IRISH MEDICINES BOARD ACTS 1995 AND 2006

MEDICINAL PRODUCTS(CONTROL OF PLACING ON THE MARKET)REGULATIONS,2007

(S.I. No.540 of 2007)

PA0281/129/002
Case No: 2077212

The Irish Medicines Board in exercise of the powers conferred on it by the above mentioned Regulations hereby grants to

Pinewood Laboratories Ltd, T/A Pinewood Healthcare

Ballymacarbry, **Clonmel**, **Co. Tipperary**, **Ireland**

an authorisation, subject to the provisions of the said Regulations, in respect of the product

Rispal 0.5mg Film-coated Tablet

The particulars of which are set out in Part I and Part II of the attached Schedule. The authorisation is also subject to the general conditions as may be specified in the said Regulations as listed on the reverse of this document.

This authorisation, unless previously revoked, shall continue in force from **07/04/2010** until **26/04/2012**.

Signed on behalf of the Irish Medicines Board this

_____

A person authorised in that behalf by the said Board.

Part II

Summary of Product Characteristics

1 NAME OF THE MEDICINAL PRODUCT

Rispal 0.5mg Film-coated Tablet

2 QUALITATIVE AND QUANTITATIVE COMPOSITION

Each film-coated tablet contains 0.5mg, of risperidone.

Also contains 65 mg of lactose monohydrate and 0.54mg of sunset yellow (E110).
For full list of excipients see 6.1.

3 PHARMACEUTICAL FORM

Red-brown colour, round, scored biconvex film-coated tablets.

The tablet can be divided into equal halves.

4 CLINICAL PARTICULARS

4.1 Therapeutic Indications

Rispal is indicated for the treatment of acute and chronic schizophrenic psychoses, and other psychotic conditions, in which positive symptoms (such as hallucinations, delusions, thought disturbances, hostility, suspiciousness), and/or negative symptoms (such as blunted affect, emotional and social withdrawal, poverty of speech) are prominent.
Rispal also alleviates affective symptoms (such as depression, guilt feelings, anxiety) associated with schizophrenia.
Rispal is effective in maintaining clinical improvement in patients who have shown an initial treatment response.

Monotherapy - Rispal is indicated for the short-term treatment of acute mania or mixed episodes associated with bipolar disorder.
Combination therapy - the combination of Rispal with Lithium or valproate is indicated for the short-term treatment of acute mania or mixed episodes associated with bipolar disorder. Episodes are characterised by symptoms such as elevated, expansive or irritable mood, inflated self-esteem, decreased need for sleep, pressured speech, racing thoughts, distractibility or poor judgement including disruptive or aggressive behaviours.
Rispal is indicated for the treatment of severe behavioural disturbances in patients with dementia in whom symptoms such as aggressiveness (verbal outbursts, physical violence), activity disturbances (agitation, wandering) or psychotic symptoms are prominent and lead to patient suffering, disability, potential danger or self harm. Such patients should be closely monitored and Rispal continued only if the benefits of treatment are considered to outweigh the risks for the individual patient. (See Section 4.4 Special Warnings and Precautions for Use and Section 4.8 Undesirable Effects.)
Rispal is also indicated as adjunctive therapy to mood stabilizers in the acute treatment of manic episodes associated with bipolar disorders.
Rispal is indicated in the treatment of conduct and other disruptive behaviour disorders in adults with impaired social, academic or occupational functioning, in whom challenging behaviours (e.g. aggression, impulsiveness, and self-injury) are prominent. Rispal is also indicated for this condition in children and adolescents when conduct disorders are severe.
Treatment of severe disruptive behavioural symptoms in children and adolescents with autism and pervasive developmental disorders.

4.2 Posology and method of administration

4.2 a Schizophrenia

Switching from other antipsychotics:
Where medically appropriate, gradual discontinuation of the previous treatment while Rispal therapy is initiated is recommended.

Where medically appropriate when switching patients from depot antipsychotics, consider initiating Rispal therapy in place of the next scheduled injection. The need for continuing existing anti-parkinson medication should be re-evaluated periodically.

