Summary of Product Characteristics

1 NAME OF THE MEDICINAL PRODUCT

Tadalafil Rowex 5 mg Film-coated tablets

2 QUALITATIVE AND QUANTITATIVE COMPOSITION

Each film-coated tablet contains 5 mg tadalafil.
Excipient(s) with known effect
Each tablet contains 88 mg lactose monohydrate.

For the full list of excipients, see section 6.1.

3 PHARMACEUTICAL FORM

Film-coated tablet.

Ochre to yellow, oval shaped film coated tablet of approximately 8 x 4 mm. On one side debossed with "5" and plain on the other side.

4 CLINICAL PARTICULARS

4.1 Therapeutic Indications

Treatment of erectile dysfunction in adult males. In order for tadalafil to be effective, sexual stimulation is required.

Treatmentof thesignsand symptomsofbenign prostatichyperplasia in adultmales.

4.2 Posology and method of administration

Posology
Erectile dysfunction in adult men
In general, the recommended dose is 10 mg taken prior to anticipated sexual activity and with or without food. In those patients in whom tadalafil 10 mg does not produce an adequate effect, 20 mg might be tried.
It may be taken at least 30 minutes prior to sexual activity.

The maximum dose frequency is once per day.

Tadalafil 10 mg and 20 mg is intended for use prior to anticipated sexual activity and it is not recommended for continuous daily use.

In patients who anticipate a frequent use of tadalafil (i.e., at least twice weekly) a once daily regimen with the lowest doses of tadalafil might be considered suitable, based on patient choice and the physician's judgement.

In these patients the recommended dose is 5 mg taken once a day at approximately the same time of day. The dose may be decreased to 2.5 mg once a day based on individual tolerability.

The appropriateness of continued use of the daily regimen should be reassessed periodically.

Benign prostatic hyperplasia in adult men
The recommended dose is 5 mg, taken at approximately the same time every day with or without food. For adult men being treated for both benign prostatic hyperplasia and erectile dysfunction the recommended dose is also 5 mg taken at approximately the same time every day. Patients who are unable to tolerate tadalafil 5 mg for the treatment of benign prostatic hyperplasia should consider an alternative therapy as the efficacy of tadalafil 2.5 mg for the treatment of benign prostatic hyperplasia has not been demonstrated.

Pulmonary arterial hypertension

Treatment should only be initiated and monitored by a physician experienced in the treatment of PAH. The recommended dose is 40 mg (2 x 20 mg) taken once daily with or without food.

Special populations

Elderly
Dose adjustments are not required in elderly patients.

Renal impairment
• Adult men with erectile dysfunction or benign prostatic hyperplasia: Dose adjustments are not required in patients with mild to moderate renal impairment. For patients with severe renal impairment 10 mg is the maximum recommended dose for on-demand treatment. Once-a-day dosing of 2.5 or 5 mg tadalafil both for the treatment of erectile dysfunction or benign prostatic hyperplasia is not recommended in patients with severe renal impairment (see sections 4. 4 and 5.2).
• Pulmonary arterial hypertension: In patients with mild to moderate renal impairment a starting dose of 20 mg once per day is recommended. The dose may be increased to 40 mg once per day, based on individual efficacy and tolerability. In patients with severe renal impairment the use of tadalafil is not recommended (see sections 4.4 and 5.2).

Hepatic impairment
• Adult men with erectile dysfunction or benign prostatic hyperplasia: For the treatment of erectile dysfunction using on-demand tadalafil the recommended dose of tadalafil is 10 mg taken prior to anticipated sexual activity and with or without food. There is limited clinical data on the safety of tadalafil in patients with severe hepatic impairment (Child-Pugh Class C); if prescribed, a careful individual benefit/risk evaluation should be undertaken by the prescribing physician. There are no available data about the administration of doses higher than 10 mg of tadalafil to patients with hepatic impairment.
Once-a-day dosing of tadalafil both for the treatment of erectile dysfunction and benign prostatic hyperplasia has not been evaluated in patients with hepatic impairment; therefore, if prescribed, a careful individual benefit/risk evaluation should be undertaken by the prescribing physician (see sections 4.4 and 5.2).
• Pulmonary arterial hypertension: Due to limited clinical experience in patients with mild to moderate hepatic cirrhosis (Child-Pugh Class A and B), following single doses of 10 mg, a starting dose of 20 mg once per day may be considered. If tadalafil is prescribed, a careful individual benefit/risk evaluation should be undertaken by the prescribing physician. Patients with severe hepatic cirrhosis (Child-Pugh Class C) have not been studied and therefore dosing of tadalafil is not recommended (see sections 4.4 and 5.2).

Diabetes
Adult men with erectile dysfunction or benign prostatic hyperplasia: Dose adjustments are not required in diabetic patients.

Paediatric population
There is no relevant use of tadalafil in the paediatric population with regard to the treatment of erectile dysfunction.
The safety and efficacy of tadalafil in individuals below 18 years of age has not yet been established. Currently available data are described in section 5.1.

Method of administration
Oral use.

4.3 Contraindications

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

In clinical studies, tadalafil was shown to augment the hypotensive effects of nitrates. This is thought to result from the combined effects of nitrates and tadalafil on the nitric oxide/cGMP pathway. Therefore, administration of tadalafil to patients who are using any form of organic nitrate is contraindicated (see section 4.5).

Tadalafil must not be used in men with cardiac disease for whom sexual activity is inadvisable. Physicians should consider the potential cardiac risk of sexual activity in patients with pre-existing cardiovascular disease.

The following groups of patients with cardiovascular disease were not included in clinical studies and the use of tadalafil is therefore contraindicated:
• patients with myocardial infarction within the last 90 days,
• patients with unstable angina or angina occurring during sexual intercourse,
• patients with New York Heart Association Class 2 or greater heart failure in the last 6 months,

• patients with uncontrolled arrhythmias, hypotension (< 90/50 mm Hg), or uncontrolled hypertension,
• patients with a stroke within the last 6 months.

Tadalafil is contraindicated in patients who have loss of vision in one eye because of non-arteritic anterior ischaemic optic neuropathy (NAION), regardless of whether this episode was in connection or not with previous PDE5 inhibitor exposure (see section 4.4).

