

1.17 Summary Product Characteristics (SPC)

1. Product Name:

VITAPYN TABLETS (Paracetamol BP 450 mg, Codeine Phosphate BP 10 mg, Doxylamine Succinate BP 5 mg and Caffeine Anhydrous BP 50 mg)

2. Qualitative / Quantitative composition of the substance (s) active (s) (in table form)

Each Un-Coated tablet contains:

Paracetamol BP.....450 mg

Codeine Phosphate BP.....10 mg

Doxylamine Succinate BP.....5 mg Caffeine

Anhydrous BP.....50 mg

Excipientsq.s.

3. Pharmaceutical form

Uncoated Tablet

A round yellow coloured tablets, scored on one side and plain on other.

4. Clinical particulars

4.1 Therapeutic indications

For the short term treatment of acute moderate pain which is not relieved by paracetamol, ibuprofen or aspirin alone such as headache, tension headache, migraine, neuralgia, toothache, dysmenorrhoea, muscular and rheumatic aches and pains and post-operative analgesia following surgical or dental procedures.

Codeine is indicated in patients older than 12 years of age for the treatment of acute moderate pain which is not considered to be relieved by other analgesics such as paracetamol or ibuprofen (alone).

4.2 Posology and method of administration Posology

The duration of treatment should be limited to 3 days and if no effective pain relief is achieved the patients/carers should be advised to seek the views of a physician. Do not take continuously for more than 3 days without consulting your doctor.

Adults

One or two tablets every four to six hours as needed for relief. Total dosage over a 24 hour period should not normally exceed eight tablets.

Elderly and debilitated

Codeine should be used with caution in the elderly and debilitated patients as they may be more susceptible to the respiratory depressant effects.

Paediatric population

Children aged less than 12 years:

Codeine should not be used in children below the age of 12 years because of the risk of opioid toxicity due to the variable and unpredictable metabolism of codeine to morphine.

Children aged 16 years to 18 years

One to two tablets every 6 hours when necessary up to a maximum of 8 tablets in 24 hours.

Children aged 12 years to 15 years

One tablet every six hours when necessary to a maximum of 4 tablets in 24 hours

Method of administration Oral

use.

4.3 Contraindications

Hypersensitivity to paracetamol, codeine or other opioid analgesics, doxylamine succinate, caffeine, or any of the other constituents.

Due to interaction with the doxylamine succinate component, the concomitant use of VITAPYN with monoamine inhibitors (MAOIs) or within 14 days of stopping treatment with these medicines is contraindicated, as there is a risk of serotonin syndrome.

Conditions where morphine and opioids are contraindicated e.g:

- Acute asthma (during an attack)
- Acute respiratory depression and in chronic obstructive pulmonary disease
- Acute alcoholism
- Head injuries
- Raised intra-cranial pressure
- Following biliary tract surgery
- Risk of paralytic ileus
- Breast-feeding

In all paediatric patients (0-18 years of age) who undergo tonsillectomy and/or adenoidectomy for obstructive sleep apnoea syndrome due to an increased risk of developing serious and life-threatening adverse reactions.

In patients for whom it is known that they are CYP2D6 ultra-rapid metabolisers.

4.4 Special warnings and precautions for use

Paediatric population

Not recommended for children under 12 years of age.

CYP2D6 metabolism

Codeine is metabolised by the liver enzyme CYP2D6 into morphine, its active metabolite. If a patient has a deficiency or is completely lacking this enzyme an adequate analgesic effect will not be obtained. Estimates indicate that up to 7% of the Caucasian population may have this deficiency. However, if the patient is an extensive or ultra-rapid metaboliser there is an increased risk of developing side effects of opioid toxicity even at commonly prescribed doses. These patients convert codeine into morphine rapidly resulting in higher than expected serum morphine levels.

General symptoms of opioid toxicity include confusion, somnolence, shallow breathing, small pupils, nausea, vomiting, constipation and lack of appetite. In severe cases this may include symptoms of circulatory and respiratory depression, which may be life-threatening and very rarely fatal. Estimates of prevalence of ultra-rapid metabolisers in different populations are summarized below:

Population	Prevalence %
African/Ethiopian	29%
African American	3.4% to 6.5%
Asian	1.2% to 2%
Caucasian	3.6% to 6.5%
Greek	6.0%
Hungarian	1.9%
Northern European	1%-2%

Post-operative use in children

There have been reports in the published literature that codeine given post-operatively in children after tonsillectomy and/or adenoidectomy for obstructive sleep apnoea, led to rare, but life-threatening adverse events including death. All children received doses of codeine that were within the appropriate dose range; however there was evidence that these children were either ultra-rapid or extensive metabolisers in their ability to metabolise codeine to morphine.

