Summary of Product Characteristics

1 NAME OF THE MEDICINAL PRODUCT

Pinaclav 250mg/125 mg tablets

2 QUALITATIVE AND QUANTITATIVE COMPOSITION

Each tablet contains 250 mg of amoxicillin as amoxicillin trihydrate and 125 mg of clavulanic acid as potassium clavulanate.

Excipients: also includes sucrose, 0.054mg per tablet.

For a full list of excipients, see section 6.1.

3 PHARMACEUTICAL FORM

Film-coated Tablets.
Yellowish-white or light yellow oblong-formed, biconvex tablet with ‘375’ on one side/engraved line on second side.

4 CLINICAL PARTICULARS

4.1 Therapeutic Indications

Pinaclav is indicated for the treatment of the following infections in adults and children (see sections 4.2, 4.4 and 5.1):

- Acute bacterial sinusitis (adequately diagnosed)
- Cystitis
- Pyelonephritis
- Cellylitis
- Animal bites
- severe dental abscess with spreading cellulitis.

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

4.2 Posology and method of administration

Doses are expressed throughout in terms of amoxicillin/clavulanic acid content except when doses are stated in terms of an individual component.

The dose of Pinaclav that is selected to treat an individual infection should take into account:

- The expected pathogens and their likely susceptibility to antibacterial agents (see section 4.4)
- The severity and the site of the infection
- The age, weight and renal function of the patient as shown below.

The use of alternative presentations of Pinaclav (e.g. those that provide higher doses of amoxicillin and/or different ratios of amoxicillin to clavulanic acid) should be considered as necessary (see sections 4.4 and 5.1).

250 mg/125 mg tablets
For adults and children ≥ 40 kg, this formulation of Pinaclav provides a total daily dose of 750 mg amoxicillin/375 mg clavulanic acid, when administered as recommended below. If it is considered that a higher daily dose of amoxicillin is required, it is recommended that another preparation of Pinaclav is selected in order to avoid administraton of unnecessary high daily dose of clavulanic acid (see sections 4.4 and 5.1).

Treatment should not be extended beyond 14 days without review.

Adults and children ≥ 40 kg

One 250 mg/125 mg tablet taken three times a day.

Children < 40 kg

250 mg/125 mg tablets
Pinaclav 250 mg/125 mg tablets are not recommended in children < 40 kg.

Elderly

No dose adjustment is considered necessary.

Renal impairment

Dose adjustments are based on the maximum recommended levels of amoxicillin.
No adjustment in dose is required in patients with creatinine clearance (CrCl) greater than 30 ml/min.
Adults and children ≥40 kg

CrCl: 10-30 ml/min	250 mg/125 mg twice daily
CrCl < 10 ml /min	250 mg/125 mg once daily
Haemodialysis	Two doses of 250 mg/125 mg every 24 hours, plus two doses of 250 mg/125 mg during dialysis, to be repeated at the end of dialysis (as serum concentrations of both amoxicillin and clavulanic acid are decreased)

Children <40 kg

In children < 40 kg with creatinine clearance less than 30 ml/min, the use of Pinaclav presentations with an amoxicillin to clavulanic acid ratio of 2:1 is not recommended, as no dose adjustments are available. In such patients, Pinaclav formulations with an amoxicillin to clavulanic acid ratio of 4:1 are recommended.

Hepatic impairment
Dose with caution and monitor hepatic function at regular intervals (see sections 4.3 and 4.4).

Method of administration

Pinaclav is for oral use.

Administer at the start of a meal to minimise potential gastrointestinal intolerance and optimise absorption of amoxicillin/clavulanic acid.

4.3 Contraindications

Hypersensitivity to the active substances, to any of the penicillins or to any of the excipients.

History of a severe immediate hypersensitivity reaction (e.g. anaphylaxis) to another beta-lactam agent (e.g. a cephalosporin, carbapenem or monobactam).

History of jaundice/hepatic impairment due to amoxicillin/clavulanic acid (see section 4.8).

4.4 Special warnings and precautions for use

Before initiating therapy with amoxicillin/clavulanic acid, careful enquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins or other beta-lactam agents (see sections 4.3 and 4.8).

Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy. These reactions are more likely to occur in individuals with a history of penicillin hypersensitivity and in atopic individuals. If an allergic reaction occurs, amoxicillin/clavulanic acid therapy must be discontinued and appropriate alternative therapy instituted.