The co-administration of PDE5 inhibitors, including tadalafil, with guanylate cyclase stimulators, such as riociguat, is contraindicated as it may potentially lead to symptomatic hypotension (see section 4.5).

4.4 Special warnings and precautions for use

Before treatment of adult men with erectile dysfunction or benign prostatic hyperplasia with tadalafil
A medical history and physical examination should be undertaken to diagnose erectile dysfunction or benign prostatic hyperplasia and determine potential underlying causes, before pharmacological treatment is considered.

Prior to initiating any treatment for erectile dysfunction, physicians should consider the cardiovascular status of their patients, since there is a degree of cardiac risk associated with sexual activity. Tadalafil has vasodilator properties, resulting in mild and transient decreases in blood pressure (see section 5.1) and as such potentiates the hypotensive effect of nitrates (see section 4.3).

The evaluation of erectile dysfunction should include a determination of potential underlying causes and the identification of appropriate treatment following an appropriate medical assessment. It is not known if tadalafil is effective in patients who have undergone pelvic surgery or radical non-nerve- sparing prostatectomy.

Prior to initiating treatment with tadalafil for benign prostatic hyperplasia patients should be examined to rule out the presence of carcinoma of the prostate and carefully assessed for cardiovascular conditions (see section 4.3).

Cardiovascular
Serious cardiovascular events, including myocardial infarction, sudden cardiac death, unstable angina pectoris, ventricular arrhythmia, stroke, transient ischemic attacks, chest pain, palpitations and tachycardia, have been reported either post marketing and/or in clinical studies using tadalafil for the treatment of erectile dysfunction or benign prostatic hyperplasia. Most of the patients in whom these events have been reported had pre-existing cardiovascular risk factors. However, it is not possible to definitively determine whether these events are related directly to these risk factors, to tadalafil, to sexual activity, or to a combination of these or other factors.

The following groups of patients with cardiovascular disease were not included in PAH clinical studies:
• Patients with clinically significant aortic and mitral valve disease
• Patients with pericardial constriction
• Patients with restrictive or congestive cardiomyopathy
• Patients with significant left ventricular dysfunction
• Patients with life-threatening arrhythmias
• Patients with symptomatic coronary artery disease
• Patients with uncontrolled hypertension.

Since there are no clinical data on the safety of tadalafil in these patients, the use of tadalafil is not recommended.

Pulmonary vasodilators may significantly worsen the cardiovascular status of patients with pulmonary veno-occlusive disease (PVOD). Since there are no clinical data on administration of tadalafil to patients with veno-occlusive disease, administration of tadalafil to such patients is not recommended. Should signs of pulmonary oedema occur when tadalafil is administered, the possibility of associated PVOD should be considered.

Tadalafil has systemic vasodilatory properties that may result in transient decreases in blood pressure. Physicians should carefully consider whether their patients with certain underlying conditions, such as severe left ventricular outflow obstruction, fluid depletion, autonomic hypotension or patients with resting hypotension, could be adversely affected by such vasodilatory effects.

In patients receiving concomitant antihypertensive medicinal products, tadalafil may induce a blood pressure decrease. When initiating daily treatment with tadalafil, appropriate clinical considerations should be given to a possible dose adjustment of the antihypertensive therapy.

In patients who are taking alpha$_1$ blockers concomitant administration of tadalafil may lead to symptomatic hypotension in some patients (see section 4.5). Therefore, the combination of tadalafil and doxazosin is not recommended.

Vision
Visual defects and cases of NAION have been reported in connection with the intake of tadalafil and other PDE5 inhibitors. Analyses of observational data suggest an increased risk of acute NAION in men with erectile dysfunction following exposure to tadalafil or other PDE5 inhibitors. As this may be relevant for all patients exposed to tadalafil, the patient should be advised that in case of sudden visual defect, he should stop taking tadalafil and consult a physician immediately (see section 4.3). Patients with known hereditary degenerative retinal disorders, including retinitis pigmentosa, were not included in the clinical studies for pulmonary arterial hypertension, and use in these patients is not recommended.

Decreased or sudden hearing loss
Cases of sudden hearing loss have been reported after use of tadalafil. Although other risk factors were present in some cases (such as age, diabetes, hypertension, previous hearing loss history and associated connective tissue diseases), patients should be advised to seek prompt medical attention in the event of sudden decrease or loss of hearing.

Renal and hepatic impairment
Due to increased tadalafil exposure (AUC), limited clinical experience, and the lack of ability to influence clearance by dialysis, once-a-day dosing of tadalafil is not recommended in patients with severe renal impairment.

There is limited clinical data on the safety of single-dose administration of tadalafil in patients with severe hepatic insufficiency (Child-Pugh Class C). If tadalafil is prescribed for on demand use, a careful individual benefit/risk evaluation should be undertaken by the prescribing physician. Once-a-day administration has not been studied in patients with severe hepatic cirrhosis (Child-Pugh Class C) and, therefore, dosing of tadalafil is not recommended.

Priapism and anatomical deformation of the penis
Priapismhasbeen reported in men treated with PDE5 inhibitors. Patients who experience erections lasting 4 hours or more should be instructed to seek immediate medical assistance. If priapism is not treated immediately, penile tissue damage and permanent loss of potency may result.

Tadalafil should be used with caution in patients with anatomical deformation of the penis (such as angulation, cavernosal fibrosis or Peyronie's disease), or in patients who have conditions which may predispose them to priapism (such as sickle cell anaemia, multiple myeloma or leukaemia).

Use with CYP3A4 inducers or inhibitors

For patients chronically taking potent inducers of CYP3A4, such as rifampicin, the use of tadalafil is not recommended (see section 4.5).

For patients taking concomitant potent inhibitors of CYP3A4, such as ketoconazole or ritonavir, the use of tadalafil is not recommended (see section 4.5).

Treatments for erectile dysfunction
The safety and efficacy of combinations of tadalafil and other PDE5 inhibitors or other treatments for erectile dysfunction have not been studied. Patients should be informed not to take tadalafil with these medicinal products.

Prostacyclin and its analogues
The efficacy and safety of tadalafil co-administered with prostacyclin or its analogues has not been studied in controlled clinical studies. Therefore, caution is recommended in case of co-administration.

Bosentan
The efficacy of tadalafil in patients already on bosentan therapy has not been conclusively demonstrated (see sections 4.5 and 5.1).

