1. NAME OF THE MEDICINAL PRODUCT

CLARICIN (CLARITHROMYCIN TABLETS USP 500 MG)

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

Each film-coated tablets contains:

Clarithromycin 500 mg

Excipients Q.S.

Colour: Titanium Dioxide

Batch size: 300,000 tablets

S/n	Ingredients	Specification	Quantity (mg)	Overages (%)	Quantity required (kg)	Use/Function
	Dry mixing					
1.	Clarithromycin	USP	500.00	--	150.000	Active ingredient
2.	Sancel 101 M.C.C.P	BP	191.80	--	57.540	Binder
3.	Cross Carmellose Sodium	BP	16.00	--	4.800	Disintegrant
4.	Tween 80	BP	2.20	--	0.660	Surfactant
	Lubrication					
5.	Sancel 101 M.C.C.P	BP	99.00	--	29.700	Diluent
6.	Cross Carmellose Sodium	BP	20.00	--	6.000	Disintegrant
7.	Magnesium Stearate	BP	8.50	--	2.550	Lubricant
8.	Talcum	BP	9.00	--	2.700	Lubricant
9.	Aerosil	BP	3.50	--	1.050	Lubricant
	Coating					
10.	Instacoat IC-U 1308 White	HIS	12.75	--	3.825	Coating agent
11.	Isopropyl alcohol	BP	--	--	19.890 Litres	Vehicle
12.	Methylene dichloride	BP	--	--	29.835 Litres	Vehicle

3. PHARMACEUTICAL FORM

The product is a white to off white coloured film-coated tablet. It should be swallowed whole and not crushed or divided into two.

4. Clinical particulars

4.1 Therapeutic indications

Claricin 500mg film-coated tablets are indicated in the treatment of the following bacterial infections, when caused by clarithromycin-susceptible bacteria.

- Bacterial pharyngitis
- Mild to moderate community acquired pneumonia
- Acute bacterial sinusitis (adequately diagnosed)
- Acute exacerbation of chronic bronchitis
- Skin infections and soft tissue infections of mild to moderate severity,
- In appropriate combination with antibacterial therapeutic regimens and an appropriate ulcer healing agent for the eradication of Helicobacter pylori in patients with Helicobacter pylori associated ulcers.

Consideration should be given to official guidelines on the appropriate use of antibacterial agents.

4.2 Posology and method of administration

Posology

Patients with respiratory tract/skin and soft tissue infections

Adults: Claricin 500mg film-coated tablets is taken as one tablet twice daily for the treatment of severe infections. The usual duration of treatment is 6 to 14 days.

Children older than 12 years: The dose for children above 12 years is the same as the dose for adults.

Children younger than 12 years: Claricin 500mg film-coated tablet is not recommended for children younger than 12 years. Clinical trials have been conducted using clarithromycin paediatric suspension in children 6 months to 12 years of age. Therefore, children under 12 years of age should use clarithromycin paediatric suspension (granules for oral suspension).

Clarithromycin may be given without regard to meals as food does not affect its extent of bioavailability.

Eradication of H. pylori in patients with duodenal ulcers (Adults)

The usual duration of treatment is 6 to 14 days.

Triple Therapy:

Clarithromycin 500mg twice daily and lansoprazole 30mg twice daily should be given with amoxycillin 1000mg twice daily. OR Clarithromycin 500mg twice daily and lansoprazole 30mg twice daily should be given

with metronidazole 400mg twice daily. OR Clarithromycin 500mg twice daily and omeprazole 40mg daily should be given with amoxycillin 1000mg twice daily or metronidazole 400mg twice daily.

Elderly: Claricin 500mg film-coated tablet dose for the elderly is the same as for adults.

Renal impairment: In pateints with renal impairment with creatinine clearance less than 30 Ml/min, the dosage of clarithromycin should be reduced by one-half, i.e. 250 mg once daily or 250 mg twice daily in more severe infections. Treatment should not be continued beyond 14 days in these patients.

Clarithromycin may be given without regard to meals as food does not affect the extent of bioavailability.