Adults
Rispal may be given once or twice daily. All patients, whether acute or chronic, should start with 2 mg/day Rispal. The dosage may be increased to 4 mg/day on the second day. Some patients such as first-episode psychotic patients may benefit from a slower rate of titration. From then on the dosage can be maintained unchanged, or further individualised, if needed. Most patients will benefit from daily doses between 4 and 6 mg/day although in some, an optimal response may be obtained at lower doses.
Doses above 10 mg/day generally have not been shown to provide additional efficacy to lower doses and may increase the risk of extrapyramidal symptoms.
Doses above 10 mg/day should only be used in individual patients if the benefit is considered to outweigh the risk.
Doses above 16 mg/day have not been extensively evaluated for safety and therefore should not be used.

Elderly
A starting dose of 0.5 mg bid is recommended. This dosage can be individually adjusted with 0.5 mg bid increments to 1 to 2 mg bid.
Patients should be monitored and treatment reviewed at regular intervals.

Children
Use of Rispal for schizophrenia in children aged less than 15 years has not been formally evaluated and experience is limited**.**

Renal and liver disease
A starting dose of 0.5 mg bid is recommended. This dosage can be individually adjusted with 0.5 mg bid increments to 1 to 2 mg bid.
Rispal should be used with caution in this group of patients until further experience is gained.

4.2. b Bipolar mania

Monotherapy
Rispal should be administered once daily, starting with 2mg. Dosage adjustments, if indicated, should occur at intervals of not less than 24 hours and in dosage increments of 1mg per day. A dosing range between 2 and 6 mg per day is recommended.
As with all symptomatic treatments, the continued use of Rispal must be evaluated and justified on an ongoing basis.

Adjunctive therapy
A starting dosage of 2 mg once daily is recommended. This can be individually adjusted by increments of up to 2 mg/day not more frequently than every other day. Most patients will benefit from doses between 2 and 6 mg/day.
Treatment with risperidone should be reviewed regularly and discontinued if no benefit is seen or intolerance occurs.

4.2 c Behavioural Disturbances in patients with Dementia

A starting dose of 0.25 mg bid is recommended. This dosage can be individually adjusted by increments of 0.25 mg bid every other day. The optimum dose is 0.5 mg bid for most patients. Some patients, however, may benefit from doses up to 1 mg bid Once patients have reached their target dose, a once daily dosing regimen can be considered.
Rispal should be used with caution in this group of patients. Treatment should be reviewed regularly and discontinued if no benefit is seen or if intolerance occurs. (See Section 4.1, Therapeutic indications, 4.4 Special warnings and special precautions for use and Section 4.8 Undesirable effects)

4.2 d Conduct and other disruptive behaviour disorders

For children and adolescents with conduct and other disruptive behaviour disorders, risperidone should be prescribed by physicians with specialist knowledge in this area (e.g. child psychiatrists).

Patients ≥50 kg

A starting dose of 0.5 mg once daily is recommended. This dosage can be individually adjusted by increments of 0.5 mg once daily not more frequently than every other day, if needed.
The optimum dose is 1 mg once daily for most patients. Some patients, however, may benefit from 0.5 mg once daily while others may require 1.5 mg once daily.

Patients ≤50 kg

A starting dose of 0.25 mg once daily is recommended. This dosage can be individually adjusted by increments of 0.25 mg once daily not more frequently than every other day, if needed.
The optimum dose is 0.5 mg once daily for most patients. Some patients, however, may benefit from 0.25 mg once daily while others may require 0.75 mg once daily.
As with all symptomatic treatments, the continued use of Risperidone must be regularly evaluated and justified on an ongoing basis.
Rispal has not been formally evaluated in children aged less than 5 years and experience is limited.

4.2. e. Autism (children aged 5 or over and adolescents)

The dosage of Rispal should be individualised according to the needs and response of the patient.

Dosing should be initiated at 0.25 mg per day for patients <20 kg and 0.5 mg per day for patients ≥20 kg.

On Day 4, the dose may be increased by 0.25 mg for patients <20 kg and 0.5 mg for patients ≥20 kg.

This dose should be maintained and response should be assessed at approximately Day 14. Only in patients not achieving sufficient clinical response should additional dose increases be considered. Dose increases may proceed at 2-week intervals in increments of 0.25 mg for patients <20 kg or 0.5 mg for patients ≥20 kg.

In clinical studies, the maximum dose studied did not exceed a total daily dose of 1.5 mg in patients <20 kg, 2.5 mg in patients ≥20 kg, or 3.5 mg in patients >45 kg.

