SUMMARY OF PRODUCT CHARACTERISTICS

Naproxen Sodium

1. NAME OF THE MEDICINAL PRODUCT

Synflex 550mg film-coated tablet.

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

Each film coated tablet contains 550 mg Naproxen sodium (USP)

Excipient with known effect:
sodium 2,17 mmol (50 mg) per tablet.

For the full list of excipients, see section 6.1.

3. PHARMACEUTICAL FORM

Film-coated tablet.

Blue colored oblong shaped, film coated tablet engraved 550 on one side and plain on other side

4. CLINICAL PARTICULARS

4.1 Therapeutic indications

Synflex is a non-steroidal anti-inflammatory drug indicated for:
the relief of the signs and symptoms of:

- rheumatoid arthritis
- osteoarthritis
- ankylosing spondylitis
- Migraine headache

Synflex is also indicated for:
the relief of signs and symptoms of:

- tendonitis
- bursitis
- acute gout
- Symptomatic treatment of primary and secondary menorrhagia associated with insertion of IUD.

For the management of:

- pain
- primary dysmenorrhea

4.2 Posology and method of administration

Posology:
General Dosing Instructions Carefully consider the potential benefits and risks of Synflex and other treatment options before deciding to use Synflex. Use the lowest effective dose for the shortest duration

consistent with individual patient treatment goals. After observing the response to initial therapy with Synflex, the dose and frequency should be adjusted to suit an individual patient's needs
Naproxen-containing products should not be used concomitantly since they all circulate in the plasma as the naproxen anion.

Rheumatoid Arthritis, Osteoarthritis and Ankylosing Spondylitis
The recommended dose of Synflex is 275 mg (one half tablet) twice daily. Alternatively, a single dose of 550 mg (naproxen 500 mg with 50 mg sodium) is given.
During long-term administration, the dose of naproxen may be adjusted up or down depending on the clinical response of the patient. A lower daily dose may suffice for long-term administration. The morning and evening doses do not have to be equal in size and administration of the drug more frequently than twice daily does not generally make a difference in response. In patients who tolerate lower doses well, the dose may be increased to naproxen 1500 mg/day for limited periods of up to 6 months when a higher level of anti-inflammatory/analgesic activity is required. When treating such patients with naproxen 1500 mg/day, the physician should observe sufficient increased clinical benefits to offset the potential increased risk.

Management of Pain, Primary Dysmenorrhea, and Acute Tendonitis and Bursitis
The recommended starting dose of Synflex (naproxen sodium) tablets is 550 mg followed by 550 mg every 12 hours or 275 mg (one half of a 550 mg tablet) every 6 to 8 hours as required. The initial total daily dose should not exceed 1375 mg (two and one-half tablets) of naproxen sodium. Thereafter, the total daily dose should not exceed 1100 mg of naproxen sodium. Because the sodium salt of naproxen is more rapidly absorbed, Synflex is recommended for the management of acute painful conditions when prompt onset of pain relief is desired

Acute Gout

Synflex may also be used at a starting dose of 825 mg (one- and one-half tablets) followed by 275 mg (one-half tablet) every 8 hours.

Dysmenorrhea

The recommended initial dose is 550 mg of naproxen sodium taken as a single dose, followed by 275 mg of naproxen sodium every 6-8 hours if necessary.

Migraine headaches

The recommended initial dose is 825 mg of naproxen sodium taken as a single dose at the first symptoms, followed by 275 mg of naproxen sodium after half an hour.

Menorrhagia

The recommended first day daily dose is 825-1375 mg of naproxen sodium, divided into two doses, followed by a daily dose of 550-1100 mg of naproxen sodium for a maximum period of four days.

Special populations

Elderly

The dose should be reduced in elderly patients and the lowest effective dose should be used for the shortest possible duration.

Patients with renal and/or hepatic insufficiency

In patients with mild or moderate renal or hepatic failure the dose should be reduced, and the lowest effective dose should be used for the shortest possible duration. This medicinal product is not recommended in patients with a baseline creatinine clearance lower than 30 ml/min, since an accumulation of naproxen metabolites has been observed in patients with severe kidney failure and patients in dialysis.

Pediatric population

Synflex tablets are not recommended for use in children and adolescents under 16 years of age.

Method of administration This medicinal product is administered orally. The tablets should be swollen whole with some liquid and preferably during or after meals.