4.3 Contraindications

- Hypersensitivity to macrolide antibiotic drugs or to any of its excipients.
- Concomitant administration of clarithromycin and ergot alkaloids (e.g. ergotamine or dihydroergotamine) is contraindicated, as this may result in ergot toxicity (see section 4.5).
- Concomitant administration of clarithromycin and oral midazolam is contraindicated.
- Concomitant administration of clarithromycin and any of the following drugs is contraindicated: astemizole, cisapride, pimozide and terfenadine as this may result in QT prolongation and cardiac arrhythmias, including ventricular tachycardia, ventricular fibrillation, and torsades de pointes.
- Concomitant administration of clarithromycin and lomitapide is contraindicated.
- Clarithromycin should not be given to patients with history of QT prolongation (congenital or documented acquired QT prolongation) or ventricular cardiac arrhythmia, including torsades de pointes (see sections 4.4 and 4.5).
- Concomitant administration with ticagrelor or ranolazine is contraindicated.
- Clarithromycin should not be used concomitantly with HMGCoA reductase inhibitors (statins) that are extensively metabolized by CYP3A4, (lovastatin or simvastatin), due to the increased risk of myopathy, including rhabdomyolysis.
- As with other strong CYP3A4 inhibitors, Clarithromycin should not be used in patients taking colchicine.

Clarithromycin should not be given to patients with electrolyte disturbances (hypokalaemia or hypomagnesemia, due to the risk of prolongation of the QT interval).

- Clarithromycin should not be used in patients who suffer from severe hepatic failure in combination with renal impairment.

4.3 Special warnings and precautions for use

Use of any antimicrobial therapy, such as clarithromycin, to treat H. pylori infection may select for drug resistant organisms.

The physician should not prescribe clarithromycin to pregnant women without carefully weighing the benefits against risk, particularly during the first three months of pregnancy.

Caution is advised in patients with severe renal insufficiency. Clarithromycin is principally metabolised by the liver. Therefore, caution should be exercised in administering this antibiotic to patients with impaired hepatic function. Caution should also be exercised when administering clarithromycin to patients with moderate to severe renal impairment. Hepatic dysfunction, including increased liver enzymes, and hepatocellular and/or cholestatic hepatitis, with or without jaundice, has been reported with clarithromycin. This hepatic dysfunction may be severe and is usually reversible. Cases of fatal hepatic failure (see section 4.8) have been reported. Some patients may have had pre-existing hepatic disease or may have been taking other hepatotoxic medicinal products. Patients should be advised to stop treatment and contact their doctor if signs and symptoms of hepatic disease develop, such as anorexia, jaundice, dark urine, pruritus, or tender abdomen. Pseudomembranous colitis has been reported with nearly all antibacterial agents, including macrolides, and may range in severity from mild to life-threatening. Clostridium difficile-associated diarrhoea (CDAD) has been reported with use of nearly all antibacterial agents including clarithromycin, and may range in severity from mild diarrhoea to fatal colitis. Treatment with antibacterial agents alters the normal flora of the colon, which may lead to overgrowth of C. difficile. CDAD must be considered in all patients who present with diarrhoea following antibiotic use. Careful medical history is necessary since CDAD has been reported to occur over two months after the administration of antibacterial agents. Therefore, discontinuation of clarithromycin therapy should be considered regardless of the indication. Microbial testing should be performed and adequate treatment initiated. Drugs inhibiting peristalsis should be avoided. There have been post-marketing reports of colchicine toxicity with concomitant use of clarithromycin and colchicine, especially in the elderly, some of which occurred in patients with renal insufficiency. Deaths have been reported in some such patients. Concomitant administration of clarithromycin and colchicine is contraindicated.

Caution is advised regarding concomitant administration of clarithromycin and triazolobenzodiazepines, such as triazolam, and intravenous or oromucosal midazolam.

Cardiovascular Events:

Prolonged cardiac repolarisation and QT interval, imparting a risk of developing cardiac arrhythmia and torsades de pointes, have been seen in treatment with macrolides including clarithromycin (see section 4.8).

Therefore as the following situations may lead to an increased risk for ventricular arrhythmias (including torsades de pointes), clarithromycin should be used with caution in the following patients;

• Patients with coronary artery disease, severe cardiac insufficiency, conduction disturbances or clinically relevant bradycardia

• Patients concomitantly taking other medicinal products associated with QT prolongation (see section 4.5).
• Concomitant administration of clarithromycin with astemizole, cisapride, pimozide and terfendine is contraindicated.
• Clarithromycin must not be used in patients with congenital or documented acquired QT prolongation or history of ventricular arrhythmia.
Epidemiological studies investigating the risk of adverse cardiovascular outcomes with macrolides have shown variable results. Some observational studies have identified a rare short-term risk of arrhythmia, myocardial infraction and cardiovascular mortality associated with macrolides including clarithromycin. Consideration of these findings should be balanced with treatment benefits when prescribing clarithromycin.