Doses of Rispal in paediatric patients with Autistic Disorder (by total mg/day)

Weight Categories	**Days 1-3**	**Days 4 – 14+**	**Increments if Dose Increases are Needed**	**Dose Range**
<20 kg	0.25 mg	0.5 mg	+0.25 mg at ≥2 week intervals	0.5 mg- 1.5 mg
≥20 kg	0.5 mg	1.0 mg	+0.5 mg at ≥2 week intervals	1.0 mg – 2.5 mg*****

*****Subjects weighing > 45 kg may require higher doses; maximum dose studied was 3.5 mg/ day

For prescribers preferring to dose on a mg/kg/day basis the following guidance is provided.

Doses of Rispal in paediatric patients With Autistic Disorder (by mg/kg/day)

Weight Categories	**Days 1-3**	**Days 4 – 14+**	**Increments if Dose Increases are Needed**	**Dose Range**
All	0.01mg/kg/day	0.02 mg/kg/day	+0.01 mg/kg/day at ≥2 week intervals	0.02 mg/kg/day – 0.06 mg/kg/day

Rispal can be administered once daily or twice daily.

Patients experiencing somnolence may benefit from a switch in dosing from once daily to either once daily at bedtime or twice daily.
Once sufficient clinical response has been achieved and maintained, consideration may be given to gradually lowering the dose to achieve the optimal balance of efficacy and safety. There is insufficient evidence from controlled trials to indicate how long the patient with Autistic Disorder should be treated with Rispal.

Method of administration
Oral use.

4.3 Contraindications

Rispal is contraindicated in patients with a known hypersensitivity to risperidone or any other ingredients in the product.

4.4 Special warnings and precautions for use

Elderly patients with dementia

Overall Mortality

Elderly patients with dementia treated with atypical antipsychotic drugs had an increased mortality compared to placebo in a meta-analysis of 17 controlled trials of atypical antipsychotic drugs, including Rispal. In placebo-controlled trials with Risperidone in this population, the incidence of mortality was 4.0% for Risperidone treated patients compared to 3.1% for placebo-treated patients. The mean age (range) of patients who died was 86 years (range 67-100).

Concomitant use with Furosemide

In the Risperidone placebo-controlled trials in elderly patients with dementia, a higher incidence of mortality was observed in patients treated with furosemide plus risperidone (7.3%; mean age 89 years, range 75-97) when compared to patients treated with risperidone alone (3.1%; mean age 84 years, range 70-96) or furosemide alone (4.1%; mean age 80 years, range 67-90. Odds ratio [95% confidence interval] was 1.82 [0.65, 5.14]). The increase in mortality in patients treated with furosemide plus risperidone was observed in two of the four clinical trials.
No pathophysiological mechanism has been identified to explain this finding, and no consistent pattern for cause of death observed. Nevertheless, caution should be exercised and the risks and benefits of this combination should be considered prior to the decision to use. There was no increased incidence of mortality among patients taking other diuretics as concomitant medication with risperidone. Irrespective of treatment, dehydration was an overall risk factor for mortality and should therefore be carefully avoided in elderly patients with dementia.

Cerebrovascular Adverse Events (CAE)

In placebo-controlled trials in elderly patients with dementia there was a higher incidence of cerebrovascular adverse events (cerebrovascular accidents and transient ischaemic attacks), including fatalities in patients (mean age 85 years, range 73-97) treated with Risperidone, compared to patients receiving placebo. Cerebrovascular adverse events (CVAEs) occurred in 3.3% (33/989) of patients treated with risperidone and 1.2% (8/693) of patients treated with placebo.
Prior to treatment, physicians should carefully consider the risk of cerebrovascular adverse events with Risperidone (given the observations in elderly patients with dementia detailed above) before treating any patient with a previous history of CVA/TIA, or vascular co-morbidities such as hypertension and cardiovascular disease. These patients should be closely monitored during treatment and patients/caregivers advised to immediately report signs and symptoms of potential CVAEs, such as sudden weakness or numbness in the face, arms or legs, and speech or vision problems. Patients presenting with such symptoms should be promptly evaluated and treatment discontinued, if appropriate.

Alpha-blocking activity

Due to the alpha-blocking activity of Risperidone, orthostatic hypotension can occur, especially during the initial dose-titration period. Risperidone should be used with caution in patients with known cardiovascular disease (e.g. heart failure, myocardial infarction, conduction abnormalities, dehydration, hypovolaemia or cerebrovascular disease) and the dosage should be gradually titrated as recommended. A dose reduction should be considered if hypotension occurs.
Tardive Dyskinesia/Extrapyramidal Symptoms (TD/EPS)
Drugs with dopamine receptor antagonist properties have been associated with the induction of tardive dyskinesia, characterised by rhythmical involuntary movements, predominantly of the tongue and/or face. It has also been reported that the occurrence of extrapyramidal symptoms is a risk factor for the development of tardive dyskinesia. Risperidone should therefore have a reduced risk of inducing tardive dyskinesia as compared to classical neuroleptics. If signs and symptoms of tardive dyskinesia appear, the discontinuation of all antipsychotic drugs should be considered.