Children with compromised respiratory function

Codeine is not recommended for use in children in whom respiratory function might be compromised including neuromuscular disorders, severe cardiac or respiratory conditions, upper respiratory or lung infections, multiple trauma or extensive surgical procedures. These factors may worsen symptoms of morphine toxicity.

Do not exceed the stated dose.

Do not take concurrently with any other paracetamol or codeine containing compounds.

This product may cause drowsiness.

Keep out of the reach and sight of children.

Care is advised in the administration of this preparation to patients with impaired kidney or liver function and in those with hypertension, hypothyroidism, adrenocortical insufficiency, prostatic hypertrophy, urinary retention, susceptibility to angle-closure glaucoma, shock, obstructive bowel disorders, acute abdominal conditions (e.g. peptic ulcer), recent gastrointestinal surgery, gallstones, myasthenia gravis, a history of cardiac arrhythmias or convulsions, and in patients with a history of drug abuse or emotional instability.

Codeine may induce faecal impaction, producing incontinence, spurious diarrhoea, abdominal pain and rarely colonic obstruction. Elderly patients may metabolise or eliminate opioid analgesics more slowly than younger adults.

Administration of pethidine and possibly other opioid analgesics to patients taking a monoamine oxidase inhibitor (MAOI) has been associated with very severe and sometimes fatal reactions. See also Section 4.3 regarding contraindication of taking VITAPYN with MAOIs because of the doxylamine component.

Risks from concomitant use of opioids and benzodiazepines

Concomitant use of opioids, including codeine, and sedative medicines such as benzodiazepines or related drugs may result in sedation, respiratory depression, coma, and death. Because of these risks, concomitant prescribing of sedative medicines, such as benzodiazepines or related drugs, with opioids should be reserved for patients for whom alternative treatment options are not possible.

If a decision is made to prescribe codeine concomitantly with sedative medicines such as benzodiazepines, the lowest effective dose should be used, and the duration of treatment should be as short as possible (see also general dose recommendation in section 4.2). The patients should be followed closely for signs and symptoms of respiratory depression and sedation. In this respect, it is strongly recommended to inform patients and their environment to be aware of these symptoms.

Risks from concomitant use of opioids and alcohol

Concomitant use of opioids, including codeine, with alcohol may result in sedation, respiratory depression, coma and death. Concomitant use with alcohol is not recommended (see section 4.5).

The hazards of overdose are greater in those with non-cirrhotic alcoholic liver diseases.

Co-administration of enzyme-inducing antiepileptic medications may increase toxicity; doses should be reduced.

E110 (sunset yellow) and E104 (quinoline yellow) may cause allergic reactions.

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

This medicine contains less than 1 mmol sodium (23 mg) per tablet, that is to say essentially 'sodium-free'.

The label will state:

Front of Pack:

- Can cause addiction • For three days use only Back of Pack:
- For the short term treatment of acute moderate pain where other painkillers have not worked. Do not take less than four hours after taking other pain killers. This medicine is used for tension headaches, migraines, muscular pains and tension.
- Do not take more medicine than the label tells you to. If you do not get better, talk to your doctor.
- Do not take anything else containing paracetamol whilst taking this medicine.
- Talk to your doctor at once if you take too much of this medicine, even if you feel well.
- If you need to take this medicine continuously for more than three days you should see your doctor or pharmacist.
- This medicine contains codeine which can cause addiction if you take it continuously for more than three days. If you take this medicine for headaches for more than three days it can make them worse.

The leaflet will state:

Important things you should know about VITAPYN

- This medicine can only be used for the short term treatment of acute moderate pain where other painkillers have not worked.
- You should only take this product for a maximum of three days at a time. If you need to take it for longer than three days you should see your doctor or pharmacist for advice.
- This medicine contains codeine which can cause addiction if you take it continuously for more than three days. This can give you withdrawal symptoms from the medicine when you stop taking it.