Pneumonia: In view of the emerging resistance of *Streptococcus pneumoniae* to macrolides, it is important that sensitivity testing be performed when prescribing clarithromycin for community-acquired pneumonia. In hospital-acquired pneumonia, clarithromycin should be used in combination with additional appropriate antibiotics.

Skin and soft tissue infections of mild to moderate severity: These infections are most often caused by *Staphylococcus aureus* and *Streptococcus pyogenes*, both of which may be resistant to macrolides. Therefore, it is important that sensitivity testing be performed. In cases where *beta*–lactam antibiotics cannot be used (e.g. allergy), other antibiotics, such as clindamycin, may be the drug of first choice. Currently, macrolides are only considered to play a role in some skin and soft tissue infections, such as those caused by *Corynebacterium minutissimum* (erythrasma), acne vulgaris, and erysipelas and in situations where penicillin treatment cannot be used.
In the event of severe acute hypersensitivity reactions, such as anaphylaxis, severe cutaneous adverse reactions (SCAR) (e.g. Acute generalised exanthematous pustulosis (AGEP), Stevens-Johnson Syndrome, toxic epidermal necrolysis and drug rash with eosinophilia and systemic symptoms (DRESS)) clarithromycin therapy should be discontinued immediately and appropriate treatment should be urgently initiated.
Clarithromycin should be used with caution when administered concurrently with medications that induce the cytochrome CYP3A4 enzyme.
HMG-CoA reductase inhibitors (statins): Concomitant use of clarithromycin with lovastatin or simvastatin is contraindicated (see section 4.3). Caution should be exercised when prescribing clarithromycin with other statins.
Rhabdomyolysis has been reported in patients taking clarithromycin and statins. Patients should be monitored for signs and symptoms of myopathy.
In situations where the concomitant use of clarithromycin with statins cannot be avoided, it is recommended to prescribe the lowest registered dose of the statin. Use of a statin that is not dependent on CYP3A metabolism (e.g. fluvastatin) can be considered.
Oral hypoglycaemic agents/Insulin: The concomitant use of clarithromycin and oral hypoglycaemic agents

(such as sulphonylurias) and/or insulin can result in significant hypoglycaemia. Careful monitoring of glucose is recommended.

Oral anticoagulants: There is a risk of serious haemorrhage and significant elevations in International Normalized Ratio (INR) and prothrombin time when clarithromycin is co-administered with warfarin (see section 4.5). INR and prothrombin times should be frequently monitored while patients are receiving clarithromycin and oral anticoagulants concurrently. Caution should be exercised when clarithromycin is co-administered with direct acting oral anticoagulants such as dabigatran, rivaroxaban and apixaban, particularly to patients at high risk of bleeding.

Long-term use may, as with other antibiotics, result in colonisation with increased numbers of non-susceptible bacteria and fungi. If superinfections occur, appropriate therapy should be instituted.

Attention should also be paid to the possibility of cross resistance between clarithromycin and other macrolide drugs, as well as lincomycin and clindamycin.

Excipients

This medicine contains less than 1 mmol sodium (23 mg) per dosage unit, that is to say essentially "Sodium-free'.

4.4 Interaction with other medicinal products and other forms of interaction

The use of the following drugs is strictly contraindicated due to the potential for severe drug interaction effects:

Cisapride, pimozide, astemizole and terfenadine

Elevated cisapride levels have been reported in patients receiving clarithromycin and cisapride concomitantly. This may result in QT prolongation and cardiac arrhythmias including ventricular tachycardia, ventricular fibrillation and torsades de pointes. Similar effects have been observed in patients taking clarithromycin and pimozide concomitantly.

Macrolides have been reported to alter the metabolism of terfenadine resulting in increased levels of terfenadine which has occasionally been associated with cardiac arrhythmias, such as QT prolongation, ventricular tachycardia, ventricular fibrillation and torsades de pointes. In one study in 14 healthy volunteers, the concomitant administration of clarithromycin and terfenadine resulted in 2- to 3-fold increase in the serum level of the acid metabolite of terfenadine and in prolongation of the QT interval which did not lead to any clinically detectable effect. Similar effects have been observed with concomitant administration of astemizole and other macrolides.