Neuroleptic Malignant Syndrome (NMS)

As with other neuroleptics, rare cases of Neuroleptic Malignant Syndrome, characterised by hyperthermia, muscle rigidity, autonomic instability, altered consciousness and elevated CPK levels have been reported. In such an event, all antipsychotic drugs, including Risperidone, should be discontinued.
Physicians should assess the risks versus the benefits when prescribing Risperidone, to patients with Lewy body dementia or Parkinson's disease since they may be at increased risk of neuroleptic malignant syndrome or a worsening of Parkinson-like symptoms.

Hyperglycaemia

Hyperglycaemia or exacerbation of pre-existing diabetes has been reported in very rare cases during treatment with Risperidone. Appropriate clinical monitoring is advisable in diabetic patients and in patients with risk factors for the development of diabetes mellitus (see also section 4.8 Undesirable effects).

Other

Classical neuroleptics are known to lower the seizure threshold. Caution is recommended when treating patients with epilepsy.
If further sedation is required, an additional drug (such as a benzodiazepine) should be administered rather than increasing the dose of Risperidone.
For posology recommendations in elderly patients, patients with renal and liver disease and patients with dementia, please see recommended doses and dosage schedule.
As with other antipsychotics, patients should be advised to refrain from excessive eating in view of the possibility of weight gain.
Patients with rare hereditary problems of galactose intolerance, the Lapp lactase deficiency or glucose-galactose malabsorption should not take this medication.

Cases of venous thromboembolism (VTE) have been reported with antipsychotic drugs. Since patients treated with antipsychotics often present with acquired risk factors for VTE, all possible risk factors for VTE should be identified before and during treatment with Rispal and preventive measure undertaken.

4.5 Interaction with other medicinal products and other forms of interaction

Possible interactions of risperidone with other drugs have not been systematically evaluated. Given the primary CNS effects of risperidone it should be used with caution in combination with other centrally acting drugs.
Risperidone may antagonise the effect of levodopa and other dopamine-agonists.
Carbamazepine has been shown to decrease the plasma levels of the active antipsychotic fraction of risperidone. A similar effect may be anticipated with other drugs which stimulate metabolising enzymes in the liver. On initiation of carbamazepine or other hepatic enzyme-inducing drugs, the dosage of Risperidone should be re-evaluated and increased if necessary. Conversely, on discontinuation of such drugs, the dosage of Risperidone should be re-evaluated and decreased if necessary.
Topiramate modestly reduces the bioavailability of risperidone, but not that of the active antipsychotic fraction. Therefore, this interaction is unlikely to be of clinical significance.
Phenothiazines, tricyclic antidepressants and some beta-blockers may increase the plasma concentrations of risperidone but not those of the active antipsychotic fraction. Fluoxetine and paroxetine, CYP2D6 inhibitors, may increase the plasma concentration of risperidone but less so of the active antipsychotic fraction. When concomitant fluoxetine or paroxetine is initiated or discontinued, the physician should re-evaluate the dosing of Risperidone. Based on *in vitro* studies, the same interaction may occur with haloperidol.
Amitriptyline does not affect the pharmacokinetics of risperidone or the active antipsychotic fraction. Cimetidine and ranitidine increased the bioavailability of risperidone, but only marginally that of the active antipsychotic fraction.
Erythromycin, a CYP 3A4 inhibitor, does not change the pharmacokinetics of risperidone and the active antipsychotic fraction. The cholinesterase inhibitors, galantamine and donezepil, do not show a clinically relevant effect on the pharmacokinetics of risperidone and the active antipsychotic fraction.
When Risperidone is taken together with other highly protein-bound drugs, there is no clinically relevant displacement of either drug from the plasma proteins.
See section 4.4 regarding increased mortality in elderly patients with dementia concomitantly receiving furosemide.