- If you take this medicine for headaches for more than three days it can make them worse.

Section 1: What VITAPYN is and what it is used for

- VITAPYN is used for the short term treatment of acute moderate pain which is not relieved by paracetamol, ibuprofen and aspirin alone such as headache, including muscle contraction or tension headache, migraine, neuralgia, period pain, toothache and other dental pain, muscular and rheumatic aches and pains and for pain relief following surgery or dental procedures.

Section 2: What you need to know before you take VITAPYN

- This medicine contains codeine which can cause addiction if you take it continuously for more than three days. This can give you withdrawal symptoms from the medicine when you stop taking it.
- If you take this medicine for headaches for more than three days it can make them worse. • Do not take VITAPYN if you know that you metabolise very rapidly codeine into morphine. (In the “Pregnancy and breast-feeding” subsection)

If you are pregnant or breast feeding, think you may be pregnant or are planning to have a baby, ask your doctor or pharmacist for advice before taking this medicine.

Do not take VITAPYN whilst breastfeeding. Codeine and morphine passes into the breast milk.

Section 3: How to take VITAPYN

- Do not take for more than 3 days. If you need to use this medicine for more than three days you must speak to your doctor or pharmacist.
- This medicine contains codeine and can cause addiction if you take it continuously for more than three days. When you stop taking it you may get withdrawal symptoms. You should talk to your doctor or pharmacist if you think you are suffering from withdrawal symptoms.

Section 4: Possible Side effects

- Reporting of side effects

If you get any side effects, talk to your doctor, pharmacist or nurse. This includes any possible side effects not listed in this leaflet. You can also report side effects directly via the Yellow Card Scheme at: www.mhra.gov.uk/yellowcard or search for MHRA Yellow Card in the Google Play or Apple App Store.

By reporting side effects you can help provide more information on the safety of this medicine.

- How do I know if I am addicted?

If you take the medicine according to the instructions on the pack it is unlikely that you will become addicted to the medicine. However, if the following apply to you it is important that you talk to your doctor:

- You need to take the medicine for longer periods of time.
- You need to take more than the recommended dose.

When you stop taking the medicine you feel very unwell but you feel better if you start taking the medicine again.

4.5 Interaction with other medicinal products and other forms of interaction

The speed of absorption of paracetamol may be increased by metoclopramide or domperidone and absorption reduced by cholestyramine.

The anticoagulant effect of warfarin and other coumarins may be enhanced by prolonged regular daily use of paracetamol with increased risk of bleeding; occasional doses have no significant effect.

VITAPYN may enhance the sedative effects of CNS depressants such as alcohol, barbiturates, anaesthetics, hypnotics, other opioid analgesics, anxiolytic sedatives, antipsychotics, tricyclic antidepressants and phenothiazines, resulting in increased CNS depression. It may also have an additive antimuscarinic action with other drugs, such as atropine and some antidepressants.

Benzodiazepines

The concomitant use of opioids with sedative medicines such as benzodiazepines or related drugs increases the risk of sedation, respiratory depression, coma and death because of additive CNS depressant effect. The dosage and duration of concomitant use should be limited (see section 4.4).

Alcohol and opioids

The concomitant use of alcohol and opioids increases the risk of sedation, respiratory depression, coma, and death because of additive CNS depressant effect. Concomitant use with alcohol is not recommended (see section 4.4).

The hypotensive actions of diuretics and anti-hypertensive agents may be potentiated when used concurrently with opioid analgesics. Concurrent use of hydroxyzine with codeine may result in increased analgesia as well as increased CNS depressant and hypotensive effects.

The respiratory depressant effect caused by neuromuscular blocking agents may be additive to the central respiratory depressant effects of opioid analgesics. Quinidine can inhibit the analgesic effect of codeine.

Concurrent use of codeine with antidiarrhoeal and antiperistaltic agents such as loperamide and kaolin may increase the risk of severe constipation. Concomitant use of antimuscarinics or medications with antimuscarinic action may result in an increased risk of severe constipation which may lead to paralytic ileus and/or urinary retention.

Codeine may delay the absorption of mexiletine and thus reduce the antiarrhythmic effect of the latter. Codeine may antagonise the gastrointestinal effects of metoclopramide, cisapride and

domperidone. Cimetidine inhibits the metabolism of opioid analgesics resulting in increased plasma concentrations.