Lactose

Tadalafil Rowex contains lactose. Patients with rare hereditary problems of galactose intolerance, total lactase deficiency or glucose-galactose malabsorption should not take this medicine.

4.5 Interaction with other medicinal products and other forms of interactions

Interaction studies were conducted with 10 mg and/or 20 mg tadalafil, as indicated below. With regard to those interaction studies where only the 10 mg tadalafil dose was used, clinically relevant interactions at higher doses cannot be completely ruled out.

Effects of other substances on tadalafil

Cytochrome P450 inhibitors
Azole Antifungals (e.g. ketoconazole)
Tadalafil is principally metabolised by CYP3A4. A selective inhibitor of CYP3A4, ketoconazole (200 mg daily) increased tadalafil (10 mg) single dose exposure (AUC) 2-fold and C_{max} by 15 %, relative to the AUC and C_{max} values for tadalafil alone. Ketoconazole (400 mg daily) increased tadalafil (20 mg) single dose exposure (AUC) 4-fold and C_{max} by 22 %.

Protease inhibitors (e.g. ritonavir)
Ritonavir, a protease inhibitor (200 mg twice daily), which is an inhibitor of CYP3A4, CYP2C9, CYP2C19, and CYP2D6, increased tadalafil (20 mg) single dose exposure (AUC) 2-fold with no change in C_{max}. Ritonavir (500 mg or 600 mg twice daily) increased tadalafil (20 mg) single-dose exposure (AUC) by 32 % and decreased C_{max} by 30 %.

Although specific interactions have not been studied, other protease inhibitors, such as saquinavir, and other CYP3A4 inhibitors, such as erythromycin, clarithromycin, itraconazole and grapefruit juice should be co-administered with caution as they would be expected to increase plasma concentrations of tadalafil (see section 4.4). Consequently the incidence of the adverse reactions listed in section 4.8 might be increased.

Transporters
The role of transporters (for example p-glycoprotein) in the disposition of tadalafil is not known. Therefore there is the potential of drug interactions mediated by inhibition of transporters.

Cytochrome P450 inducers
Antimicrobial medicinal products (e.g. rifampicin)
A CYP3A4 inducer, rifampicin (600 mg daily), reduced tadalafil AUC by 88 % and C_{max} by 46 %, relative to the AUC and C_{max} values for tadalafil alone (10 mg). This reduced exposure can be anticipated to decrease the efficacy of tadalafil; the magnitude of decreased efficacy is unknown.
Other inducers of CYP3A4 such as phenobarbital, phenytoin and carbamazepine, may also decrease plasma concentrations of tadalafil.

Endothelin-1 receptor antagonists (e.g. bosentan)
Bosentan (125 mg twice daily), a substrate of CYP2C9 and CYP3A4 and a moderate inducer of CYP3A4, CYP2C9 and possibly CYP2C19, reduced tadalafil (40 mg once per day) systemic exposure by 42 % and C_{max} by 27 % following multiple dose co-administration. The efficacy of tadalafil in patients already on bosentan therapy has not been conclusively demonstrated (see sections 4.4 and 5.1). Tadalafil did not affect the exposure (AUC and C_{max}) of bosentan or its metabolites. The safety and efficacy of combinations of tadalafil and other endothelin-1 receptor antagonists have not been studied.

Effects of tadalafil on other medicinal products

Nitrates
In clinical studies, tadalafil (5, 10 and 20 mg) was shown to augment the hypotensive effects of nitrates. Therefore, administration of tadalafil to patients who are using any form of organic nitrate is contraindicated (see section 4.3). Based on the results of a clinical study in which 150 subjects receiving daily doses of tadalafil 20 mg for 7 days and 0.4 mg sublingual nitroglycerin at various times, this interaction lasted for more than 24 hours and was no longer detectable when 48 hours had elapsed after the last tadalafil dose. Thus, in a patient prescribed any dose of tadalafil (2.5 mg-20 mg), where nitrate administration is deemed medically necessary in a life-threatening situation, at least 48 hours should have elapsed after the last dose of tadalafil before nitrate administration is considered. In such circumstances, nitrates should only be administered under close medical supervision with appropriate haemodynamic monitoring.

Anti-hypertensives (including calcium channel blockers)

The co-administration of doxazosin (4 and 8 mg daily) and tadalafil (5 mg daily dose and 20 mg as a single dose) increases the blood pressure-lowering effect of this alpha-blocker in a significant manner. This effect lasts at least twelve hours and may be symptomatic, including syncope. Therefore, this combination is not recommended (see section 4.4).

In interaction studies performed in a limited number of healthy volunteers, these effects were not reported with alfuzosin or tamsulosin. However, caution should be exercised when using tadalafil in patients treated with any alpha-blockers, and notably in the elderly. Treatments should be initiated at minimal dose and progressively adjusted.

In clinical pharmacology studies, the potential for tadalafil (10 and 20 mg) to augment the hypotensive effects of antihypertensive medicinal products was examined. Major classes of antihypertensive medicinal products were studied (either as monotherapy or as part of combination therapy), including calcium channel blockers (amlodipine), angiotensin converting enzyme (ACE) inhibitors (enalapril), beta-adrenergic receptor blockers (metoprolol), thiazide diuretics (bendrofluazide), and angiotensin II receptor blockers (various types and doses, alone or in combination with thiazides, calcium channel blockers, beta-blockers, and/or alpha-blockers). Tadalafil (10 mg except for studies with angiotensin II receptor blockers and amlodipine in which a 20 mg dose was applied) had no clinically significant interaction with any of these classes. In another clinical pharmacology study tadalafil (20 mg) was studied in combination with up to 4 classes of antihypertensives. In subjects taking multiple antihypertensives, the ambulatory-blood-pressure changes appeared to relate to the degree of blood-pressure control. In this regard, study subjects whose blood pressure was well controlled, the reduction was minimal and similar to that seen in healthy subjects. In study subjects whose blood pressure was not controlled, the reduction was greater although this reduction was not associated with hypotensive symptoms in the majority of subjects. In patients receiving concomitant antihypertensive medicinal products, tadalafil 20 mg may induce a blood pressure decrease, which (with the exception of alpha blockers (e.g. doxazosin) -see above-) is, in general, minor and not likely to be clinically relevant. Analysis of phase 3 clinical study data showed no difference in adverse events in patients taking tadalafil with or without antihypertensive medicinal products. However, appropriate clinical advice should be given to patients regarding a possible decrease in blood pressure when they are treated with antihypertensive medicinal products.

