo in clinical trials.

‡This adverse experience, reported as Common in the patients who received montelukast, was also reported as Common in the patients who received placebo in clinical trials.

§Frequency Category: Rare

Reporting of suspected adverse reactions

Reporting suspected adverse reactions after authorisation of the medicinal product is important. It allows continued monitoring of the benefit/risk balance of the medicinal product. Healthcare professionals are asked to report any suspected adverse reactions.

4.9 Overdose

In chronic asthma studies, montelukast has been administered at doses up to 200 mg/day to adult patients for 22 weeks and in short term studies, up to 900 mg/day to patients for approximately one week without clinically important adverse experiences.

There have been reports of acute overdose in post-marketing experience and clinical studies with montelukast. These include reports in adults and children with a dose as high as 1 000 mg (approximately 61 mg/kg in a 42 month old child). The clinical and laboratory findings observed were consistent with the safety profile in adults and paediatric patients. There were no adverse experiences in the majority of overdose reports.

Symptoms of overdose

The most frequently occurring adverse experiences were consistent with the safety profile of montelukast and included abdominal pain, somnolence, thirst, headache, vomiting and psychomotor hyperactivity.

Management of overdose

No specific information is available on the treatment of overdose with montelukast. It is not known whether montelukast is dialysable by peritoneal- or haemodialysis.

5. PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: Leukotriene receptor antagonist

ATC-code: R03D C03

Mechanism of action

The cysteinyl leukotrienes (LTC_4, LTD_4, LTE_4) are potent inflammatory eicosanoids released from various cells including mast cells and eosinophils. These important pro-asthmatic mediators bind to cysteinyl leukotriene receptors (CysLT) found in the human airway and cause airway actions, including bronchoconstriction, mucous secretion, vascular permeability and eosinophil recruitment.

Pharmacodynamic effects

Montelukast is an orally active compound which binds with high affinity and selectivity to the $CysLT_1$ receptor. In clinical studies, montelukast inhibits bronchoconstriction due to inhaled LTD_4 at doses as low as 5 mg. Bronchodilation was observed within 2 hours of oral administration. The bronchodilation effect caused by a β-agonist was additive to that caused by montelukast. Treatment with montelukast inhibited both early- and late-phase bronchoconstriction due to antigen challenge. Montelukast, compared with placebo, decreased peripheral blood eosinophils in adult and paediatric patients. In a separate study, treatment with montelukast significantly decreased eosinophils in the airways (as measured in sputum) and in peripheral blood while improving clinical asthma control.

Clinical efficacy and safety

In studies in adults, montelukast, 10 mg once daily, compared with placebo, demonstrated significant improvements in morning FEV_1 (10,4 % vs. 2,7 % change from baseline), AM peak expiratory flow rate (PEFR) (24,5 l/min vs. 3,3 l/min change from baseline) and significant decrease in total β-agonist use (-26,1 % vs. -4,6 % change from baseline). Improvement in patient-reported daytime and night-time asthma symptoms scores was significantly better than placebo.

Studies in adults demonstrated the ability of montelukast to add to the clinical effect of inhaled corticosteroid (% change from baseline for inhaled beclomethasone plus montelukast vs. beclomethasone, respectively for FEV_1: 5,43 % vs. 1,04 %; β-agonist use: -8,70 % vs. 2,64 %). Compared with inhaled beclomethasone (200 µg twice daily with a spacer device), montelukast demonstrated a more rapid initial response, although over the 12-week study, beclomethasone provided a greater average treatment effect (% change from baseline for montelukast vs. beclomethasone, respectively for FEV_1: 7,49 % vs. 13,3 %; β-agonist use: - 28,28 % vs. -43,89 %). However, compared with beclomethasone, a high percentage of patients treated with montelukast achieved similar clinical responses (e.g. 50 % of patients treated with beclomethasone achieved an

improvement in FEV_1 of approximately 11 % or more over baseline while approximately 42 % of patients treated with montelukast achieved the same response).

In an 8-week study in paediatric patients 6 to 14 years of age, montelukast 5 mg once daily, compared with placebo, significantly improved respiratory function (FEV_1 8,71 % vs. 4,16 % change from baseline; AM PEFR 27,9 l/min vs. 17,8 l/min change from baseline) and decreased "as-needed" β-agonist use (-11,7 % vs. +8,2 % change from baseline).

In a 12-month study comparing the efficacy of montelukast to inhaled fluticasone on asthma control in paediatric patients 6 to 14 years of age with mild persistent asthma, montelukast was non-inferior to fluticasone in increasing the percentage of asthma rescue-free days (RFDs), the primary endpoint. Averaged over the 12-month treatment period, the percentage of asthma RFDs increased from 61,6 to 84,0 in the montelukast group and from 60,9 to 86,7 in the fluticasone group. The between group difference in LS mean increase in the percentage of asthma RFDs was statistically significant (-2,8 with a 95 % CI of -4,7, -0,9), but within the limit pre-defined to be clinically not inferior.