Risperidone does not show a clinically relevant effect on the pharmacokinetics of lithium, valproate, digoxin or topiramate.
The combined use of psychostimulants (e.g. methylphenidate) with Risperidone in children and adolescents did not alter the pharmacokinetics and efficacy of Risperidone. The incidence of somnolence was reduced when psychostimulants were used concomitantly.
Food does not affect the absorption of risperidone from the stomach. The effect of food particles in the mouth on absorption has not been studied.

4.6 Pregnancy and lactation

Although, in experimental animals, risperidone did not show direct reproductive toxicity, some indirect, prolactin- and CNS-mediated effects were observed, typically delayed oestrus and changes in mating and nursing behaviour in rats. No teratogenic effect of risperidone was noted in any study.
The safety of Risperidone for use during human pregnancy has not been established. Therefore, Rispal should only be used during pregnancy if the benefits outweigh the risks.
In animal studies, risperidone and 9-hydroxyrisperidone are excreted in the milk. It has been demonstrated that risperidone and 9-hydroxyrisperidone are also excreted in human breast milk. Therefore, women receiving Rispal should not breast feed.

4.7 Effects on ability to drive and use machines

Risperidone may interfere with activities requiring mental alertness. Therefore, patients should be advised not to drive or operate machinery until their individual susceptibility is known.

4.8 Undesirable effects

Risperidone is generally well tolerated and in many instances it has been difficult to differentiate adverse events from symptoms of the underlying disease.
Adverse events observed in association with the use of Risperidone include:

Common: insomnia, agitation, anxiety, headache. In children and adolescents, mild and transient sedation has been reported more frequently than in adults.

Less common: somnolence, fatigue, dizziness, impaired concentration, constipation, dyspepsia, nausea/vomiting, abdominal pain, blurred vision, priapism, erectile dysfunction, ejaculatory dysfunction, orgasmic dysfunction, urinary incontinence, rhinitis, rash and other allergic reactions.

Cerebrovascular adverse events, including cerebrovascular accidents (some of which were fatal), and transient ischaemic attacks, have been reported during treatment with Risperidone. (See also Section 4.4, Special warnings and special precautions for Use.)

Risperidone has a lower propensity to induce extrapyramidal symptoms than classical neuroleptics. However, in some cases the following extrapyramidal symptoms may occur: tremor, rigidity, hypersalivation, bradykinesia, akathisia, acute dystonia. If acute in nature, these symptoms are usually mild and are reversible upon dose reduction and/or administration of antiparkinson medication, if necessary.

Occasionally, orthostatic dizziness, hypotension including orthostatic, tachycardia including reflex tachycardia and hypertension have been observed following administration of Risperidone.

Risperidone can induce a dose-dependent increase in plasma prolactin concentration. Possible associated manifestations are: galactorrhoea, gynaecomastia, disturbances of the menstrual cycle and amenorrhoea.

Weight gain, oedema and increased hepatic enzyme levels have been observed during treatment with Risperidone.

A decrease in neutrophil and/or thrombocyte count has been reported.

Cases of venous thromboembolism, including cases of pulmonary embolism and cases of deep vein thrombosis have been reported with antipsychotic drugs – Frequency unknown.

As with classical neuroleptics, the following have occasionally been reported in psychotic patients: water intoxication due to either polydipsia or the syndrome of inappropriate secretion of antidiuretic hormone (SIADH); tardive dyskinesia, Neuroleptic Malignant Syndrome, body temperature dysregulation and seizures.

In clinical trials in patients with acute mania, risperidone treatment resulted in an incidence of EPS > 10%. This is lower than the incidence observed in patients treated with classical neuroleptics.

The following adverse events have been reported as very common in children and adolescents with conduct disorders: somnolence, headache, hyperprolactinaemia, weight increase**.**
Hyperglycemia and exacerbation of pre-existing diabetes have been reported in very rare cases during risperidone treatment.

4.9 Overdose

Overdosages of up to 360 mg have been reported. In general, reported signs and symptoms have been those resulting from an exaggeration of the drug's known pharmacological effects. These include drowsiness and sedation, tachycardia and hypotension, and extrapyramidal symptoms. In overdose rare cases of QT-prolongation have been reported. In case of acute overdosage, the possibility of multiple drug involvement should be considered.
Establish and maintain a clear airway, and ensure adequate oxygenation and ventilation. Gastric lavage (after intubation, if the patient is unconscious) and administration of activated charcoal together with a laxative should be considered. Cardiovascular monitoring should commence immediately and should include continuous

electrocardiographic monitoring to detect possible arrhythmias.