Riociguat
Preclinical studies showed an additive systemic blood pressure lowering effect when PDE5 inhibitors were combined with riociguat. In clinical studies, riociguat has been shown to augment the hypotensive effects of PDE5 inhibitors. There was no evidence of favourable clinical effect of the combination in the population studied. Concomitant use of riociguat with PDE5 inhibitors, including tadalafil, is contraindicated (see section 4.3).

5- alpha reductase inhibitors
In a clinical study that compared tadalafil 5 mg co- administered with finasteride 5 mg to placebo plus finasteride 5 mg in the relief of BPH symptoms, no new adverse reactions were identified. However, as a formal drug-drug interaction study evaluating the effects of tadalafil and 5-alpha reductase inhibitors (5-ARIs) has not been performed, caution should be exercised when tadalafil is co- administered with 5-ARIs.

CYP1A2 substrates (e.g. theophylline)
When tadalafil 10 mg was administered with theophylline (a non-selective phosphodiesterase inhibitor) in a clinical pharmacology study, there was no pharmacokinetic interaction. The only pharmacodynamic effect was a small (3.5 bpm) increase in heart rate. Although this effect is minor and was of no clinical significance in this study, it should be considered when co-administering these medicinal products.

Ethinylestradiol and terbutaline
Tadalafil has been demonstrated to produce an increase in the oral bioavailability of ethinylestradiol. At steady-state, tadalafil (40 mg once per day) increased ethinylestradiol exposure (AUC) by 26 % and C_{max} by 70 % relative to oral contraceptive administered with placebo. There was no statistically significant effect of tadalafil on levonorgestrel which suggests the effect of ethinylestradiol is due to inhibition of gut sulphation by tadalafil. The clinical relevance of this finding is uncertain.
A similar increase in AUC and C_{max} seen with ethinylestradiol may be expected with oral administration of terbutaline, probably due to inhibition of gut sulphation by tadalafil. The clinical relevance of this finding is uncertain.

Alcohol
Alcohol concentrations (mean maximum blood concentration 0.08 %) were not affected by co-administration with tadalafil (10 mg or 20 mg). In addition, no changes in tadalafil concentrations were seen 3 hours after co-administration with alcohol. Alcohol was administered in a manner to maximise the rate of alcohol absorption (overnight fast with no food until 2 hours after alcohol). Tadalafil (20 mg) did not augment the mean blood pressure decrease produced by alcohol (0.7 g/kg or approximately 180 ml of 40 % alcohol [vodka] in an 80 kg male) but, in some subjects, postural dizziness and orthostatic hypotension were observed. When tadalafil was administered with lower doses of alcohol (0.6 g/kg), hypotension was not

observed and dizziness occurred with similar frequency to alcohol alone. The effect of alcohol on cognitive function was not augmented by tadalafil (10 mg).

Cytochrome P450 metabolised medicinal products
Tadalafil is not expected to cause clinically significant inhibition or induction of the clearance of medicinal products metabolised by CYP450 isoforms. Studies have confirmed that tadalafil does not inhibit or induce CYP450 isoforms, including CYP3A4, CYP1A2, CYP2D6, CYP2E1, CYP2C9 and CYP2C19.

CYP2C9 substrates (e.g. R-warfarin)
Tadalafil (10 mg and 20 mg) had no clinically significant effect on exposure (AUC) to S-warfarin or R-warfarin (CYP2C9 substrate), nor did tadalafil affect changes in prothrombin time induced by warfarin.

Acetyl salicylic acid (aspirin)
Tadalafil (10 mg and 20 mg) did not potentiate the increase in bleeding time caused by acetyl salicylic acid.

P-glycoprotein substrates (e.g. digoxin)
Tadalafil (40 mg once per day) had no clinically significant effect on the pharmacokinetics of digoxin.

Antidiabetic medicinal products
Specific interaction studies with antidiabetic medicinal products were not conducted.

4.6 Fertility, pregnancy and lactation

Pregnancy
There are limited data from the use of tadalafil in pregnant women. 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). As a precautionary measure, it is preferable to avoid the use of tadalafil during pregnancy.

Breastfeeding
Available pharmacodynamic/toxicological data in animals have shown excretion of tadalafil in milk. A risk to the breastfed child cannot be excluded. Tadalafil should not be used during breast feeding.

Fertility
Effects were seen in dogs that might indicate impairment of fertility. Two subsequent clinical studies suggest that this effect is unlikely in humans, although a decrease in sperm concentration was seen in some men (see sections 5.1 and 5.3).

4.7 Effects on ability to drive and use machines

Tadalafil has negligible influence on the ability to drive and use machines. Although the frequency of reports of dizziness in placebo and tadalafil arms in clinical studies was similar, patients should be aware of how they react to tadalafil, before driving or using machines.

4.8 Undesirable effects

Tadalafil for erectile dysfunction or benign prostatic hyperplasia

Summary of the safety profile

The most commonly reported adverse reactions in patients taking tadalafil for the treatment of erectile dysfunction or benign prostatic hyperplasia were headache, dyspepsia, back pain and myalgia, in which the incidences increase with increasing dose of tadalafil. The adverse reactions reported were transient, and generally mild or moderate. The majority of headaches reported with tadalafil once-a- day dosing are experienced within the first 10 to 30 days of starting treatment.

Tabulated summary of adverse reactions

The table below lists the adverse reactions observed from spontaneous reporting and in placebo- controlled clinical studies (comprising a total of 8022 patients on tadalafil and 4422 patients on placebo) for on-demand and once-a-day treatment of erectile dysfunction and the once-a-day treatment of benign prostatic hyperplasia.

Frequency convention: 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) and not known (cannot be estimated from the available data).