In the case that an infection is proven to be due to an amoxicillin-susceptible organisms(s) then consideration should be given to switching from amoxicillin/clavulanic acid to amoxicillin in accordance with official guidance.

This presentation of Pinaclav is not suitable for use when there is a high risk that the presumptive pathogens have reduced susceptibility or resistance to beta-lactam agents that is not mediated by betalactamases susceptible to inhibition by clavulanic acid. This presentation should not be used to treat penicillin-resistant *S. pneumoniae*.

Convulsions may occur in patients with impaired renal function or in those receiving high doses (see section 4.8).

Amoxicillin/clavulanic acid should be avoided if infectious mononucleosis is suspected since the occurrence of a morbilliform rash has been associated with this condition following the use of amoxicillin.

Concomitant use of allopurinol during treatment with amoxicillin can increase the likelihood of allergic skin reactions.

Prolonged use may occasionally result in overgrowth of non-susceptible organisms.

The occurrence at the treatment initiation of a feverish generalised erythema associated with pustula may be a symptom of acute generalised exanthemous pustulosis (AGEP) (see Section 4.8). This reaction requires Pinaclav discontinuation and contra-indicates any subsequent administration of amoxicillin.

Amoxicillin/clavulanic acid should be used with caution in patients with evidence of hepatic impairment (see section 4.2).

Hepatic events have been reported predominantly in males and elderly patients and may be associated with prolonged treatment. These events have been very rarely reported in children. In all populations, signs and symptoms usually occur during or shortly after treatment but in some cases may not become apparent until several weeks after treatment has ceased. These are usually reversible. Hepatic events may be severe and, in extremely rare circumstances, deaths

have been reported. These have almost always occurred in patients with serious underlying disease or taking concomitant medications known to have the potential for hepatic effects (see section 4.8).

Antibiotic-associated colitis has been reported with nearly all antibacterial agents and may range in severity from mild to life threatening (see section 4.8). Therefore, it is important to consider this diagnosis in patients who present with diarrhoea during or subsequent to the administration of any antibiotics. Should antibiotic-associated colitis occur, amoxicillin/clavulanic acid should immediately be discontinued, a physician be consulted and an appropriate therapy initiated. Anti-peristaltic medicinal products are contra-indicated in this situation.

Periodic assessment of organ system functions, including renal, hepatic and haematopoietic function is advisable during prolonged therapy.

Prolongation of prothrombin time has been reported rarely in patients receiving amoxicillin/clavulanic acid. Appropriate monitoring should be undertaken when anticoagulants are prescribed concomitantly. Adjustments in the dose of oral anticoagulants may be necessary to maintain the desired level of anticoagulation (see section 4.5 and 4.8).

In patients with renal impairment, the dose should be adjusted according to the degree of impairment (see section 4.2).

In patients with reduced urine output, crystalluria has been observed very rarely, predominantly with parenteral therapy. During the administration of high doses of amoxicillin, it is advisable to maintain adequate fluid intake and urinary output in order to reduce the possibility of amoxicillin crystalluria. In patients with bladder catheters, a regular check of patency should be maintained (see section 4.9).

During treatment with amoxicillin, enzymatic glucose oxidase methods should be used whenever testing for the presence of glucose in urine because false positive results may occur with nonenzymatic methods.

The presence of Clavulanic acid in Pinaclav may cause a non-specific binding of IgG and albumin by red cell membranes leading to a false positive Coombs test.

There have been reports of positive test results using the Bio-Rad Laboratories Platelia *Aspergillus* EIA test in patients receiving amoxicillin/clavulanic acid who were subsequently found to be free of *Aspergillus* infection. Cross-reactions with non-*Aspergillus* polysaccharides and polyfuranoses with Bio-Rad Laboratories Platelia *Aspergillus* EIA test have been reported. Therefore, positive test results in patients receiving amoxicillin/clavulanic acid should be interpreted cautiously and confirmed by other diagnostic methods.

Patients with rare hereditary problems of fructose intolerance, glucose-galactose malabsorption or sucrase-isomaltase insufficiency should not take this medicine.

4.5 Interaction with other medicinal products and other forms of interaction

Oral anticoagulants

Oral anticoagulants and penicillin antibiotics have been widely used in practice without reports of interaction. However, in the literature there are cases of increased international normalised ratio in patients maintained on acenocoumarol or warfarin and prescribed a course of amoxicillin. If coadministration is necessary, the prothrombin time or international normalised ratio should be carefully monitored with the addition or withdrawal of amoxicillin. Moreover, adjustments in the dose of oral anticoagulants may be necessary (see sections 4.4 and 4.8).