There is no specific antidote to Risperidone. Therefore appropriate supportive measures should be instituted. Hypotension and circulatory collapse should be treated with appropriate measures such as intravenous fluids and/or sympathomimetic agents.
In case of severe extrapyramidal symptoms, anticholinergic medication should be administered. Close medical supervision and monitoring should continue until the patient recovers.

5 PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: Antipsychotics
ATC code: N05AX08

Risperidone is a novel antipsychotic belonging to a new class of antipsychotic agents, the benzisoxazole-derivatives.

Risperidone is a selective monoaminergic antagonist with a high affinity for both serotonergic 5-HT_2 and dopaminergic D_2 receptors. Risperidone binds also to $alpha_1$-adrenergic receptors and, with lower affinity, to H_1-histaminergic and $alpha_2$-adrenergic receptors. Risperidone has no affinity for cholinergic receptors. Although Risperidone is a potent D_2 antagonist, an activity which is considered to improve the positive symptoms of schizophrenia, it causes less depression of motor activity and induction of catalepsy than classical neuroleptics. Balanced central serotonin and dopamine antagonism may reduce the tendency to cause extrapyramidal side effects, and extend the therapeutic activity to the negative and affective symptoms of schizophrenia.

5.2 Pharmacokinetic properties

Risperidone is completely absorbed after oral administration, reaching peak plasma concentrations within 1 to 2 hours. The absorption is not affected by food and thus Risperidone can be given with or without meals.

Risperidone is partly metabolised by cytochrome P-450 IID6 to 9-hydroxy-risperidone which has a similar pharmacological activity to risperidone. Risperidone plus 9-hydroxy-risperidone form the active antipsychotic fraction. Another metabolic pathway of risperidone is N-dealkylation.
After oral administration to psychotic patients, risperidone is eliminated with a half-life of about 3 hours. The elimination half-life of 9-hydroxy-risperidone and of the active antipsychotic fraction is 24 hours.

Steady-state of risperidone is reached within 1 day in most patients. Steady-state of 9-hydroxy-risperidone is reached within 4-5 days of dosing. Risperidone plasma concentrations are dose-proportional within the therapeutic dose range. Risperidone is rapidly distributed. The volume of distribution is 1-2 L/kg. In plasma, risperidone is bound to albumin and $alpha_1$-acid glycoprotein. The plasma protein binding of risperidone is 88%, that of 9-hydroxy-risperidone is 77%.
One week after administration, 70% of the dose is excreted in the urine and 14% in the faeces. In urine, risperidone plus 9-hydroxy-risperidone represent 35-45% of the dose. The remainder are inactive metabolites.
A single dose study showed higher active plasma concentrations and a slower elimination of risperidone in the elderly and in patients with renal insufficiency. Risperidone plasma concentrations were normal in patients with liver insufficiency.
The pharmacokinetics of risperidone, 9-hydroxy-risperidone and the active moiety in children are similar to those in adults.

5.3 Preclinical safety data

There are no preclinical data of relevance to the prescriber other than those already provided in other sections of the SPC.

6 PHARMACEUTICAL PARTICULARS

6.1 List of excipients

All tablet strengths contain the following excipients.

Tablet core

Sodium Starch Glycollate (Type A),
Lactose Monohydrate,
Microcrystalline cellulose,
Colloidal Silica anhydrous,
Magnesium stearate,
Sodium lauryl sulphate,
Pregelatinised starch

In addition, the tablets also contain the following excipients:

Opadry II Orange (31F26784) containing;
Lactose Monohydrate
Hypromellose (E464)
Sunset Yellow FCF Aluminium Lake (E110)
Macrogol
Titanium Dioxide (E171)
Iron Oxide Yellow (E172)
Indigo Carmine Aluminium Lake (E132)

6.2 Incompatibilities

Not applicable

6.3 Shelf Life

3 years

6.4 Special precautions for storage

This medicinal product does not require any special storage conditions.

6.5 Nature and contents of container

Blister strips consisting of clear polyvinylchloride (PVC)/ polyvinylidene chloride (PVDC) and aluminium foil.

Pack sizes: 20, 28, 60
Not all pack sizes may 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,
Trading as Pinewood Healthcare,
Ballymacarbry,
Clonmel
Co. Tipperary

8 MARKETING AUTHORISATION NUMBER

PA 281/129/2

9 DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUTHORISATION

Date of First Authorisation 27th April 2007.

10 DATE OF REVISION OF THE TEXT

April 2010