Naxolone antagonises the analgesic, CNS and respiratory depressant effects of opioid analgesics. Naltrexone also blocks the therapeutic effect of opioids.

Doxylamine: Monamine oxidase inhibitors (MAOIs) or within 14 days of stopping treatment with these products as there is a risk of serotonin syndrome (see section 4.3).

Concomitant administration of pethidine and possibly other opioid analgesics to patients taking MAOIs has been associated with very severe and sometimes fatal reactions such as severe CNS excitation or depression, including hypertension or hypotension. Although this has not been documented with codeine, it is possible that a similar interaction may occur and

therefore the use of codeine should be avoided while the patient is taking MAOIs and for 2 weeks after MAOI discontinuation.

Incompatibilities: Codeine has been reported to be incompatible with phenobarbitone sodium forming a codeine-phenobarbitone complex, and with potassium-iodide, forming crystals of codeine periodide. Acetylation of codeine phosphate by aspirin has occurred in solid dosage forms containing the two drugs, even at low moisture levels.

Interference with laboratory tests: Opioid analgesics interfere with a number of laboratory tests including plasma amylase, lipase, bilirubin, alkaline phosphatase, lactate dehydrogenase, alanine aminotransferase and aspartate aminotransferase. Opioids may also interfere with gastric emptying studies as they delay gastric emptying and with hepatobiliary imaging using technetium Tc 99m disofenin as opioid treatment may cause constriction of the sphincter of Oddi and increase biliary tract pressure.

The metabolism of paracetamol is possibly accelerated by carbamazepine, phenytoin, phenobarbital, primidone (also there have been isolated reports of hepatotoxicity)”

4.6 Fertility, pregnancy and lactation Pregnancy

Epidemiological studies in human pregnancy have shown no ill effects due to paracetamol used in the recommended dosage, but patients should follow the advice of their doctor regarding its use.

A large amount of data on pregnant women indicate neither malformative, nor fetoneonatal toxicity. Epidemiological studies on neurodevelopment in children exposed to paracetamol in utero show inconclusive results. If clinically needed, paracetamol can be used during pregnancy however it should be used at the lowest effective dose for the shortest possible time and at the lowest possible frequency.

Codeine crosses the placenta. There is no adequate evidence of safety in human pregnancy and a possible association with respiratory and cardiac malformations has been reported. Regular use during pregnancy may cause physical dependence in the foetus leading to withdrawal symptoms in the neonate. Use during pregnancy should be avoided if possible.

Use of opioid analgesia during labour may cause respiratory depression in the neonate, especially the premature neonate. These agents should not be given during the delivery of a premature baby.

Breastfeeding

Paracetamol is excreted in breast milk but not in a clinically significant amount.

Codeine should not be used during breastfeeding (see section 4.3).

At normal therapeutic doses codeine and its active metabolites may be present in breast milk at very low doses and is unlikely to adversely affect the breast fed infant. However, if the patient is an ultra-rapid metaboliser of CYP2D6, higher levels of the active metabolites may be present in breast milk and on very rare occasions may result in symptoms of opioid toxicity in the infant, which may be fatal.

4.7 Effects on ability to drive and use machines

Some side effects related to doxylamine succinate include drowsiness (usually diminishes within a few days), paradoxical stimulation, headaches, psychomotor impairment, hypotension, dizziness, confusion, tremor and convulsions.

Opioid analgesics can impair mental function and cause blurred vision and dizziness. Rare side effects may include convulsions, hallucinations, blurred or double vision, dizziness and orthostatic hypotension

These side effects may have a noticeable impact on the ability to driving and operate machinery. Patients should ensure they are not affected before driving or operating machinery.

See section 4.8 for more information on side effects.

This medicine can impair cognitive function and can affect a patient's ability to drive safely. This class of medicine is in the list of drugs included in regulations under 5a of the Road Traffic Act 1988. When prescribing this medicine, patients should be told:

- The medicine is likely to affect your ability to drive
- Do not drive until you know how the medicine affects you
- It is an offence to drive while under the influence of this medicine
- However, you would not be committing an offence (called 'statutory defence') if:
 - The medicine has been prescribed to treat a medical or dental problem and
 - You have taken it according to the instructions given by the prescriber and in the information provided with the medicine and
 - It was not affecting your ability to drive safely

4.8 Undesirable effects

Adverse effects of doxylamine succinate:

Common side effects:

CNS effects: Drowsiness (usually diminishes within a few days), paradoxical stimulation, headaches, psychomotor impairment.