Ergot alkaloids:

Post-marketing reports indicate that co-administration of clarithromycin with ergotamine or dihydroergotamine has been associated with acute ergot toxicity characterized by vasospasm, and ischaemia of the extremities and other tissues including the central nervous system. Concomitant administration of clarithromycin and ergot alkaloids is contraindicated.

Oral Midazolam

When midazolam was coadministered with clarithromycin tablets (500 mg twice daily), midazolam AUC was increased 7fold after oral administration of midazolam. Concomitant administration of oral midazolam and clarithromycin is contraindicated.

HMG-CoA Reductase Inhibitors (statins)

Concomitant use of clarithromycin with lovastatin or simvastatin is contraindicated (see 4.3) as these statins are extensively metabolized by CYP3A4 and concomitant treatment with clarithromycin increases their plasma concentration, which increases the risk of myopathy, including rhabdomyolysis. Reports of rhabdomyolysis have been received for patients taking clarithromycin concomitantly with these statins. If treatment with clarithromycin cannot be avoided, therapy with lovastatin or simvastatin must be suspended during the course of treatment.

Caution should be exercised when prescribing clarithromycin with statins. In situations where the concomitant use of clarithromycin with statins cannot be avoided, it is recommended to prescribe the lowest registered dose of the statin. Use of a statin that is not dependent on CYP3A metabolism (e.g.fluvastatin) can be considered. Patients should be monitored for signs and symptoms of myopathy.

Lomitapide

Concomitant administration of clarithromycin with lomitapide is contraindicated due to the potential for markedly increased transaminases.

Effects of Other Medicinal Products on Clarithromycin

Drugs that are inducers of CYP3A (e.g. rifampicin, phenytoin, carbamazepine, phenobarbital, St John's wort) may induce the metabolism of clarithromycin. This may result in sub-therapeutic levels of clarithromycin leading to reduced efficacy. Furthermore, it might be necessary to monitor the plasma levels of the CYP3A inducer, which could be increased owing to the inhibition of CYP3A by clarithromycin (see also the relevant product information for the CYP3A4 inhibitor administered). Concomitant administration of rifabutin and clarithromycin resulted in an increase in rifabutin, and decrease in clarithromycin serum levels together with an increased risk of uveitis.

The following drugs are known or suspected to affect circulating concentrations of clarithromycin; clarithromycin dosage adjustment or consideration of alternative treatments may be required.

Efavirenz, nevirapine, rifampicin, rifabutin and rifapentine

Strong inducers of the cytochrome P450 metabolism system such as efavirenz, nevirapine, rifampicin, rifabutin, and rifapentine may accelerate the metabolism of clarithromycin and thus lower the plasma levels of clarithromycin, while increasing those of 14-OH-clarithromycin, a metabolite that is also microbiologically active. Since the microbiological activities of clarithromycin and 14-OH-clarithromycin are different for different bacteria, the intended therapeutic effect could be impaired during concomitant administration of clarithromycin and enzyme inducers.

Etravirine

Clarithromycin exposure was decreased by etravirine; however, concentrations of the active metabolite, 14- OHclarithromycin, were increased. Because 14-OH-clarithromycin has reduced activity against Mycobacterium avium complex (MAC), overall activity against this pathogen may be altered; therefore alternatives to clarithromycin should be considered for the treatment of MAC.

Fluconazole

Concomitant administration of fluconazole 200 mg daily and clarithromycin 500 mg twice daily to 21 healthy volunteers led to increases in the mean steady-state minimum clarithromycin concentration (Cmin) and area under the curve (AUC) of 33% and 18% respectively. Steady state concentrations of the active metabolite 14-OH-clarithromycin were not significantly affected by concomitant administration of fluconazole. No clarithromycin dose adjustment is necessary.

4.5 Pregnancy and Lactation

Pregnancy

The safety of clarithromycin for use during pregnancy has not been established. Based on variable results obtained from animal studies and experience in humans, the possibility of adverse effects on embryofoetal development cannot be excluded. Some observational studies evaluating exposure to clarithromycin during the first and second trimester have reported an increased risk of miscarriage compared to no antibiotic use or other antibiotic use during the same period. The available epidemiological studies on the risk of major congenital malformations with use of macrolides including clarithromycin during pregnancy provide conflicting results. Therefore, use during pregnancy is not advised without carefully weighing the benefits against risks.