Both montelukast and fluticasone also improved asthma control on secondary variables assessed over the 12 month treatment period:

FEV_1 increased from 1,83 l to 2,09 l in the montelukast group and from 1,85 l to 2,14 l in the fluticasone group. The between-group difference in LS mean increase in FEV_1 was -0,02 l with a 95 % CI of -0,06, 0,02. The mean increase from baseline in % predicted FEV_1 was 0,6 % in the montelukast treatment group and 2,7 % in the fluticasone treatment group. The difference in LS means for the change from baseline in the % predicted FEV_1 was significant: -2,2 % with a 95 % CI of -3,6, -0,7.

The percentage of days with β-agonist use decreased from 38,0 to 15,4 in the montelukast group and from 38,5 to 12,8 in the fluticasone group. The between group difference in LS means for the percentage of days with β-agonist use was significant: 2,7 with a 95 % CI of 0,9, 4,5.

The percentage of patients with an asthma attack (an asthma attack being defined as a period of

worsening asthma that required treatment with oral steroids, an unscheduled visit to the doctor's office, an emergency room visit or hospitalisation) was 32,2 in the montelukast group and 25,6 in the fluticasone group; the odds ratio (95 % CI) being significant: equal to 1,38 (1,04, 1,84).
The percentage of patients with systemic (mainly oral) corticosteroid use during the study period was 17,8 % in the montelukast group and 10,5 % in the fluticasone group. The between group difference in LS means was significant: 7,3 % with a 95 %CI of 2,9; 11,7.

Significant reduction of exercise-induced bronchoconstriction (EIB) was demonstrated in a 12-week study in adults (maximal fall in FEV_1 22,33 % for montelukast vs. 32,40 % for placebo; time to recovery to within 5 % of baseline FEV_1 44,22 min vs. 60,64 min). This effect was consistent throughout the 12-week study period. Reduction in EIB was also demonstrated in a short-term study in paediatric patients (maximal fall in FEV_1 18,27 % vs. 26,11 %; time to recovery to within 5 % of baseline FEV_1 17,76 min vs. 27,98 min). The effect in both studies was demonstrated at the end of the once-daily dosing interval.

In aspirin-sensitive asthmatic patients receiving concomitant inhaled and/or oral corticosteroids, treatment with montelukast, compared with placebo, resulted in significant improvement in asthma control (FEV_1 8,55 % vs. -1,74 % change from baseline and decrease in total β-agonist use -27,78 % vs. 2,09 % change from baseline).

5.2 Pharmacokinetic properties

Absorption

Montelukast is rapidly absorbed following oral administration. For the 10 mg film-coated tablet, the mean peak plasma concentration (C_{max}) is achieved 3 hours (T_{max}) after administration in adults in the fasted state. The mean oral bioavailability is 64 %. The oral bioavailability and C_{max} are not influenced by a standard meal. Safety and efficacy were demonstrated in clinical trials where the 10 mg film-coated tablet was administered without regard to the timing of food ingestion.

For the 5 mg chewable tablet, the C_{max} is achieved in 2 hours after administration in adults in the fasted state. The mean oral bioavailability is 73 % and is decreased to 63 % by a standard meal.

Distribution

Montelukast is more than 99 % bound to plasma proteins. The steady-state volume of distribution of montelukast averages 8-11 litres. Studies in rats with radio-labelled montelukast indicate minimal distribution across the blood-brain barrier. In addition, concentrations of radio-labelled material at 24 hours post-dose were minimal in all other tissues.

Biotransformation

Montelukast is extensively metabolised. In studies with therapeutic doses, plasma concentrations of metabolites of montelukast are undetectable at steady-state in adults and children.

Cytochrome P450 2C8 is the major enzyme in the metabolism of montelukast. Additionally, CYP 3A4 and 2C9 may have a minor contribution, although itraconazole, an inhibitor of CYP 3A4, was shown not to change pharmacokinetic variables of montelukast in healthy subjects that received 10 mg montelukast daily. Based on *in vitro* results in human liver microsomes, therapeutic plasma concentrations of montelukast do not inhibit cytochromes P450 3A4, 2C9, 1A2, 2A6, 2C19 or 2D6. The contribution of metabolites to the therapeutic effect of montelukast is minimal.

Elimination

The plasma clearance of montelukast averages 45 ml/min in healthy adults. Following an oral dose of radio-labelled montelukast, 86 % of the radioactivity was recovered in 5-day faecal collections and < 0,2 % was recovered in urine. Coupled with estimates of montelukast oral bioavailability, this indicates that montelukast and its metabolites are excreted almost exclusively via the bile.