Very common	**Common**	**Uncommon**	**Rare**
Immune system disorders			
		Hypersensitivity reactions	Angioedema[2]
Nervous system disorders			
	Headache	Dizziness	Stroke[1] (including haemorrhagic events), Syncope, Transient ischaemic attacks[1], Migraine[2], Seizures[2], Transient amnesia
Eye disorders			
		Blurred vision, Sensations described as eye pain	Visual field defect, Swelling of eyelids, Conjunctival hyperaemia, Non- arteritic anterior ischemic optic neuropathy (NAION)[2], Retinal vascular occlusion[2]
Ear and labyrinth disorders			
		Tinnitus	Sudden hearing loss
Cardiac disorders[1]			
		Tachycardia, Palpitations	Myocardial infarction, Unstable angina pectoris[2], Ventricular arrhythmia[2]
Vascular disorders			
	Flushing	Hypotension[3], Hypertension	
Respiratory, thoracic and mediastinal disorders			
	Nasal congestion	Dyspnoea, Epistaxis	
Gastrointestinal disorders			
	Dyspepsia	Abdominal pain, Vomiting, Nausea, Gastro-oesophageal reflux	
Skin and subcutaneous tissue disorders			
		Rash	Urticaria, Stevens-Johnson syndrome[2], Exfoliative dermatitis[2], Hyperhydrosis (sweating)
Musculoskeletal and connective tissue disorders			
	Back pain, Myalgia, Pain in extremity		
Renal and urinary disorders			
		Haematuria	
Reproductive system and breast disorders			
		Prolonged erections	Priapism, Penile haemorrhage, Haematospermia
General disorders and administration site conditions			

		Chest pain[1], Peripheral oedema, Fatigue	Facial oedema[2], Sudden cardiac death[1,2]

(1) Most of the patients had pre-existing cardiovascular risk factors (see section 4.4).
(2) Postmarketing surveillance reported adverse reactions not observed in placebo-controlled clinical studies.
(3) More commonly reported when tadalafil is given to patients who are already taking antihypertensive medicinal products.

Description of selected adverse reactions

A slightly higher incidence of ECG abnormalities, primarily sinus bradycardia, has been reported in patients treated with tadalafil once a day as compared with placebo. Most of these ECG abnormalities were not associated with adverse reactions.

Other special populations

Data in patients over 65 years of age receiving tadalafil in clinical studies, either for the treatment of erectile dysfunction or the treatment of benign prostatic hyperplasia, are limited. In clinical studies with tadalafil taken on demand for the treatment of erectile dysfunction, diarrhoea was reported more frequently in patients over 65 years of age. In clinical studies with tadalafil 5 mg taken once a day for the treatment of benign prostatic hyperplasia, dizziness and diarrhoea were reported more frequently in patients over 75 years of age.

Tadalafil for pulmonary arterial hypertension

Summary of the safety profile

The most commonly reported adverse reactions, occurring in ≥ 10 % of patients in the tadalafil 40 mg treatment arm, were headache, nausea, back pain, dyspepsia, flushing, myalgia, nasopharingitis and pain in extremity. The adverse reactions reported were transient, and generally mild or moderate. Adverse reaction data are limited in patients over 75 years of age.

In the pivotal placebo-controlled study of tadalafil for the treatment of PAH, a total of 323 patients were treated with tadalafil at doses ranging from 2.5 mg to 40 mg once daily and 82 patients were treated with placebo. The duration of treatment was 16 weeks. The overall frequency of discontinuation due to adverse events was low (tadalafil 11 %, placebo 16 %). Three hundred and fifty seven (357) patients who completed the pivotal study entered a long-term extension study. Doses studied were 20 mg and 40 mg once daily.

Tabulated summary of adverse reactions
The table below lists the adverse reactions reported during the placebo-controlled clinical study in patients with PAH treated with tadalafil. Also included in the table are some adverse reactions which have been reported in clinical studies and/or post marketing with tadalafil in the treatment of male erectile dysfunction. These events have either been assigned a frequency of "Not known," as the frequency in PAH patients cannot be estimated from the available data or assigned a frequency based on the clinical study data from the pivotal placebo-controlled study of tadalafil.

Frequency convention: 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) and not known (cannot be estimated from the available data).

Very common	**Common**	**Uncommon**	**Rare**	**Not known[1]**
Immune system disorders				
	Hypersensitivity reactions[5]			Angioedema
Nervous system disorders				
Headache[6]	Syncope, Migraine[5]	Seizures[5], Transient amnesia[5]		Stroke[2] (including haemorrhagic events)

Eye disorders				
	Blurred vision			Non-arteritic anterior ischemic optic neuropathy (NAION), Retinal vascular occlusion, Visual field defect
Ear and labyrinth disorders				
		Tinnitus		Sudden hearing loss
Cardiac disorders				
	Palpitations[2], [5]	Sudden cardiac death[2], [5], Tachycardia[2], [5]		Unstable angina pectoris, Ventricular arrhythmia, Myocardial infarction[2]
Vascular disorders				
Flushing	Hypotension	Hypertension		
Respiratory, thoracic and mediastinal disorders				
Nasopharyngitis (including nasal congestion, sinus congestion and rhinitis)	Epistaxis			
Gastrointestinal disorders				
Nausea, Dyspepsia (including abdominal pain/discomfort[3])	Vomiting, Gastroesophageal reflux			
Skin and subcutaneous tissue disorders				
	Rash	Urticaria[5], Hyperhydrosis (sweating)[5]		Stevens-Johnson Syndrome, Exfoliative dermatitis
Musculoskeletal and connective tissue disorders				
Myalgia, Back pain, Pain in extremity (including limb discomfort)				
Renal and urinary disorders				
		Haematuria		
Reproductive system and breast disorders				
	Increased uterine bleeding[4]	Priapism[5], Penile haemorrhage, Haematospermia		Prolonged erections
General disorders and administration site conditions				
	Facial oedema, Chest pain[2]			

Description of selected adverse reactions

(1) Events not reported in registration studies and cannot be estimated from the available data. The adverse reactions have been included in the table as a result of postmarketing or clinical study data from the use of tadalafil in the treatment of erectile dysfunction.

(2) Most of the patients in whom these events have been reported had pre-existing cardiovascular risk factors.

