Summary of Product Characteristics

1 NAME OF THE MEDICINAL PRODUCT

Calcichew-D3 Forte Double Strength 1000 mg / 800 IU Chewable Tablets

2 QUALITATIVE AND QUANTITATIVE COMPOSITION

One tablet contains:
Calcium carbonate equivalent to 1000 mg calcium.
Cholecalciferol concentrate (powder form) equivalent to 800 IU (20 microgram) cholecalciferol (vitamin D_3)

Excipients with known effect:
One tablet contains 88.6 mg isomalt (E953) and 1.5 mg sucrose.

For the full list of excipients, see section 6.1.

3 PHARMACEUTICAL FORM

Chewable tablet

Round, white, uncoated and convex tablets of 18 mm. May have small specks.

4 CLINICAL PARTICULARS

4.1 Therapeutic Indications

Prevention and treatment of vitamin D and calcium deficiency in adults with an identified risk.

Vitamin D and calcium supplement as an adjunct to specific osteoporosis treatment of patients who are at risk of vitamin D and calcium deficiency.

4.2 Posology and method of administration

Posology
Adults including elderly

One tablet, once daily.

Special Patient Populations
Paediatric population:
Calcichew-D3 Forte Double Strength 1000mg/800 IU are not intended for use in children and adolescents.

Impaired renal function:
Calcichew-D3 Forte Double Strength 1000mg/800 IU Chewable Tablets should not be used in patients with severe renal impairment (see section 4.3).

Impaired hepatic function:
No dose adjustment is required.

Method of Administration
Oral. The tablet should be chewed or sucked.

4.3 Contraindications

- Hypersensitivity to the active substances or to any of the excipients listed in section 6.1
- Severe renal impairment (glomerular filtration rate < 30 ml/min/1.73m^2)
- Diseases and/or conditions resulting in hypercalcaemia and/or hypercalcuria

- Renal calculi (nephrolithiasis)
- Hypervitaminosis D

4.4 Special warnings and precautions for use

During long-term treatment, serum calcium levels should be monitored. Renal function should also be monitored through measurements of serum creatinine. Monitoring is especially important in elderly patients on concomitant treatment with cardiac glycosides or diuretics (see section 4.5) and in patients with a high tendency to calculus formation. In case of hypercalcaemia or signs of impaired renal function the dose should be reduced or the treatment discontinued.

Calcium carbonate with cholecalciferol tablets should be used with caution in patients with hypercalcaemia or signs of impaired of renal function and the effect on calcium and phosphate levels should be monitored. The risk of soft tissue calcification should be taken into account.

During concomitant treatment with other sources of vitamin D and/or medications or nutrients (such as milk) containing calcium, there is a risk of hypercalcaemia and milk-alkali syndrome with subsequent kidney function impairment. In these patients serum calcium levels and renal function should be monitored.

Calcichew-D3 Forte Double Strength should be prescribed with caution to patients suffering from sarcoidosis, due to the risk of increased metabolism of vitamin D into its active form. These patients should be monitored with regard to the calcium content in serum and urine.

Calcichew-D3 Forte Double Strength should be used cautiously in immobilised patients with osteoporosis due to increased risk of hypercalcaemia.

Calcichew-D3 Forte Double Strength contains sucrose, which may be harmful to the teeth. The tablet also contains isomalt (E953). Patients with rare hereditary problems of fructose intolerance, glucose- galactose malabsorption or sucrase-isomaltase insufficiency should not take this medicine.

Calcichew-D3 Forte Double Strength contains less than 23 mg sodium per tablet, that is to say essentially 'sodium-free'.

4.5 Interaction with other medicinal products and other forms of interactions

Thiazide diuretics reduce the urinary excretion of calcium, therefore, due to increased risk of hypercalcaemia, serum calcium should be regularly monitored during concomitant use of thiazide diuretics.

Calcium carbonate may interfere with the absorption of concomitantly administered tetracycline preparations. For this reason, tetracycline preparations should be administered at least two hours before or four to six hours after oral intake of calcium carbonate.

Hypercalcaemia may increase the toxicity of cardiac glycosides during treatment with calcium and vitamin D. Patients should be monitored with regard to electrocardiogram (ECG) and serum calcium levels.