Breast-feeding

The safety of clarithromycin for using during breast-feeding of infants has not been established. Clarithromycin is excreted into human breast milk in small amounts. It has been estimated that an exclusively breastfed infant would receive about 1.7% of the maternal weight-adjusted dose of clarithromycin.

Fertility

In the rat, fertility studies have not shown any evidence of harmful effects.

4.6 Effects on ability to drive and use machines

There are no data on the effect of clarithromycin on the ability to drive or use machines. The potential for dizziness, vertigo, confusion and disorientation, which may occur with the medication, should be taken into account before patients drive or use machines.

4.7 Undesirable effects

The most frequent and common adverse reactions related to clarithromycin therapy for both adult and peadiatric populations are abdominal pain, diarrhoea, nausea, vomiting and taste perversion. These adverse
reactions are usually mild in intensity and are consistent with the known safety profile of macrolide antibiotics.

Other common adverse effects are: Insomnia, rash, inflammation.

Rare adverse effects includes: Cellulitis, candidiasis, loss of consciousness, dyskinesia , dizziness, somnolence, tremor, convulsion, anorexia, vertigo, chest pain, asthma.

4.8 Overdose

Reports indicate that the ingestion of large amounts of clarithromycin can be expected to produce gastro intestinal symptoms. One patient who had a history of bipolar disorder ingested 8 grams of clarithromycin and showed altered mental status, paranoid behaviour, hypokalemia and hypoxemia. Adverse reactions accompanying overdose should be treated by the prompt elimination of unabsorbed drug and supportive measures. As with other macrolides, Clarithromycin serum levels are not expected to be appreciably affected by haemodialysis or peritoneal dialysis.

5. PHARMACOLOGICAL PROPERTIES

5.1

ATC Classification:

Pharmacotherapeutic Group: Antibacterial for systemic use, macrolide

ATC Code: J01FA09

Mechanism of action:

Clarithromycin is an antibiotic belonging to the macrolide antibiotic group. It exerts its antibacterial action by selectively binding to the 50s ribosomal subunit of susceptible bacteria preventing translocation of activated amino acids. It inhibits the intracellular protein synthesis of susceptible bacteria.

The 14-hydroxy metabolite of clarithromycin, a product of parent drug metabolism also has antimicrobial activity. The metabolite is less active than the parent compound for most organisms, including mycobacterium spp. An exception is Haemophilus influenza where the 14-hydroxy metabolite is two-fold more active than the parent compound.

Clarithromycin is usually active against the following organisms in vitro:-

Gram-positive Bacteria: *Staphylococcus aureus* (methicillin susceptible); *Streptococcus pyogenes* (Group A beta-hemolytic streptococci); alpha-hemolytic streptococci (viridans group); *Streptococcus (Diplococcus) pneumoniae; Streptococcus agalactiae; Listeria monocytogenes.*

Gram-negative Bacteria: *Haemophilus influenzae; Haemophilus parainfluenzae; Moraxella*

(Branhamella) catarrhalis; Neisseria gonorrhoeae; Legionella pneumophila; Bordetella pertussis; Helicobacter pylori; Campylobacter jejuni.

Mycoplasma: *Mycoplasma pneumoniae; Ureaplasma urealyticum.*

Other Organisms: *Chlamydia trachomatis; Mycobacterium avium; Mycobacterium leprae;*

Anaerobes: Macrolide-susceptible *Bacteroides fragilis; Clostridium perfringens;* Peptococcus species; Peptostreptococcus species; *Propionibacterium acnes.*

Clarithromycin has bactericidal activity against several bacterial strains. The organisms include *Haemophilus influenzae, Streptococcus pneumoniae, Streptococcus pyogenes, Streptococcus agalactiae, Moraxella (Branhamella) catarrhalis, Neisseria gonorrhoeae, H. pylori* and *Campylobacter spp.*

5.2 Pharmacokinetic properties

H. pylori is associated with acid peptic disease including duodenal ulcer and gastric ulcer in which about 95% and 80% of patients respectively are infected with the agent. *H. pylori* is also implicated as a major contribution factor in the development of gastric and ulcer recurrence in such patients.

Clarithromycin has been used in small numbers of patients in other treatment regimens. Possible kinetic interactions have not been fully investigated. These regimens include:

Clarithromycin plus tinidazole and omeprazole; clarithromycin plus tetracycline, bismuth subsalicylate and ranitidine; clarithromycin plus ranitidine alone.