(3) Actual MedDRA terms included are abdominal discomfort, abdominal pain, abdominal pain lower, abdominal pain upper, and stomach discomfort.
(4) Clinical non-MedDRA term to include reports of abnormal/excessive menstrual bleeding conditions such as menorrhagia, metrorrhagia, menometrorrhagia, or vaginal hemorrhage.
(5) The adverse reactions have been included in the table as a result of postmarketing or clinical study data from the use of tadalafil in the treatment of erectile dysfunction; and in addition, the frequency estimates are based on only 1 or 2 patients experiencing the adverse reaction in the pivotal placebo- controlled study of tadalafil.
(6) Headache was the most commonly reported adverse reaction. Headache may occur at the beginning of therapy; and decreases over time even if treatment is continued.

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 website: www.hpra.ie

4.9 Overdose

Single doses of up to 500 mg have been given to healthy subjects, and multiple daily doses up to 100 mg have been given to patients with erectile dysfunction. Adverse reactions were similar to those seen at lower doses.
In cases of overdose, standard supportive measures should be adopted as required. Haemodialysis contributes negligibly to tadalafil elimination.

5 PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: Urologicals, drugs used in erectile dysfunction. ATC code: G04BE08.

Mechanism of action
Tadalafil is a potent and selective, reversible inhibitor of phosphodiesterase type 5 (PDE5), the specific enzyme responsible for the degradation of cyclic guanosine monophosphate (cGMP).

Erectile dysfunction and benign prostatic hyperplasia
When sexual stimulation causes the local release of nitric oxide, inhibition of PDE5 by tadalafil produces increased levels of cGMP in the corpus cavernosum. This results in smooth muscle relaxation and inflow of blood into the penile tissues, thereby producing an erection. Tadalafil has no effect in the treatment of erectile dysfunction in the absence of sexual stimulation.

The effect of PDE5 inhibition on cGMP concentration in the corpus cavernosum is also observed in the smooth muscle of the prostate, the bladder and their vascular supply. The resulting vascular relaxation increases blood perfusion which may be the mechanism by which symptoms of benign prostatic hyperplasia are reduced. These vascular effects may be complemented by inhibition of bladder afferent nerve activity and smooth muscle relaxation of the prostate and bladder.

Pulmonary arterial hypertension
Pulmonary arterial hypertension is associated with impaired release of nitric oxide by the vascular endothelium and consequent reduction of cGMP concentrations within the pulmonary vascular smooth muscle. PDE5 is the predominant phosphodiesterase in the pulmonary vasculature. Inhibition of PDE5 by tadalafil increases the concentrations of cGMP resulting in relaxation of the pulmonary vascular smooth muscle cell and vasodilation of the pulmonary vascular bed.

Pharmacodynamic effects
Studies *in vitro* have shown that tadalafil is a selective inhibitor of PDE5. PDE5 is an enzyme found in corpus cavernosum smooth muscle, vascular and visceral smooth muscle, skeletal muscle, platelets, kidney, lung, and cerebellum. The effect of tadalafil is more potent on PDE5 than on other phosphodiesterases. Tadalafil is >10,000-fold more potent for PDE5 than for PDE1, PDE2, and PDE4, enzymes which are found in the heart, brain, blood vessels, liver, and other organs. Tadalafil is > 10,000-fold more potent for PDE5 than for PDE3, an enzyme found in the heart and blood vessels. This selectivity for PDE5 over PDE3 is important because PDE3 is an enzyme involved in cardiac contractility. Additionally, tadalafil is approximately 700-fold more potent for PDE5 than for PDE6, an enzyme which is found in the retina and is responsible for phototransduction. Tadalafil is also >10,000-fold more potent for PDE5 than for PDE7 through PDE10.

Clinical efficacy and safety

Erectile dysfunction

Three clinical studies were conducted in 1054 patients in an at-home setting to define the period of responsiveness to tadalafil on demand. Tadalafil demonstrated statistically significant improvement in erectile function and the ability to have successful sexual intercourse up to 36 hours following dosing, as well as patients' ability to attain and maintain erections for successful intercourse compared to placebo as early as 16 minutes following dosing.
For tadalafil on demand doses of 2 to 100 mg has been evaluated in 16 clinical studies involving 3,250 patients, including patients with erectile dysfunction of various severities (mild, moderate, severe), aetiologies, ages (range 21-86 years), and ethnicities. Most patients reported erectile dysfunction of at least 1 year in duration. In the primary efficacy studies of general populations, 81 % of patients reported that tadalafil improved their erections as compared to 35 % with placebo. Also, patients with erectile dysfunction in all severity categories reported improved erections whilst taking tadalafil (86 %, 83 %, and 72 % for mild, moderate, and severe, respectively, as compared to 45 %, 42 %, and 19 % with placebo). In the primary efficacy studies, 75 % of intercourse attempts were successful in tadalafil treated patients as compared to 32 % with placebo.

For once-a-day evaluation of tadalafil at doses of 2.5, 5, and 10 mg 3 clinical studies were initially conducted involving 853 patients of various ages (range 21-82 years) and ethnicities, with erectile dysfunction of various severities (mild, moderate, severe) and aetiologies. In the two primary efficacy studies of general populations, the mean per-subject proportion of successful intercourse attempts were 57 and 67 % on tadalafil 5 mg, 50 % on tadalafil 2.5 mg as compared to 31 and 37 % with placebo. In the study in patients with erectile dysfunction secondary to diabetes, the mean per-subject proportion of successful attempts were 41 and 46 % on tadalafil 5 mg and 2.5 mg, respectively, as compared to 28 % with placebo. Most patients in these three studies were responders to previous on- demand treatment with PDE5 inhibitors. In a subsequent study, 217 patients who were treatment- naïve to PDE5 inhibitors were randomised to tadalafil 5 mg once a day vs. placebo. The mean per- subject proportion of successful sexual intercourse attempts was 68 % for tadalafil patients compared to 52 % for patients on placebo.

Benign prostatic hyperplasia

Tadalafil was studied in 4 clinical studies of 12 weeks duration enrolling over 1500 patients with signs and symptoms of benign prostatic hyperplasia. The improvement in the total international prostate symptom score with tadalafil 5mg in the four studies were -4.8, -5.6, -6.1 and -6.3 compared to -2.2, - 3.6, -3.8 and -4.2 with placebo. The improvements in total international prostate symptom score occurred as early as 1 week. In one of the studies, which also included tamsulosin 0.4 mg as an active comparator, the improvement in total international prostate symptom score with tadalafil 5 mg, tamsulosin and placebo were -6.3, -5.7 and -4.2 respectively.