Antimuscarinic effects: Urinary retention, dry mouth, blurred vision, gastrointestinal disturbances, thickened respiratory tract secretions Rare side effects:

Hypotension, extrapyramidal effects, dizziness, confusion, depression, sleep disturbances, tremor, convulsions, palpitation, arrhythmia hypersensitivity reactions, blood disorders and liver dysfunction.

Adverse effects of paracetamol:

Blood and lymphatic system disorders

Very rare: thrombocytopenia

Not known: agranulocytosis

Immune system disorders

Hypersensitivity including skin rash may occur.

Not known: Anaphylactic shock, angioedema.

Skin and subcutaneous tissue disorders

Very rare cases of serious skin reactions have been reported.

Adverse effects of Codeine:

The most frequent undesirable effects of codeine are constipation and drowsiness. Less frequent effects are nausea, vomiting, sweating, facial flushing, dry mouth, blurred or double vision, dizziness, orthostatic hypotension, malaise, tiredness, headache, anorexia, vertigo, bradycardia, palpitations, respiratory depression, dyspnoea, allergic reactions (itch, skin rash, facial oedema) and difficulties in micturition (dysuria, increased frequency, decrease in amount). Side effects, which occur rarely, include convulsions, hallucinations, nightmares, uncontrolled muscle movements, muscle rigidity, mental depression and stomach cramps. Very rare cases of pancreatitis have been reported.

Regular prolonged use of codeine is known to lead to addiction and symptoms of restlessness and irritability may result when treatment is stopped. Prolonged use of a painkiller for headaches can make them worse.

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 Yellow Card Scheme at: www.mhra.gov.uk/yellowcard or search for MHRA Yellow Card in the Google Play or Apple App Store.

4.9 Overdose Paracetamol

Liver damage is possible in adults who have taken 10g or more of paracetamol. Ingestion of 5g or more of paracetamol may lead to liver damage if the patient has risk factors (see below).

Risk Factors: If

the patient

a, Is on long term treatment with carbamazepine, phenobarbitone, phenytoin, primidone, rifampicin, St John's Wort or other drugs that induce liver enzymes.

Or b, Regularly consumes ethanol in excess of recommended amounts. Or

c, Is likely to be glutathione deplete e.g. eating disorders, cystic fibrosis, HIV infection, starvation, cachexia.

Symptoms

Symptoms of paracetamol overdose in the first 24 hours are pallor, nausea, vomiting, anorexia and abdominal pain. Liver damage may become apparent 12 to 48 hours after ingestion. Increased levels of hepatic transaminases, lactate dehydrogenase and bilirubin may occur and the INR may increase. Abnormalities of glucose metabolism and metabolic acidosis may occur. In severe poisoning, hepatic failure may progress to encephalopathy, haemorrhage, hypoglycaemia, cerebral oedema, gastrointestinal bleeding and death. Acute renal failure with acute tubular necrosis, strongly suggested by loin pain, haematuria and proteinuria, may develop even in the absence of severe liver damage. Cardiac arrhythmias and pancreatitis have been reported.

Management

Immediate treatment is essential in the management of paracetamol overdose. Despite a lack of significant early symptoms, patients should be referred to hospital urgently for immediate medical attention. Symptoms may be limited to nausea or vomiting and may not reflect the severity of overdose or the risk of organ damage. Management should be in accordance with established treatment guidelines, see BNF overdose section.

Treatment with activated charcoal should be considered if the overdose has been taken within 1 hour. Plasma paracetamol concentration should be measured at 4 hours or later after ingestion (earlier concentrations are unreliable). Treatment with N- acetylcysteine may be used up to 24 hours after ingestion of paracetamol, however, the maximum protective effect is obtained up to 8 hours post-ingestion. The effectiveness of the antidote declines sharply after this time. If

required the patient should be given intravenous N-acetylcysteine, in line with the established dosage schedule. If vomiting is not a problem, oral methionine may be a suitable alternative for remote areas, outside hospital. Management of patients who present with serious hepatic dysfunction beyond 24h from ingestion should be discussed with the NPIS or a liver unit.