Clinical studies using various different *H. pylori* eradication regimens have shown that eradication of *H. pylori* prevents ulcer recurrence.

Clarithromycin is rapidly and well absorbed from the gastro-intestinal tract after oral administration of Clarithromycin tablets. The microbiologically active metabolite 14-hydroxyclarithromycin is formed by first pass metabolism. Clarithromycin may be given without regard to meals as food does not affect the extent of bioavailability of Clarithromycin tablets. Food does slightly delay the onset of absorption of Clarithromycin and formation of the 14-hydroxymetabolite.

The pharmacokinetics of Clarithromycin are non linear; however, steady-state is attained within 2 days of dosing. At 250 mg b.i.d. 15-20% of unchanged drug is excreted in the urine. With 500 mg b.i.d. daily dosing urinary excretion is greater (approximately 36%). The 14-hydroxyclarithromycin is the major urinary metabolite and accounts for 10-15% of the dose. Most of the remainder of the dose is eliminated in the faeces, primarily via the bile. 5-10% of the parent drug is recovered from the faeces.

When Clarithromycin 500 mg is given three times daily, the Clarithromycin plasma concentrations are increased with respect to the 500 mg twice daily dosage.

Clarithromycin provides tissue concentrations that are several times higher than the circulating drug levels. Increased levels have been found in both tonsillar and lung tissue. Clarithromycin is 80% bound to plasma proteins at therapeutic levels.

Clarithromycin also penetrates the gastric mucus. Levels of Clarithromycin in gastric mucus and gastric

tissue are higher when Clarithromycin is co-administered with omeprazole than when Clarithromycin is administered alone.

5.3 Preclinical safety data

In acute mouse and rat studies, the median lethal dose was greater than the highest feasible dose for administration (5g/kg).

In repeated dose studies, toxicity was related to dose, duration of treatment and species. Dogs were more sensitive than primates or rats. The major clinical signs at toxic doses included emesis, weakness, reduced food consumption and weight gain, salivation, dehydration and hyperactivity. In all species the liver was the primary target organ at toxic doses. Hepatotoxicity was detectable by early elevations of liver function tests.

Discontinuation of the drug generally resulted in a return to or toward normal results. Other tissues less commonly affected included the stomach, thymus and other lymphoid tissues and the kidneys. At near therapeutic doses, conjunctival injection and lacrimation occurred only in dogs. At a massive dose of 400mg/kg/day, some dogs and monkeys developed corneal opacities and/or oedema.

Fertility, Reproduction and Teratogenicity

Studies performed in rats at oral doses up to 500 mg/kg/day (highest dose associated with overt renal toxicity) demonstrated no evidence for clarithromycin-related adverse effects on male fertility. This dose corresponds to a human equivalent dose (HED) of approximately 5 times the maximum recommended human dose (MRHD) on a mg/m2 basis for a 60-kg individual.

Fertility and reproduction studies in female rats have shown that a daily dosage of 150 mg/kg/ day (highest dose tested) caused no adverse effects on the oestrus cycle, fertility parturition and number and viability of offspring. Oral teratogenicity studies in rats (Wistar and Spraque-Dawley), rabbits (New Zealand White) and cynomolgous monkeys failed to demonstrate any teratogenicity from Clarithromycin at the highest doses tested up to 1.5, 2.4 and 1.5 times the MRHD on a mg/m2 basis in the respective species.. However, a similar study in Sprague-Dawley rats indicated a low (6%) incidence of cardiovascular abnormalities, which appeared to be due to spontaneous expression of genetic changes. Two mouse studies revealed a variable incidence (3-30%) of cleft palate at ~5 times the MRHD on a mg/m2 basis for a 60-kg individual.

Embryonic loss was seen in monkeys but only at dose levels, which were clearly toxic to the mothers.

6. PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Sancel 101 M.C.C.P
Cross Carmellose Sodium
Tween 80
Magnesium Stearate
Talcum
Aerosil
Instacoat IC-U 1308 White
Isopropyl Alcohol
Methylene Dichloride

6.2 Incompatibilities

Not applicable

6.3 Shelf life

36 months

6.4 Special precautions for storage

Do not store above 25°C. Keep in a dry place in the original package.

6.5 Nature and contents of container

Seven tablets packed in a blister. Such 2 blister packed in a printed carton along with one insert.

6.6 Special precautions for disposal

No special requirements.

7. APPLICANT/MANUFACTURER

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