4.3 Contraindications

Naproxen sodium are contraindicated in the following patients:

• Known hypersensitivity (e.g., anaphylactic reactions and serious skin reactions) to naproxen or any components of the drug product

• History of asthma, urticaria, or other allergic-type reactions after taking aspirin or other NSAIDs. Severe, sometimes fatal, anaphylactic reactions to NSAIDs have been reported in such patients

• In the setting of coronary artery bypass graft (CABG) surgery

4.4 Special warnings and precautions for use

Cardiovascular Thrombotic Events

Known clinical trials of several COX-2 selective and nonselective NSAIDs of up to three years duration have shown an increased risk of serious cardiovascular (CV) thrombotic events, including myocardial infarction (MI) and stroke, which can be fatal. Based on available data, it is unclear that the risk for CV thrombotic events is similar for all NSAIDs. The relative increase in serious CV thrombotic events over baseline conferred by NSAID use appears to be similar in those with and without known CV disease or risk factors for CV disease. However, patients with known CV disease or risk factors had a higher absolute incidence of excess serious CV thrombotic events, due to their increased baseline rate. The increase in CV thrombotic risk has been observed most consistently at higher doses.

To minimize the potential risk for an adverse CV event in NSAID-treated patients, use the lowest effective dose for the shortest duration possible. Physicians and patients should remain alert for the development of such events, throughout the entire treatment course, even in the absence of previous CV symptoms. Patients should be informed about the symptoms of serious CV events and the steps to take if they occur.

There is no consistent evidence that concurrent use of aspirin mitigates the increased risk of serious CV thrombotic events associated with NSAID use. The concurrent use of aspirin and an NSAID, such as naproxen, increases the risk of serious gastrointestinal (GI) events.

Status Post Coronary Artery Bypass Graft (CABG) Surgery

NSAIDs are contraindicated in the setting of CABG.

Post-MI Patients

Avoid the use of naproxen sodium in patients with a recent MI unless the benefits are expected to outweigh the risk of recurrent CV thrombotic events. If naproxen is used in patients with a recent MI, monitor patients for signs of cardiac ischemia.

Gastrointestinal Bleeding, Ulceration, and Perforation

NSAIDs, including naproxen, cause serious gastrointestinal (GI) adverse events including inflammation, bleeding, ulceration, and perforation of the esophagus, stomach, small intestine, or large intestine, which can be fatal.

Risk Factors for GI Bleeding, Ulceration, and Perforation

Patients with a prior history of peptic ulcer disease and/or GI bleeding who used NSAIDs had a greater than 10-fold increased risk for developing a GI bleed compared to patients without these risk factors. Other factors that increase the risk of GI bleeding in patients treated with NSAIDs include longer duration of NSAID therapy; concomitant use of oral corticosteroids, aspirin, anticoagulants, or selective serotonin reuptake inhibitors (SSRIs); smoking; use of alcohol; older age; and poor general health status

- Use the lowest effective dosage for the shortest possible duration.
- Avoid administration of more than one NSAID at a time.
- Avoid use in patients at higher risk unless benefits are expected to outweigh the increased risk of bleeding. For such patients, as well as those with active GI bleeding, consider alternate therapies other than NSAIDs.
- Remain alert for signs and symptoms of GI ulceration and bleeding during NSAID therapy.
- If a serious GI adverse event is suspected, promptly initiate evaluation and treatment, and discontinue naproxen until a serious GI adverse event is ruled out. In the setting of concomitant use of low-dose aspirin for cardiac prophylaxis, monitor patients more closely for evidence of GI bleeding.

Hepatotoxicity

Elevations of ALT or AST (less than three times ULN) may occur in up to 15% of patients treated with NSAIDs including naproxen. Inform patients of the warning signs and symptoms of hepatotoxicity (e.g., nausea, fatigue, lethargy, diarrhea, pruritus, jaundice, right upper quadrant tenderness, and "flu-like" symptoms). If clinical signs and symptoms consistent with liver disease develop, or if systemic manifestations occur (e.g., eosinophilia, rash, etc.), discontinue naproxen immediately, and perform a clinical evaluation of the patient.

Hypertension

NSAIDs, including naproxen, can lead to new onset of hypertension or worsening of pre-existing hypertension, either of which may contribute to the increased incidence of CV events. Patients taking angiotensin converting enzyme (ACE) inhibitors, thiazide diuretics, or loop diuretics may have impaired response to these therapies when taking NSAID.