Codeine

The effects in overdose will be potentiated by simultaneous ingestion of alcohol and psychotropic drugs.

Symptoms

Central nervous system depression, including respiratory depression, may develop but is unlikely to be severe unless other sedative agents have been co-ingested, including alcohol, or the overdose is very large. The pupils may be pin-point in size; nausea and vomiting are common. Hypotension and tachycardia are possible but unlikely.

Management

This should include general symptomatic and supportive measures including a clear airway and monitoring of vital signs until stable. Consider activated charcoal if an adult presents within one hour of ingestion of more than 350mg or a child more than 5mg/kg.

Give naloxone if coma or respiratory depression is present. Naloxone is a competitive antagonist and has a short half-life so large and repeated doses may be required in a seriously poisoned patient. Observe for at least four hours after ingestion, or eight hours if a sustained release preparation has been taken. **5. Pharmacological properties**

5.1 Pharmacodynamic properties

Paracetamol - analgesic, antipyretic

Codeine Phosphate - analgesic

Doxylamine Succinate - antihistamine

Caffeine - mild stimulant

Pharmacotherapeutic group: Anilides, Paracetamol combinations

ATC Code: NO2B E51

Paracetamol is an analgesic which acts peripherally, probably by blocking impulse generation at the bradykinin sensitive chemo-receptors which evoke pain. Although it is a prostaglandin synthetase inhibitor, the synthetase system in the CNS rather than the periphery appears to be more sensitive to it. This may explain paracetamol's lack of appreciable anti-inflammatory activity. Paracetamol also exhibits antipyretic activity.

Codeine is a centrally acting weak analgesic. Codeine exerts its effect through μ opioid receptors, although codeine has low affinity for these receptors, and its analgesic effect is due to

its conversion to morphine. Codeine, particularly in combination with other analgesics such as paracetamol, has been shown to be effective in acute nociceptive pain.

5.2 Pharmacokinetic properties

The pharmacokinetics of paracetamol, codeine phosphate and caffeine are widely published (see Goodman and Gilman's Pharmacological Basis of Therapeutics, Seventh Edition pgs. 693, 505 and 596 respectively). Doxylamine succinate is readily absorbed from the gastrointestinal tract. Following oral administration the effects start within 15 to 30 minutes and peak within one hour. In humans 60 - 80% of doxylamine given has been recovered in urine at 24 hours post-dose.

The bioavailabilities of paracetamol and codeine phosphate when given as the combination are similar to those when they are given separately.

Codeine is mainly metabolized by glucuronidation to codeine-6-glucuronide. Minor routes of metabolism include O- demethylation leading to morphine, N-demethylation to norcodeine and both O- and N-demethylation to normorphine. Morphine and norcodeine are further

transformed to glucuronide conjugates. Unchanged codeine and its metabolites are mainly excreted by urinary route within 48h (84.4±15.9%).

The O-demethylation of codeine to morphine is catalyzed by the cytochrome P450 isozyme 2D6 (CYP2D6) which shows genetic polymorphism that may affect the efficacy and toxicity of codeine.

Genetic polymorphism in CYP2D6 leads to ultra-rapid, extensive and poor metaboliser phenotypes.

5.3 Preclinical safety data None stated

Conventional studies using the currently accepted standards for the evaluation of toxicity to reproduction and development are not available.

6.1 Pharmaceutical Parameters:

6.2 List of excipients

- Starch for dry mixing
- Starch for paste
- Sodium Benzoate
- Gelatin BP
- Sodium Methyl Paraben
- Sodium Propyl Paraben
- Magnesium Stearate BP

- Talc BP
- Tartrazine colour

6.3 Incompatibilities None Known.

6.4 Shelf life:

24 Months

6.5 Special precautions for storage Store below 30°C in a cool & dry place.

6.6 Nature and contents of container

9 tablets are packed in one blister; such 2 blisters packed in one carton with insert coded with batch number, manufacturing date and expiry date packed in an inner carton.

6.7 Special precautions for disposal and other handling

Any unused product or waste material should be disposed of in accordance with local requirements. **7.0 Marketing Authorisation Holder:**

Eastleigh Pharmaceuticals Co. Ltd

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