Pulmonary arterial hypertension (PAH)

A randomised, double-blind, placebo-controlled study was conducted in 405 patients with pulmonary arterial hypertension. Allowed background therapy included bosentan (stable maintenance dose up to 125 mg twice daily) and chronic anticoagulation, digoxin, diuretics and oxygen. More than half
(53.3 %) of the patients in the study were receiving concomitant bosentan therapy.

Patients were randomised to one of five treatment groups (tadalafil 2.5 mg, 10 mg, 20 mg, 40 mg, or placebo). Patients were at least 12 years of age and had a diagnosis of PAH that was idiopathic, related to collagen disease, related to anorexigen use, related to human immunodeficiency virus (HIV) infection, associated with an atrial-septal defect, or associated with surgical repair of at least 1 year in duration of a congenital systemic-to-pulmonary shunt (for example, ventricular septal defect, patent ductus arteriosus). The mean age of all patients was 54 years (range 14 to 90 years) with the majority of patients being Caucasian (80.5 %) and female (78.3 %). Pulmonary arterial hypertension (PAH) etiologies were predominantly idiopathic PAH (61.0 %) and related to collagen vascular disease
(23.5 %). The majority of patients had a World Health Organization (WHO) Functional Class III (65.2 %) or II (32.1 %). The mean baseline 6-minute-walk-distance (6MWD) was 343.6 meters.

The primary efficacy endpoint was the change from baseline at week 16 in 6-minute walk distance (6MWD). Only tadalafil 40 mg achieved the protocol defined level of significance with a placebo-adjusted median increase in 6MWD of 26 metres ($p=0.0004$; 95 % CI: 9.5, 44.0; Pre-specified Hodges-Lehman method) (mean 33 metres, 95 % CI: 15.2, 50.3). The improvement in walk distance was apparent from 8 weeks of treatment. Significant improvement ($p<0.01$) in the 6MWD was demonstrated at week 12 when the patients were asked to delay taking study medicinal product in order to reflect trough active substance concentration. Results were generally consistent in subgroups according to age, gender, PAH aetiology and baseline WHO functional class and 6MWD. The placebo-adjusted median increase in 6MWD was 17 metres ($p=0.09$; 95 % CI: : -7.1, 43.0;

Pre-specified Hodges-Lehman method) (mean 23 metres, 95 % CI; -2.4, 47.8) in those patients who received tadalafil 40 mg in addition to their concomitant bosentan (n=39), and was 39 metres (p<0.01, 95 % CI:13.0, 66.0; Pre-specified Hodges-Lehman method) (mean 44 metres, 95 % CI: 19.7, 69.0) in those patients who received tadalafil 40 mg alone (n=37).

The proportion of patients with improvement in WHO functional class by week 16 was similar in the tadalafil 40 mg and placebo groups (23 % vs. 21 %). The incidence of clinical worsening by week 16 in patients treated with tadalafil 40 mg (5 %; 4 of 79 patients) was less than placebo (16 %; 13 of 82 patients). Changes in the Borg dyspnoea score were small and non-significant with both placebo and tadalafil 40 mg.

Additionally, improvements compared to placebo were observed with tadalafil 40 mg in the physical functioning, role-physical, bodily pain, general health, vitality and social functioning domains of the SF-36. No improvements were observed in the role emotional and mental health domains of the SF36. Improvements compared to placebo were observed with tadalafil 40 mg in the EuroQol (EQ-5D) US and UK index scores comprising mobility, self-care, usual activities, pain/discomfort, anxiety/depression components, and in the visual analogue scale (VAS).

Cardiopulmonary hemodynamics was performed in 93 patients. Tadalafil 40 mg increased cardiac output (0.6 L/min) and reduced pulmonary artery pressures (-4.3 mmHg) and pulmonary vascular resistance (-209 dyn.s/cm5) compared to baseline (p<0.05). However, post hoc analyses demonstrated that changes from baseline in cardiopulmonary hemodynamic parameters for the tadalafil 40 mg treatment group were not significantly different compared to placebo.

Long-term treatment
357 patients from the placebo-controlled study entered a long-term extension study. Of these, 311 patients had been treated with tadalafil for at least 6 months and 293 for 1 year (median exposure 365 days; range 2 days to 415 days). For those patients for which there are data, the survival rate at 1 year is 96.4 %. Additionally, 6 minute walk distance and WHO functional class status appeared to be stable in those treated with tadalafil for 1 year.

Paediatric population
A single study has been performed in paediatric patients with Duchenne Muscular Dystrophy (DMD) in which no evidence of efficacy was seen. The randomised, double-blind, placebo-controlled, parallel, 3-arm study of tadalafil was conducted in 331 boys aged 7-14 years with DMD receiving concurrent corticosteroid therapy. The study included a 48-week double-blind period where patients were randomised to tadalafil 0.3 mg/kg, tadalafil 0.6 mg/kg, or placebo daily. Tadalafil did not show efficacy in slowing the decline in ambulation as measured by the primary 6 minute walk distance (6MWD) endpoint: least squares (LS) mean change in 6MWD at 48 weeks was -51.0 meters (m) in the placebo group, compared with -64.7 m in the tadalafil 0.3 mg/kg group (p = 0.307) and -59.1 m in the tadalafil 0.6 mg/kg group (p = 0.538). In addition, there was no evidence of efficacy from any of the secondary analyses performed in this study. The overall safety results from this study were generally consistent with the known safety profile of tadalafil and with adverse events (AEs) expected in a paediatric DMD population receiving corticosteroids.

The European Medicines Agency has deferred the obligation to submit the results of studies with the reference medicinal product containing tadalafil in all subsets of the paediatric population in the treatment of erectile dysfunction and pulmonary arterial hypertension (see section 4.2 for information on paediatric use).

5.2 Pharmacokinetic properties

Absorption
Tadalafil is readily absorbed after oral administration and the mean maximum observed plasma concentration (C_{max}) is achieved at a median time of 2 hours after dosing. Absolute bioavailability of tadalafil following oral dosing has not been determined.
The rate and extent of absorption of tadalafil are not influenced by food, thus it may be taken with or without food. The time of dosing (morning versus evening after a single 10 mg administration) had no clinically relevant effects on the rate and extent of absorption.