If a bisphosphonate is used concomitantly, this preparation should be administered at least one hour before the intake of Calcichew-D3 Forte Double Strength since gastrointestinal absorption may be reduced.

The efficacy of levothyroxine can be reduced by the concurrent use of calcium, due to decreased levothyroxine absorption. Administration of calcium and levothyroxine should be separated by at least four hours.

The absorption of quinolone antibiotics may be impaired if administered concomitantly with calcium. Quinolone antibiotics should be taken two hours before or six hours after intake of calcium.

Calcium salts may decrease the absorption of iron, zinc and strontium ranelate. Consequently, iron, zinc or strontium ranelate preparations should not be taken within two hours of the calcium preparation.

Treatment with orlistat may potentially impair the absorption of fat-soluble vitamins (e.g. vitamin D_3).

4.6 Fertility, pregnancy and lactation

Pregnancy
Calcichew-D3 Forte Double Strength 1000mg/800IU can be used during pregnancy, in case of a calcium and vitamin D deficiency. During pregnancy the daily intake should not exceed 2500 mg calcium and 4000 IU vitamin D. Studies in animals have shown reproductive toxicity of high doses of vitamin D (see section 5.3). In pregnant women, overdoses of calcium and vitamin D should be avoided as permanent hypercalcaemia has been related to adverse effects on the developing foetus. There are no indications that vitamin D at therapeutic doses is teratogenic in humans.

Breast-feeding
Calcichew-D3 Forte Double Strength 1000mg/800IU can be used during breast-feeding. Calcium and vitamin D_3 pass into breast milk. This should be considered when giving additional vitamin D to the child.

4.7 Effects on ability to drive and use machines

Calcichew-D3 Forte Double Strength 1000mg/800IU has no known influence on ability to drive and use machines.

4.8 Undesirable effects

Adverse reactions are listed below, by system organ class and frequency. Frequencies are defined as: uncommon (≥1/1,000 to <1/100), rare (≥1/10,000 to <1/1,000), or very rare (<1/10,000), or not known (cannot be estimated from the available data).

Immune system disorders
Not known: Hypersensitivity reactions such as angio-oedema or laryngeal oedema.

Metabolism and nutrition disorders
Uncommon: Hypercalcaemia and hypercalciuria.
Very rare: Milk-alkali syndrome (frequent urge to urinate; continuing headache; continuing loss of appetite; nausea or vomiting; unusual tiredness or weakness; hypercalcaemia, alkalosis and renal impairment). Seen usually only in overdose (see section 4.9).

Gastrointestinal disorders
Rare: Constipation, dyspepsia, flatulence, nausea, abdominal pain, and diarrhoea.

Skin and subcutaneous tissue disorders
Very rare: Pruritus, rash and urticaria.

Other special population
Patients with renal impairment: potential risk of hyperphosphatemia, nephrolithiasis and nephrocalcinosis. See section 4.4.

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 the national reporting system:
HPRA Pharmacovigilance
Website: www.hpra.ie

4.9 Overdose

Symptoms
Overdose can lead to hypercalcaemia and hypervitaminosis D. Symptoms of hypercalcaemia may include anorexia, thirst, nausea, vomiting, constipation, abdominal pain, muscle weakness, fatigue, mental disturbances, polidipsia, polyuria, bone pain, nephrocalcinosis, renal calculi and in severe cases, cardiac arrhythmias. Extreme hypercalcaemia may result in coma and death. Persistently high calcium levels may lead to irreversible renal damage and soft tissue calcification.

Milk-alkali syndrome may occur in patients who ingest large amounts of calcium and absorbable alkali.

Treatmentof hypercalcaemia

Treatment is essentially symptomatic and supportive. The treatment with calcium and vitamin D must be discontinued. Treatment with thiazide diuretics, and cardiac glycosides must also be discontinued (see section 4.5). Emptying of the stomach in patients with impaired consciousness. Rehydration, and, according to severity, isolated or combined treatment with loop diuretics, bisphosphonates, calcitonin and corticosteroids. Serum electrolytes, renal function and diuresis must be monitored. In severe cases, ECG and CVP should be followed.

5 PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: Mineral supplements. Calcium, combinations with vitamin D and/or other drugs
ATC code: A12AX

Vitamin D_3 increases the intestinal absorption of calcium.