Methotrexate

Penicillins may reduce the excretion of methotrexate causing a potential increase in toxicity.

Probenecid

Concomitant use of probenecid is not recommended. Probenecid decreases the renal tubular secretion of amoxicillin. Concomitant use of probenecid may result in increased and prolonged blood levels of amoxicillin but not of clavulanic

acid.

Mycophenolate mofetil

In patients receiving mycophenolate mofetil, reduction in pre-dose concentration of the active metabolite mycophenolic acid (MPA) of approximately 50% has been reported following commencement of oral amoxicillin plus clavulanic acid. The change in pre-dose level may not accurately represent changes in overall MPA exposure. Therefore, a change in the dose of mycophenolate mofetil should not normally be necessary in the absence of clinical evidence of graft dysfunction. However, close clinical monitoring should be performed during the vcombination and shortly after antibiotic treatment.

4.6 Fertility, pregnancy and lactation

Pregnancy

Animal studies do not indicate direct or indirect harmful effects with respect to pregnancy, embryonal/foetal development, parturition or postnatal development (see section 5.3). Limited data on the use of amoxicillin/clavulanic acid during pregnancy in humans do not indicate an increased risk of congenital malformations. In a single study in women with preterm, premature rupture of the foetal membrane it was reported that prophylactic treatment with amoxicillin/clavulanic acid may be associated with an increased risk of necrotising enterocolitis in neonates. Use should be avoided during pregnancy, unless considered essential by the physician.

Lactation
Both substances are excreted into breast milk (nothing is known of the effects of clavulanic acid on the breast-fed infant). Consequently, diarrhoea and fungus infection of the mucous membranes are possible in the breast-fed infant, so that breast-feeding might have to be discontinued. The possibility
of sensitisation should be taken into account. Amoxicillin/clavulanic acid should only be used during breast-feeding after benefit/risk assessment by the physician in charge.

4.7 Effects on ability to drive and use machines

No studies on the effects on the ability to drive and use machines have been performed. However, undesirable effects may occur (e.g. allergic reactions, dizziness, convulsions), which may influence the ability to drive and use machines (see section 4.8).

4.8 Undesirable effects

The most commonly reported adverse drug reactions (ADRs) are diarrhoea, nausea and vomiting.

The ADRs derived from clinical studies and post-marketing surveillance with Pinaclav, sorted by MedDRA System Organ Class are listed below.

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)
Not known (cannot be estimated from the available data)

Infections and infestations	
Mucocutaneous candidosis	Common
Overgrowth of non-susceptible organisms	Not known
Blood and lymphatic system disorders	
Reversible leucopenia (including neutropenia)	Rare

Thrombocytopenia	Rare
Reversible agranulocytosis	Not known
Haemolytic anaemia	Not known
Prolongation of bleeding time and prothrombin time1	Not known
Immune system disorders[10]	
Angioneurotic oedema	Not known
Anaphylaxis	Not known
Serum sickness-like syndrome	Not known
Hypersensitivity vasculitis	Not known
Nervous system disorders	
Dizziness	Uncommon
Headache	Uncommon
Reversible hyperactivity	Not known
Convulsions[2]	Not known
Aseptic Meningitis	Not known
Gastrointestinal disorders	
Diarrhoea	Common
Nausea[3]	Common
Vomiting	Common
Indigestion	Uncommon
Antibiotic-associated colitis[4]	Not known
Black hairy tongue	Not known
Hepatobiliary disorders	
Rises in AST and/or ALT[5]	Uncommon
Hepatitis[6]	Not known
Cholestatic jaundice[6]	Not known
Skin and subcutaneous tissue disorders [7]	
Skin rash	Uncommon
Pruritus	Uncommon
Urticaria	Uncommon
Erythema multiforme	Rare
Stevens-Johnson syndrome	Not known
Toxic epidermal necrolysis	Not known
Bullous exfoliative-dermatitis	Not known
Acute generalised exanthemous pustulosis (AGEP)[9]	Not known
Renal and urinary disorders	
Interstitial nephritis	Not known
Crystalluria[8]	Not known