Distribution
The mean volume of distribution is approximately 77 litres at steady state, indicating that tadalafil is distributed into tissues. At therapeutic concentrations, 94 % of tadalafil in plasma is bound to proteins.
Protein binding is not affected by impaired renal function.
Less than 0.0005 % of the administered dose appeared in the semen of healthy subjects.

Biotransformation

Tadalafil is predominantly metabolised by the cytochrome P450 (CYP) 3A4 isoform. The major circulating metabolite is the methylcatechol glucuronide. This metabolite is at least 13,000-fold less potent than tadalafil for PDE5. Consequently, it is not expected to be clinically active at observed metabolite concentrations.

Elimination
The mean oral clearance for tadalafil is 3.4 l/h at steady state and the mean terminal half-life is 16 hours in healthy subjects. Tadalafil is excreted predominantly as inactive metabolites, mainly in the faeces (approximately 61 % of the dose) and to a lesser extent in the urine (approximately 36% of the dose).

Linearity/non-linearity
Tadalafil pharmacokinetics in healthy subjects are linear with respect to time and dose. Over a dose range of 2.5 mg to 20 mg, tadalafil exposure (AUC) increases proportionally with dose in healthy subjects. Between 20 mg to 40 mg, a less than proportional increase in exposure is observed. During tadalafil 20 mg and 40 mg once daily dosing, steady-state plasma concentrations are attained within 5 days and exposure is approximately 1.5 fold of that after a single dose.

Population pharmacokinetics
Pharmacokinetics determined with a population approach in patients with erectile dysfunction are similar to pharmacokinetics in subjects without erectile dysfunction.

In patients with pulmonary hypertension not receiving concomitant bosentan, the average tadalafil exposure at steady-state following 40 mg was 26 % higher when compared to those of healthy volunteers. There were no clinically relevant differences in C_{max} compared to healthy volunteers. The results suggest a lower clearance of tadalafil in patients with pulmonary hypertension compared to healthy volunteers.

Special populations

Elderly
Healthy elderly subjects (65 years or over) had a lower oral clearance of tadalafil, resulting in 25 % higher exposure (AUC) relative to healthy subjects aged 19 to 45 years after a 10 mg dose. This effect of age is not clinically significant and does not warrant a dose adjustment.

Renal insufficiency
In clinical pharmacology studies using single dose tadalafil (5 mg - 20 mg), tadalafil exposure (AUC) approximately doubled in subjects with mild (creatinine clearance 51 to 80 ml/min) or moderate (creatinine clearance 31 to 50 ml/min) renal impairment and in subjects with end-stage renal disease on dialysis. In haemodialysis patients, C_{max} was 41% higher than that observed in healthy subjects. Haemodialysis contributes negligibly to tadalafil elimination.

Due to increased tadalafil exposure (AUC), limited clinical experience, and the lack of ability to influence clearance by dialysis, tadalafil is not recommended in patients with severe renal impairment.

Hepatic insufficiency
Tadalafil exposure (AUC) in subjects with mild and moderate hepatic impairment (Child-Pugh Class A and B) is comparable to exposure in healthy subjects when a dose of 10 mg is administered.
There is limited clinical data on the safety of tadalafil in patients with severe hepatic insufficiency (Child-Pugh class C). If tadalafil is prescribed, a careful individual benefit/risk evaluation should be undertaken by the prescribing physician. There are no available data about the administration of doses higher than 10 mg of tadalafil to patients with hepatic impairment. There are no available data about the administration of once-a-day dosing of tadalafil to patients with hepatic impairment. If tadalafil is prescribed once-a-day, a careful individual benefit/risk evaluation should be undertaken by the prescribing physician.
Patients with severe hepatic cirrhosis (Child-Pugh Class C) have not been studied and therefore dosing of tadalafil in these patients is not recommended.

Patients with diabetes
Tadalafil exposure (AUC) in patients with diabetes was approximately 19 % lower than the AUC value for healthy subjects after a 10 mg dose. This difference in exposure does not warrant a dose adjustment.

Race
Pharmacokinetic studies have included subjects and patients from different ethnic groups, and no differences in the typical exposure to tadalafil have been identified. No dose adjustment is warranted.

Gender
In healthy female and male subjects following single and multiple-doses of tadalafil, no clinically relevant differences in exposure were observed. No dose adjustment is warranted.

5.3 Preclinical safety data

Non-clinical data reveal no special hazard for humans based on conventional studies of safety pharmacology, repeated dose toxicity, genotoxicity, carcinogenic potential, and toxicity to reproduction.

There was no evidence of teratogenicity, embryotoxicity, or foetotoxicity in rats or mice that received up to 1000 mg/kg/day tadalafil. In a rat prenatal and postnatal development study, the no observed effect dose was 30 mg/kg/day. In the pregnant rat the AUC for calculated free active substance at this dose was approximately 18-times the human AUC at a 20 mg dose.

There was no impairment of fertility in male and female rats. In dogs given tadalafil daily for 6 to 12 months at doses of 25 mg/kg/day (resulting in at least a 3-fold greater exposure [range 3.7-18.6] than seen in humans given a single 20 mg dose) and above, there was regression of the seminiferous tubular epithelium that resulted in a decrease in spermatogenesis in some dogs. See also section 5.1.

6 PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Tablet core:
Lactose monohydrate
Sodium laurilsulfate
Povidone K-12
Crospovidone (Type B)
Sodium stearyl fumarate

Film-coating:
Polyvinyl alcohol
Macrogol 3350
Titanium dioxide (E171)
Talc
Iron oxide yellow (E172)

6.2 Incompatibilities

Not applicable.

6.3 Shelf life

2 years.

6.4 Special precautions for storage

This medicinal product does not require any special storage conditions.

6.5 Nature and contents of container

Alu-Alu (Al-OPA/Al/PVC) blisters
PVC/ACLAR/PVC - Al blisters
PVC/ACLAR/PVdC/PVC - Al blisters

Pack sizes:

14, 24, 28, 84 film-coated 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

Rowex Ltd
Newtown
Bantry
Co. Cork
Ireland

8 MARKETING AUTHORISATION NUMBER

PA0711/261/002

9 DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUTHORISATION

Date of first authorisation: 20th January 2016

10 DATE OF REVISION OF THE TEXT

August 2020