Administration of calcium and vitamin D_3 counteracts the increase of parathyroid hormone (PTH) which is caused by calcium deficiency and which causes increased bone resorption.

A clinical study of institutionalised patients suffering from vitamin D deficiency indicated that a daily intake of 1000 mg calcium and 800 IU vitamin D for six months normalised the value of the 25-hydroxylated metabolite of vitamin D_3 and reduced secondary hyperparathyroidism and alkaline phosphatases.

An 18 month double-blind, placebo controlled study including 3270 institutionalised women aged 84+/- 6 years who received supplementation of vitamin D (800 IU/day) and calcium phosphate (corresponding to 1200 mg/day of elemental calcium), showed a significant decrease of PTH secretion. After 18 months, an "intent-to treat" analysis showed 80 hip fractures in the calcium-vitamin D group and 110 hip fractures in the placebo group (p=0,004). A follow-up study after 36 months showed 137 women with at least one hip fracture in the calcium-vitamin D group (n=1176) and 178 in the placebo group (n=1127) (p<0,02).

5.2 Pharmacokinetic properties

Calcium
Absorption: Generally, the amount of calcium absorbed through the gastrointestinal tract is approximately 30% of the swallowed dose.

Distribution and biotransformation: 99% of the calcium in the body is concentrated in the hard structure of bones and teeth. The remaining 1% is present in the intra- and extracellular fluids. About 50% of the total blood-calcium content is in the physiologically active ionised form with approximately 10% being complexed to citrate, phosphate or other anions, the remaining 40% being bound to proteins, principally albumin.

Elimination: Calcium is eliminated through faeces, urine and sweat. Renal excretion depends on glomerular filtration and calcium tubular reabsorption.

Cholecalciferol
Absorption: Vitamin D_3 is easily absorbed in the small intestine.

Distribution and biotransformation:: Colecalciferol and its metabolites circulate in the blood bound to a specific globulin. Colecalciferol is converted in the liver by hydroxylation to 25-hydroxycolecalciferol. It is then further converted in the kidneys to the active form 1,25 dihydroxycolecalciferol. 1,25 dihydroxycolecalciferol is the metabolite responsible for increasing calcium absorption. Vitamin D which is not metabolised is stored in adipose and muscle tissues.

Elimination: Vitamin D_3 is excreted in faeces and urine.

5.3 Preclinical safety data

At doses far higher than the human therapeutic range teratogenicity has been observed in animal studies. There is further no information of relevance to the safety assessment in addition to what is stated in other parts of the SPC.

6 PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Xylitol (E967)
Povidone
Isomalt (E953)
Flavouring (lemon)
Magnesium stearate

Sucralose (E955)
Mono- and diglycerides of fatty acids
All-rac-alpha-tocopherol
Sucrose
Modified maize starch
Triglycerides, medium chain
Sodium ascorbate
Silica, colloidal anhydrous

6.2 Incompatibilities

Not applicable.

6.3 Shelf life

HDPE bottle: 30 months

Blister: 2 years

6.4 Special precautions for storage

HDPE bottle: Do not store above 30°C. Store in the original container in order to protect from light. Keep the container tightly closed in order to protect from moisture.

Blister: Do not store above 25°C. Store in the original package in order to protect from moisture. Keep blister in the outer carton in order to protect from light.

6.5 Nature and contents of container

The chewable tablets are packed in:
HDPE bottles with HDPE screw caps

Pack sizes: 15, 30, 40, 60 and 90 tablets.

PVC/PE/PVdC/Aluminium blisters
Pack sizes: 7, 14, 28, 50x1 (unit dose), 56, 84, 112, 140 and 168 tablets

Not all pack sizes may be marketed.

6.6 Special precautions for disposal

No special requirements for disposal

7 MARKETING AUTHORISATION HOLDER

CHEPLAPHARM Arzneimittel GmbH
Ziegelhof 24
17489

Greifswald
Germany

8 MARKETING AUTHORISATION NUMBER

PA2239/013/003

9 DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUTHORISATION

Date of first authorisation: 11th December 2009
Date of last renewal: 4th June 2013

10 DATE OF REVISION OF THE TEXT

July 2021