1 See section 4.4
2 See section 4.4
3 Nausea is more often associated with higher oral doses. If gastrointestinal reactions are evident, they may be reduced by taking Pinaclav at the start of a meal.
4 Including pseudomembranous colitis and haemorrhagic colitis (see section 4.4)
5 A moderate rise in AST and/or ALT has been noted in patients treated with beta-lactam class antibiotics, but the significance of these findings is unknown.
6 These events have been noted with other penicillins and cephalosporins (see section 4.4).
7 If any hypersensitivity dermatitis reaction occurs, treatment should be discontinued (see section 4.4).
8 See section 4.9
9 See section 4.4
10 See sections 4.3 and 4.4

11 Superficial tooth discolouration has been reported very rarely in children. Good oral hygiene may help to prevent tooth discolouration as it can usually be removed by brushing.

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 via HPRA Pharmacovigilance, Earlsfort Terrace, IRL - Dublin 2; Tel: +353 1 6764971; Fax: +353 1 6762517. Website: http://www.hpra.ie/; E-mail: medsafety@hpra.ie.

4.9 Overdose

Symptoms and signs of overdose

Gastrointestinal symptoms and disturbance of the fluid and electrolyte balances may be evident. Amoxicillin crystalluria, in some cases leading to renal failure, has been observed (see section 4.4).

Convulsions may occur in patients with impaired renal function or in those receiving high doses.

Amoxicillin has been reported to precipitate in bladder catheters, predominantly after intravenous administration of large doses. A regular check of patency should be maintained (see section 4.4)

Treatment of intoxication.

Gastrointestinal symptoms may be treated symptomatically, with attention to the water/electrolyte balance.

Amoxicillin/clavulanic acid can be removed from the circulation by haemodialysis

5 PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: Combinations of penicillins, incl. beta-lactamase inhibitors; ATC code: J01CR02.

Mode of action

Amoxicillin is a semisynthetic penicillin (beta-lactam antibiotic) that inhibits one or more enzymes (often referred to as penicillin-binding proteins, PBPs) in the biosynthetic pathway of bacterial peptidoglycan, which is an integral structural component of the bacterial cell wall. Inhibition of
peptidoglycan synthesis leads to weakening of the cell wall, which is usually followed by cell lysis and death.

Amoxicillin is susceptible to degradation by beta-lactamases produced by resistant bacteria and therefore the spectrum of activity of amoxicillin alone does not include organisms which produce these enzymes.

Clavulanic acid is a beta-lactam structurally related to penicillins. It inactivates some beta-lactamase enzymes thereby preventing inactivation of amoxicillin. Clavulanic acid alone does not exert a clinically useful antibacterial effect.

PK/PD relationship

The time above the minimum inhibitory concentration (T>MIC) is considered to be the major determinant of efficacy for amoxicillin.

Mechanisms of resistance

The two main mechanisms of resistance to amoxicillin/clavulanic acid are:

- Inactivation by those bacterial beta-lactamases that are not themselves inhibited by clavulanic acid, including class B, C and D.
- Alteration of PBPs, which reduce the affinity of the antibacterial agent for the target.

Impermeability of bacteria or efflux pump mechanisms may cause or contribute to bacterial resistance, particularly in Gram-negative bacteria.

Breakpoints

MIC breakpoints for amoxicillin/clavulanic acid are those of the European Committee on Antimicrobial Susceptibility Testing (EUCAST)

Organism	Susceptibility Breakpoints (µg/ml)		
	Susceptible	Intermediate	Resistant
Haemophilus influenza [1]	≤ 1	-	> 1
Moraxella catarrhalis [1]	≤ 1	-	> 1
Staphylococcus aureus [2]	≤ 2	-	> 2
Coagulase-negative staphylococci [2]	≤ 0.25		> 0.25
Enterococcus [1]	≤ 4	8	> 8
Streptococcus A, B, C, G[5]	≤ 0.25	-	> 0.25
Streptococcus pneumoniae[3]	≤ 0.5	1-2	> 2
.Enterobacteriaceae[1,4]	-	-	> 8
Gram-negative Anaerobes [1]	≤ 4	8	> 8
Gram-positive Anaerobes [1]	≤ 4	8	> 8
Non-species related breakpoints[1]	≤ 2	4-8	> 8

[1] The reported values are for Amoxicillin concentrations. For susceptibility testing purposes, the concentration of Clavulanic acid is fixed at 2 mg/l.
[2] The reported values are Oxacillin concentrations.
[3] Breakpoint values in the table are based on Ampicillin breakpoints.
[4] The resistant breakpoint of R>8 mg/l ensures that all isolates with resistance mechanisms are reported resistant.
[5] Breakpoint values in the table are based on Benzylpenicillin breakpoints.