Heart Failure and Edema

Fluid retention and edema have been observed in some patients treated with NSAIDs. Use of naproxen may blunt the CV effects of several therapeutic agents used to treat these medical conditions.

Renal Toxicity and Hyperkalemia

Renal toxicity has also been seen in patients in whom renal prostaglandins have a compensatory role in the maintenance of renal perfusion. In these patients, administration of an NSAID may cause a dose-dependent reduction in prostaglandin formation and, secondarily, in renal blood flow, which may precipitate overt renal decompensation. Patients at greatest risk of this reaction are those with impaired renal function, dehydration, hypovolemia, heart failure, liver dysfunction, those taking diuretics and ACE inhibitors or ARBs, and the elderly. Discontinuation of NSAID therapy is usually followed by recovery to the pretreatment state. No information is available from controlled clinical studies regarding the use of naproxen sodium in patients with advanced renal disease. The renal effects of naproxen may hasten the progression of renal dysfunction in patients with preexisting renal disease.

Correct volume status in dehydrated or hypovolemic patients prior to initiating naproxen. Monitor renal function in patients with renal or hepatic impairment, heart failure, dehydration, or hypovolemia during use of naproxen sodium.

<u>Hyperkalemia</u>

Increases in serum potassium concentration, including hyperkalemia, have been reported with use of NSAIDs, even in some patients without renal impairment. In patients with normal renal function, these effects have been attributed to a hyporeninemic hypoaldosteronism state.

Anaphylactic reaction

Naproxen has been associated with anaphylactic reactions in patients with and without known hypersensitivity to naproxen and in patients with aspirin-sensitive asthma

Exacerbation of Asthma Related to Aspirin Sensitivity

A subpopulation of patients with asthma may have aspirin-sensitive asthma which may include chronic rhinosinusitis complicated by nasal polyps; severe, potentially fatal bronchospasm; and/or intolerance to aspirin and other NSAIDs.

Serious Skin Reactions

NSAIDs, including naproxen, can cause serious skin adverse reactions such as exfoliative dermatitis, Stevens-Johnson Syndrome (SJS), and toxic epidermal necrolysis (TEN), which can be fatal.

Fetal Toxicity:

Avoid use of NSAIDs, including naproxen sodium, in pregnant women at about 30 weeks of gestation and later. NSAIDs, including naproxen sodium, increase the risk of premature closure of the fetal ductus arteriosus at approximately this gestational age.

Use of NSAIDs, including naproxen sodium, at about 20 weeks gestation or later in pregnancy may cause fetal renal dysfunction leading to oligohydramnios and, in some cases, neonatal renal impairment

Hematologic Toxicity

Anemia has occurred in NSAID-treated patients. Co-morbid conditions such as coagulation disorders or concomitant use of warfarin and other anticoagulants, antiplatelet agents (e.g., aspirin), serotonin reuptake inhibitors (SSRIs), and serotonin norepinephrine reuptake inhibitors (SNRIs) may increase this risk. Monitor these patients for signs of bleeding.

Long-Term Use and Laboratory Monitoring

Because serious GI bleeding, hepatotoxicity, and renal injury can occur without warning symptoms or signs, consider monitoring patients on long-term NSAID treatment with a CBC and a chemistry profile periodically

Patients with initial hemoglobin values of 10g or less who are to receive long-term therapy should have hemoglobin values determined periodically. Because of adverse eye findings in animal studies with drugs of this class, it is recommended that ophthalmic studies be carried out if any change or disturbance in vision occurs.

4.5 Interaction with other medicinal products and other forms of interaction

Drugs That Interfere with Hemostasis

Naproxen and anticoagulants such as warfarin have a synergistic effect on bleeding. The concomitant use of naproxen and anticoagulants have an increased risk of serious bleeding compared to the use of either drug alone.

Aspirin

Concomitant use of Naproxen sodium and analgesic doses of aspirin is not generally recommended because of the increased risk of bleeding.