Characteristics in Patients

No dosage adjustment is necessary for the elderly or mild to moderate hepatic insufficiency. Studies in patients with renal impairment have not been undertaken. Because montelukast and its metabolites are eliminated by the biliary route, no dose adjustment is anticipated to be necessary in patients with renal impairment. There are no data on the pharmacokinetics of montelukast in patients with severe hepatic insufficiency (Child-Pugh score > 9).

With high doses of montelukast (20- and 60-fold the recommended adult dose), a decrease in plasma theophylline concentration was observed. This effect was not seen at the recommended dose of 10 mg once daily.

5.3 Preclinical safety data

In animal toxicity studies, minor serum biochemical alterations in ALT, glucose, phosphorus and triglycerides were observed which were transient in nature. The signs of toxicity in animals were increased excretion of saliva, gastrointestinal symptoms, loose stools and ion imbalance. These occurred at dosages which provided > 17-fold the systemic exposure seen at the clinical dosage. In monkeys, the adverse effects appeared at doses from 150 mg/kg/day (> 232-fold the systemic exposure seen at the clinical dose). In animal studies, montelukast did not affect fertility or reproductive performance at systemic exposure exceeding the clinical systemic exposure by greater than 24-fold. A slight decrease in pup body weight was noted in the female fertility study in rats at 200 mg/kg/day (> 69-fold the clinical systemic exposure). In studies in rabbits, a higher incidence of incomplete ossification, compared with concurrent control animals, was seen at systemic exposure > 24-fold the clinical systemic exposure seen at the clinical dose. No abnormalities were seen in rats. Montelukast has been shown to cross the placental barrier and is excreted in breast milk of animals.

No deaths occurred following a single oral administration of montelukast sodium at doses up to 5 000 mg/kg in mice and rats (15 000 mg/m^2 and 30 000 mg/m^2 in mice and rats, respectively), the

maximum dose tested. This dose is equivalent to 25 000 times the recommended daily adult human dose (based on an adult patient weight of 50 kg).

Montelukast was determined not to be phototoxic in mice for UVA, UVB or visible light spectra at doses up to 500 mg/kg/day (approximately > 200-fold based on systemic exposure).

Montelukast was neither mutagenic in *in vitro* and *in vivo* tests nor tumorigenic in rodent species.

6. PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Mannitol (E 421)

Microcrystalline cellulose

Hyprolose (E 463)

Red ferric oxide (E 172)

Croscarmellose sodium

Cherry flavour containing benzyl alcohol (E 1519)

Aspartame (E 951)

Magnesium stearate

6.2 Incompatibilities

Not applicable.

6.3 Shelf-life

2 years.

6.4 Special precautions for storage

Store in the original package in order to protect from light and moisture. Do not store above 30 °C.

Keep out of the reach and sight of children.

6.5 Nature and contents of container

Packaged in polyamide/PVC/aluminium blister package in:

Blisters in packages of 7, 10, 14, 20, 28, 30, 50, 56, 84, 90, 98, 100, 140 and 200 tablets.

Blisters (unit doses), in packages of 49, 50 and 56 tablets.

Not all pack sizes may be marketed.

6.6 Special precautions for disposal

Any unused medicinal product or waste material should be disposed of in accordance with local requirements.

7. MARKETING AUTHORISATION HOLDER

Organon South Africa (Pty) Ltd

Spaces, 1st Floor, 22 Magwa Crescent, Gateway West

Waterfall City, Midrand, 2090

South Africa

8. NAME OF MANUFACTURER

Organon Pharma (UK) Limited

Shotton Lane, Cramlington,

Northumberland NE23 3JU

UK

9. MARKETING AUTHORISATION NUMBER(S)

COUNTRY	
BOTSWANA	VA220375; BOT1202259
ETHIOPIA	08083/08014/VAR/2022
KENYA	H2014/CTD1315/723
NAMIBIA	04/10.2.2/1157
NIGERIA (NAFDAC REG. NO.)	B4-0022
TANZANIA	A0015/HM/0062/A7
UGANDA	TBA
ZAMBIA	TBA
ZIMBABWE	TBA

10. SCHEDULING STATUS

POM	R_X ONLY

BOTSWANA SCHEDULING: S2

NAMIBIA SCHEDULING: NS2

ZIMBABWE SCHEDULING: TBA

11. DATE OF FIRST AUTHORISATION

COUNTRY	
BOTSWANA	06/12/2012
ETHIOPIA	01/11/2012
KENYA	18/12/2014
NAMIBIA	18/08/2004

NIGERIA	02/08/2013
TANZANIA	08/02/2016
UGANDA	TBA
ZAMBIA	TBA
ZIMBABWE	TBA

12. DATE OF REVISION OF THE TEXT

08 December 2023

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