The prevalence of resistance may vary geographically and with time for selected species, and local information on resistance is desirable, particularly when treating severe infections. As necessary, expert advice should be sought when the local prevalence of resistance is such that the utility of the
agent in at least some types of infections is questionable.

Commonly susceptible species
Aerobic Gram-positive micro-organisms *Enterococcus faecalis* *Staphylococcus aureus (*methicillin-susceptible)£ *Streptococcus agalactiae* *Streptococcus pneumoniae*[1] *Streptococcus pyogenes* and other beta-haemolytic streptococci *Streptococcus viridans* group Aerobic Gram-negative micro-organisms

Capnocytophaga spp. *Eikenella corrodens* *Haemophilus influenzae*[2] *Moraxella catarrhalis* *Pasteurella multocida* Anaerobic micro-organisms *Bacteroides fragilis* *Fusobacterium nucleatum* *Prevotella* spp.
Species for which acquired resistance may be a problem
Aerobic Gram-positive micro-organisms *Enterococcus faecium* $ Aerobic Gram-negative micro-organisms *Escherichia coli* *Klebsiella oxytoca* *Klebsiella pneumoniae* *Proteus mirabilis* *Proteus vulgaris*
Inherently resistant organisms
Aerobic Gram-negative micro-organisms *Acinetobacter* sp. *Citrobacter freundii* *Enterobacter* sp. *Morganella morganii* *Providencia* spp. *Pseudomonas* sp. *Serratia* sp. *Stenotrophomonas maltophilia*
$ Natural intermediate susceptibility in the absence of acquired mechanism of resistance. £All methicillin-resistant staphylococci are resistant to amoxicillin/clavulanic acid [1]*Streptococcus pneumoniae* that is fully susceptible to penicillin may be treated with this presentation of amoxicillin/clavulanic acid. Organisms that show any degree of reduced susceptibility to penicillin should not be treated with this presentation (see sections 4.2 and 4.4). [2] Strains with decreased susceptibility have been reported in some countries in the EU with a frequency higher than 10%.

5.2 Pharmacokinetic properties

Absorption

Amoxicillin and clavulanic acid, are fully dissociated in aqueous solution at physiological pH. Both components are rapidly and well absorbed by the oral route of administration. Absorption of amoxicillin/clavulanic acid is optimised when taken at the start of a meal. Following oral
administration, amoxicillin and clavulanic acid are approximately 70% bioavailable. The plasma profiles of both components are similar and the time to peak plasma concentration (Tmax) in each case is approximately one hour.

The pharmacokinetic results for a study, in which amoxicillin/clavulanic acid (250mg/125mg tablets three times daily) was administered n the fasting state to groups of healthy are presented below.

Mean (±SD) pharmacokinetic parameters					
	Dose	C_{max}	T_{max}*	AUC $_{(0-24h)}$	T 1/2
Active	(mg)	(µg/ml)	(h)	((µg.h/ml)	(h)

substance(s) administered					
Amoxicillin					
AMX/CA 250 mg/125 mg	250	3.3 ± 1.12	1.5 (1.0-2.0)	26.7± 4.56	1.36± 0.56
Clavulanic Acid					
AMX/CA 250 mg/125 mg	125	1.5 ± 0.70	1.2 (1.0-2.0)	12.6 ± 3.25	1.01 ± 0.11
AMX – amoxicillin, CA – clavulanic acid *Median (range)					

Amoxicillin and clavulanic acid serum concentrations achieved with amoxicillin/clavulanic acid are similar to those produced by the oral administration of equivalent doses of amoxicillin or clavulanic acid alone.

Distribution

About 25% of total plasma clavulanic acid and 18% of total plasma amoxicillin is bound to protein. The apparent volume of distribution is around 0.3-0.4 l/kg for amoxicillin and around 0.2 l/kg for clavulanic acid.

Following intravenous administration, both amoxicillin and clavulanic acid have been found in gall bladder, abdominal tissue, skin, fat, muscle tissues, synovial and peritoneal fluids, bile and pus. Amoxicillin does not adequately distribute into the cerebrospinal fluid.