ACE Inhibitors, Angiotensin Receptor Blockers, and Beta-Blockers

NSAIDs may diminish the antihypertensive effect of angiotensin converting enzyme (ACE) inhibitors, angiotensin receptor blockers (ARBs), or beta-blockers (including propranolol). In patients who are elderly, volume-depleted (including those on diuretic therapy), or have renal impairment, co-administration of an NSAID with ACE inhibitors or ARBs may result in deterioration of renal function, including possible acute renal failure. These effects are usually reversible.

Diuretics

NSAIDs reduced the natriuretic effect of loop diuretics (e.g., furosemide) and thiazide diuretics in some patients.

Digoxin

The concomitant use of naproxen with digoxin has been reported to increase the serum concentration and prolong the half-life of digoxin.

Lithium

NSAIDs have produced elevations in plasma lithium levels and reductions in renal lithium clearance.

Methotrexate

Concomitant use of NSAIDs and methotrexate may increase the risk for methotrexate toxicity (e.g., neutropenia, thrombocytopenia, renal dysfunction).

Cyclosporine

Concomitant use of naproxen sodium and cyclosporine may increase cyclosporine's nephrotoxicity.

NSAIDs and Salicylates

Concomitant use of naproxen with other NSAIDs or salicylates (e.g., diflunisal, salsalate) increases the risk of GI toxicity, with little or no increase in efficacy.

Pemetrexed

Concomitant use of naproxen sodium and pemetrexed may increase the risk of pemetrexed-associated myelosuppression, renal, and GI toxicity (see the pemetrexed prescribing information).

Antacids and Sucralfate

Concomitant administration of some antacids (magnesium oxide or aluminum hydroxide) and sucralfate can delay the absorption of naproxen.

Cholestyramine

Concomitant administration of cholestyramine can delay the absorption of naproxen.

Probenecid

Probenecid given concurrently increases naproxen anion plasma levels and extends its plasma half-life significantly

Other albumin-bound drugs

Naproxen is highly bound to plasma albumin; it thus has a theoretical potential for interaction with other albumin-bound drugs such as coumarin-type anticoagulants, sulphonylureas, hydantoins, other NSAIDs, and aspirin.

4.6 Fertility, pregnancy, and lactation

Fertility

Based on the mechanism of action, the use of prostaglandin mediated NSAIDs, including Naproxen sodium, may delay or prevent rupture of ovarian follicles, which has been associated with reversible infertility in some women. Consider withdrawal of NSAIDs, including Naproxen sodium, in women who have difficulties conceiving or who are undergoing investigation of infertility.

Pregnancy

Risk Summary

Use of NSAIDs, including naproxen sodium, can cause premature closure of the fetal ductus arteriosus and fetal renal dysfunction leading to oligohydramnios and, in some cases, neonatal renal impairment. Because of these risks, limit dose and duration of naproxen sodium, use between about 20 and 30 weeks of gestation, and avoid naproxen sodium use at about 30 weeks of gestation and later in pregnancy.

Premature Closure of Fetal Ductus Arteriosus

Use of NSAIDs, including naproxen sodium, at about 30 weeks gestation or later in pregnancy increases the risk of premature closure of the fetal ductus arteriosus.

Oligohydramnios/Neonatal Renal Impairment

Use of NSAIDs at about 20 weeks gestation or later in pregnancy has been associated with cases of fetal renal dysfunction leading to oligohydramnios, and in some cases, neonatal renal impairment.

Lactation
The naproxen anion has been found in the milk of lactating women at a concentration equivalent to approximately 1% of maximum naproxen concentration in plasma. The developmental and health benefits of breastfeeding should be considered along with the mother's clinical need for Naproxen sodium and any potential adverse effects on the breastfed infant from the naproxen sodium or from the underlying maternal condition.

4.7 Effects on ability to drive and use machines

Some patients experience somnolence, dizziness, vertigo, insomnia, or depression during treatment with this medicinal product.

Patients who experience these or other similar effects must be cautious when engaging in activities that require a great deal of attentiveness. It must be used with caution in patients whose occupation requires attentiveness and who have noticed vertigo or visual abnormalities during treatment with this drug.

4.8 Undesirable effects

Most frequently reported adverse reaction (1% to 10%)
Gastrointestinal (GI): heartburn, abdominal pain, nausea, constipation, diarrhea, dyspepsia, stomatitis
Central Nervous System: headache*, dizziness*, drowsiness*, lightheadedness, vertigo
Dermatologic: pruritus (itching)*, skin eruptions*, ecchymoses*, sweating, purpura
Special Senses: tinnitus*, visual disturbances, hearing disturbances Cardiovascular: edema*, palpitations
General: dyspnea*, thirst
*Incidence of reported reaction between 3% and 9%. Those reactions occurring in less than 3% of the patients are unmarked.
In patients taking NSAIDs, the following adverse experiences have also been reported in approximately 1% to 10% of patients.
Gastrointestinal (GI), including flatulence, gross bleeding/perforation, GI ulcers (gastric/duodenal), vomiting General: abnormal renal function, anemia, elevated liver enzymes, increased bleeding time, rashes
Adverse reaction in <1%.
Gastrointestinal: pancreatitis, vomiting Hepatobiliary: jaundice Hemic and Lymphatic: melena, thrombocytopenia, agranulocytosis Nervous System: inability to concentrate Dermatologic: skin rashes

In known post marketing reports reported adverse reaction are:
Body as a Whole: anaphylactoid reactions, angioneurotic edema, menstrual disorders, pyrexia (chills and fever)
Cardiovascular: congestive heart failure, vasculitis, hypertension, pulmonary edema
Gastrointestinal: inflammation, bleeding (sometimes fatal, particularly in the elderly), ulceration, perforation, and obstruction of the upper or lower gastrointestinal tract. Esophagitis, stomatitis,

hematemesis, colitis, exacerbation of inflammatory bowel disease (ulcerative colitis, Crohn's disease).
Hepatobiliary: abnormal liver function tests, hepatitis (some cases have been fatal) Hemic and Lymphatic: eosinophilia, leucopenia, granulocytopenia, hemolytic anemia, aplastic anemia
Metabolic and Nutritional: hyperglycemia, hypoglycemia
Nervous System: depression, dream abnormalities, insomnia, malaise, myalgia, muscle weakness, aseptic meningitis, cognitive dysfunction, convulsions
Respiratory: eosinophilic pneumonitis, asthma
Dermatologic: alopecia, urticaria, toxic epidermal necrolysis, erythema multiforme, erythema nodosum, fixed drug eruption, lichen planus, pustular reaction, systemic lupus erythematoses, bullous reactions, including Stevens-Johnson syndrome, photosensitive dermatitis, photosensitivity reactions, including rare cases resembling porphyria cutanea tarda (pseudoporphyria) or epidermolysis bullosa. If skin fragility, blistering or other symptoms suggestive of pseudoporphyria occur, treatment should be discontinued, and the patient monitored.
Special Senses: hearing impairment, corneal opacity, papillitis, retrobulbar optic neuritis, papilledema
Urogenital: glomerular nephritis, hematuria, hyperkalemia, interstitial nephritis, nephrotic syndrome, renal disease, renal failure, renal papillary necrosis, raised serum creatinine
Reproduction (female): infertility

Reporting of suspected adverse reactions
Reporting suspected adverse reactions after authorization 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 email productsafety@martindow.com.

4.9 Overdose
Symptoms following acute NSAID overdosages have been typically limited to lethargy, drowsiness, nausea, vomiting, and epigastric pain, which have been generally reversible with supportive care. Gastrointestinal bleeding has occurred. Hypertension, acute renal failure, respiratory depression, and coma have occurred, but were rare Because naproxen sodium may be rapidly absorbed, high and early blood levels should be anticipated. A few patients have experienced convulsions, but it is not clear whether or not these were drug related. It is not known what dose of the drug would be life threatening Manage patients with symptomatic and supportive care following an NSAID overdosage. There are no specific antidotes. Consider emesis and/or activated charcoal (60 to 100 grams in adults, 1 to 2 grams per kg of body weight in pediatric patients) and/or osmotic cathartic in symptomatic patients seen within four hours of ingestion or in patients with a large overdosage (5 to 10 times the recommended dosage). Forced diuresis, alkalinization of urine, hemodialysis, or hemoperfusion may not be useful due to high protein binding.

5. PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: anti-inflammatory and antirheumatic products, non-steroids, propionic acid derivates

Mechanism of Action

Naproxen has analgesic, anti-inflammatory, and antipyretic properties. Naproxen sodium has been developed as a more rapidly absorbed formulation of naproxen for use as an analgesic. The mechanism of action of naproxen, like that of other NSAIDs, is not completely understood but involves inhibition of cyclooxygenase (COX-1 and COX-2). Naproxen is a potent inhibitor of prostaglandin synthesis. Prostaglandins are mediators of inflammation. Because naproxen is an inhibitor of prostaglandin synthesis, its mode of action may be due to a decrease of prostaglandins in peripheral tissues.