From animal studies there is no evidence for significant tissue retention of drug-derived material for either component. Amoxicillin, like most penicillins, can be detected in breast milk. Trace quantities of clavulanic acid can also be detected in breast milk (see section 4.6)

Both amoxicillin and clavulanic acid have been shown to cross the placental barrier (see section 4.6).

Biotransformation

Amoxicillin is partly excreted in the urine as the inactive penicilloic acid in quantities equivalent to up to 10 to 25% of the initial dose. Clavulanic acid is extensively metabolized in man, and eliminated in urine and faeces and as carbon dioxide in expired air.

Elimination

The major route of elimination for amoxicillin is via the kidney, whereas for clavulanic acid it is by both renal and non-renal mechanisms.
Amoxicillin/clavulanic acid has a mean elimination half-life of approximately one hour and a mean total clearance of approximately 25 l/h in healthy subjects. Approximately 60 to 70% of the amoxicillin and approximately 40 to 65% of the clavulanic acid are excreted unchanged in urine
during the first 6 h after administration of single amoxicillin/clavulanic acid 250 mg/125 mg or 500 mg/125 mg tablets. Various studies have found the urinary excretion to be 50-85% for amoxicillin and between 27-60% for clavulanic acid over a 24 hour period. In the case of clavulanic acid, the largest amount
of drug is excreted during the first 2 hours after administration.

Concomitant use of probenecid delays amoxicillin excretion but does not delay renal excretion of clavulanic acid (see section 4.5).

Age

The elimination half-life of amoxicillin is similar for children aged around 3 months to 2 years and older children and adults. For very young children (including preterm newborns) in the first week of life the interval of administration

should not exceed twice daily administration due to immaturity of
the renal pathway of elimination. Because elderly patients are more likely to have decreased renal function, care should be taken in dose selection, and it may be useful to monitor renal function.

Gender
Following oral administration of amoxicillin/clavulanic acid to healthy males and female subjects, gender has no significant impact on the pharmacokinetics of either amoxicillin or clavulanic acid.

Renal impairment

The total serum clearance of amoxicillin/clavulanic acid decreases proportionately with decreasing renal function. The reduction in drug clearance is more pronounced for amoxicillin than for clavulanic acid, as a higher proportion of amoxicillin is excreted *via* the renal route. Doses in renal
impairment must therefore prevent undue accumulation of amoxicillin while maintaining adequate levels of clavulanic acid (see section 4.2).

Hepatic impairment

Hepatically impaired patients should be dosed with caution and hepatic function monitored at regular intervals.

5.3 Preclinical safety data

Nonclinical data reveal no special hazard for humans based on studies of safety pharmacology, enotoxicity and toxicity to reproduction.

Repeat dose toxicity studies performed in dogs with amoxicillin/clavulanic acid demonstrate gastric irritancy and vomiting, and discoloured tongue.

Carcinogenicity studies have not been conducted with amoxicillin/clavulanic acid or its components.

6 PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Microcrystalline cellulose
Quinoline yellow (E104)
Titanium dioxide (E171)
Crospovidone
Povidone
Colloidal anhydrous silica
Stearic acid
Macrogol 6000
Hypromellose
Sodium saccharin
Magnesium stearate
Vanilla flavour (contains sucrose)

6.2 Incompatibilities

Not applicable.

6.3 Shelf life

The shelf-life is 3 years for tablets packed in amber glass bottles and 2 years for the tablets packed in blister strips.

6.4 Special precautions for storage

Bottles: Do not store above 25°C. Keep the container tightly closed in order to protect from moisture.
Blisters: Do not store above 25°C. Store in the original package in order to protect from moisture.

6.5 Nature and contents of container

Pack size 21, 30 and 100 tablets in pharmaceutical type III amber glass bottles and pack sizes of 21 and 30 aluminium blister strips in a carton box.
Not all pack sizes to be marketed.

6.6 Special precautions for disposal of a used medicinal product or waste materials derived from such medicinal product and other handling of the product

No special requirements.

7 MARKETING AUTHORISATION HOLDER

Pinewood Laboratories Limited
T/A Pinewood Healthcare
Ballymacarbry
Clonmel
County Tipperary

8 MARKETING AUTHORISATION NUMBER

PA0281/093/002

9 DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUTHORISATION

Date of first authorisation: 08 February 2002
Date of last renewal: 08 February 2007

10 DATE OF REVISION OF THE TEXT

April 2015