5.2 Pharmacokinetics

Absorption

Naproxen sodium are rapidly and completely absorbed from the gastrointestinal tract with an in vivo bioavailability of 95%. After oral administration of Naproxen sodium, peak plasma levels are attained in 1 to 2 hours

Distribution

Naproxen has a volume of distribution of 0.16 L/kg. At therapeutic levels naproxen is greater than 99% albumin bound. At doses of naproxen greater than 500 mg/day there may be less than proportional increase in plasma levels due to an increase in clearance caused by saturation of plasma protein binding at higher doses. The naproxen anion may be found in the milk of lactating women at a concentration equivalent to approximately 1% of maximum naproxen concentration in plasma.

Metabolism

Naproxen is extensively metabolized in the liver to 6-0-desmethyl naproxen, and both parent and metabolites do not induce metabolizing enzymes. Both naproxen and 6-0-desmethyl naproxen are further metabolized to their respective acylglucuronide conjugated metabolites.

Excretion

The clearance of naproxen is 0.13 mL/min/kg. Approximately 95% of the naproxen from any dose is excreted in the urine, primarily as naproxen (<1%), 6-0-desmethyl naproxen (<1%) or their conjugates (66% to 92%). The plasma half- life of the naproxen anion is from 12 to 17 hours. The corresponding half-lives of both naproxen's metabolites and conjugates are shorter than 12 hours, and their rates of excretion may be found to coincide closely with the rate of naproxen disappearance from the plasma. Small amounts, 3% or less of the administered dose, are excreted in the feces. In patients with renal failure metabolites may accumulate.

Special Population

Pediatric:

The terminal half-life appears to be similar as adult patients. Pharmacokinetic studies of naproxen were not performed in pediatric patients younger than 5 years of age. Pharmacokinetic parameters appear to be similar following administration of naproxen tablets in pediatric patients.

Geriatrics

Although total plasma concentration of naproxen is unchanged, the unbound plasma fraction of naproxen is increased in the elderly, although the unbound fraction is <1 % of the total naproxen concentration, Unbound trough naproxen concentrations in elderly subjects have been reported to range from 0.12% to 0.19% of total naproxen concentration, compared with 0.05% to 0.075% in younger subjects.

Hepatic Impairment:

Naproxen pharmacokinetics has not been determined in subjects with hepatic insufficiency. Chronic alcoholic liver disease and probably other diseases with decreased or abnormal plasma proteins (albumin) reduce the total plasma concentration of naproxen, but the plasma concentration of unbound naproxen is increased.

Renal Impairment:
Naproxen pharmacokinetics has not been determined in subjects with renal insufficiency. Elimination of naproxen is decreased in patients with severe renal impairment.

5.3 Preclinical safety data

In animals, the administration of a prostaglandin synthesis inhibitor has shown an increase in pre- and post-implantation losses and embryo-foetal mortality. Furthermore, an increase in the incidence of various malformations, including cardiovascular malformations, has been reported in animals that received a prostaglandin synthesis inhibitor during the organogenesis period.

6. PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Synflex 550mg Tablets:

Tablet core:

Microcrystalline Cellulose PH-102, Povidone K-30, Talc, Magnesium Stearate

Coating material
Opadry II Blue 85 F205034

6.2 Incompatibilities

Not applicable.

6.3 Shelf life

2 years

6.4 Special precautions for storage

Do not store above 30°C.

Keep the blister in the outer carton in order to protect from light.

6.5 Nature and contents of container

Synflex 550mg Tablet

Synflex tablets packed in PVC/PVDC blister.

- **Contents of the pack**
  Synflex is supplied in following dosage forms, strengths, and pack sizes:
  Tablets 550mg 20's and 30's

6.6 Special precautions for disposal

No special requirements.

7. MARKETING AUTHORISATION HOLDER

MARTIN DOW LIMITED
Plot No. 37, Sector 19,
Korangi industrial area,
Karachi-74900, Pakistan

8. MARKETING AUTHORISATION NUMBER(S)

010197

9. DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUTHORISATION

06-12-1989

Renewal: 13-03-2020