SUMMARY OF PRODUCT CHARACTERISTICS

1 NAME OF THE MEDICINAL PRODUCT

Chlordiazepoxide 5 mg Capsules

2 QUALITATIVE AND QUANTITATIVE COMPOSITION

Each capsule contains 5 mg of the active ingredient Chlordiazepoxide Hydrochloride.
Each capsule also contains 127.0 mg lactose.

Excipient(s) with known effects
For the full list of excipients, see section 6.1

3 PHARMACEUTICAL FORM

Capsule, hard

Size 4 capsule with yellow body and black cap, printed MP1 in white.

4 CLINICAL PARTICULARS

4.1 Therapeutic indications

For short-term (2-4 weeks only) use:

- symptomatic relief of anxiety, that is severe, disabling or subjecting the individual to unacceptable distress, occurring alone or in association with insomnia or short-term psychosomatic, organic or psychotic illness.
- Muscle spasm of varied aetiology
- Symptomatic relief of acute alcohol withdrawal

Not for use:

- Long term (i.e. longer than 4 weeks)

- For mild anxiety
- In children

4.2 Posology and method of administration

Prior to starting treatment with Chlordiazepoxide, a discussion should be held with patients to put in place a strategy for ending treatment with Chlordiazepoxide in order to minimise the risk of dependence, addiction and drug withdrawal syndrome (see section 4.4).

Treatment should be given for the shortest possible duration.

Posology

Anxiety
Adults:
The usual dose should be 10 mg, 2 – 3 times daily and up to 30 mg daily in divided doses

For severe symptoms 20 mg, 2 – 4 times a day and maximum dose up to 100 mg daily in divided doses, adjusted on an individual basis.

Generally, duration of treatment should not be more than 4 weeks, including a tapering- off process.

Insomnia associated with anxiety

Adults:
10-30 mg before retiring. Generally, duration of treatment varies from a few days to two weeks, with a maximum including a tapering-off process of four weeks.

Symptomatic relief of acute alcohol withdrawal

Adults:
25-100 mg dose, repeated if necessary in 2 - 4 hours.

Muscle spasm of varied aetiology

Adults:
10-30 mg daily in divided doses.

Paediatric patients

Chlordiazepoxide is not for paediatric use

Special populations

Elderly and/or debilitated patients/patients with organic brain damage, respiratory impairment

Dosage should not exceed half the adult dose.

Hepatic or renal function;

- Dosage should not exceed half the adult dose and steps should be taken to ensure that there is no accumulation of plasma chlordiazepoxide
- Contraindicated in severe hepatic insufficiency (see section 4.3)

The lowest dose which can control symptoms should be used. The dosage and duration of treatment should be determined on an individual basis dependent by the patients response and severity of the disorder. Given that chlordiazepoxide is a long-acting benzodiazepine, the patient should be monitored regularly at the start of the treatment to decrease, if necessary, the dose or frequency of administration to prevent overdose due to accumulation

Patients who have taken benzodiazepines for a prolonged time may require a longer period of dosage reduction and specialist help may be appropriate.
Treatment to be given

- under close medical supervision and the need for continued treatment should be evaluated, especially in case the patient is symptom free
- at the lowest effective dose
- for the shortest possible duration (not exceeding 4 weeks)

In certain cases extension beyond the maximum treatment period may be necessary; if so, it should not take place without re-evaluation of the patient's status with special expertise.

Little is known regarding the efficacy or safety of benzodiazepines in long-term use. Long-term chronic use is not recommended (see section 4.4)

Treatment should always be tapered off gradually. Patients who have taken benzodiazepines for a prolonged time may require a longer period during which doses are reduced. Specialist help may be appropriate.

Method of administration:

Chlordiazepoxide capsules are for oral administration and must be taken with water and not be chewed

4.3 Contraindications

- Hypersensitivity to the benzodiazepines or to any of the excipients listed in section 6.1
- Myasthenia gravis
- severe pulmonary insufficiency
- respiratory depression
- sleep apnoea syndrome (risk of further respiratory depression)
- Severe hepatic insufficiency (may precipitate encephalopathy)
- Phobic or Obsessional states
- Chronic psychosis

- Spinal or cerebral ataxia

4.4 Special warnings and precautions for use

Tolerance

Some loss of efficacy to the hypnotic effects of chlordiazepoxide may develop after repeated use for a few weeks.

Drug dependence, tolerance and potential for abuse :

The dependent potential of the benzodiazepines is low, particularly when limited to short-term use. Risk for physical and psychological dependence increases when high doses are used, especially when given over long periods. This is particularly so in patients with a history of alcoholism or drug abuse or in patients with marked personality disorders. Regular monitoring in such patients is essential. Routine repeat prescriptions should be avoided and treatment should be withdrawn gradually.

Drug addiction comprises behavioural, cognitive and physiological phenomena that may include a strong desire to take the drug, difficulties in controlling drug use and possible tolerance or physical dependence. Physical dependence is a state that develops as a result of physiological adaptation in response to repeated drug use, which manifests as withdrawal signs and symptoms after abrupt discontinuation or a significant dose reduction of a drug. Addiction and dependence are related but distinct presentations and in discussing these themes, terminology that apportion blame to the individual should be avoided.

For all patients, prolonged use of this product may lead to drug dependence and addiction but can occur with short-term use at recommended therapeutic doses. The risks are increased in individuals with current or past history of substance misuse disorder (including alcohol misuse) or mental health disorder (e.g., major depression).

Additional support and monitoring may be necessary when prescribing for patients at risk of drug misuse.

A comprehensive patient history should be taken to document concomitant medications, including over-the-counter medicines and medicines obtained on-line, and past and present medical and psychiatric conditions.

Patients may find that treatment is less effective with chronic use and express a need to increase the dose to obtain the same level of symptom control as initially experienced. Patients may also supplement their treatment with additional medications to achieve the same effect. These could be signs that the patient is developing tolerance. The risks of developing tolerance should be explained to the patient.

Overuse or misuse may result in overdose and/or death. It is important that patients only use medicines that are prescribed for them at the dose they have been prescribed and do not give this medicine to anyone else.

Patients should be closely monitored for signs of misuse, abuse, or addiction.

The clinical need for treatment with Chlordiazepoxide should be reviewed regularly, with frequent assessments of patients being undertaken during the course of their treatment.

Drug withdrawal syndrome

Prior to starting treatment with Chlordiazepoxide, a discussion should be held with patients to explain the risk of dependence, addiction, and drug withdrawal syndrome. A withdrawal strategy for ending treatment with Chlordiazepoxide should also be put in place with the patient before starting treatment (there may be exceptions to this in specific clinical situations such as symptom management in end of life palliative care).

Drug withdrawal syndrome may occur upon abrupt cessation of therapy or dose reduction. When a patient no longer requires therapy, it is advisable to taper the dose gradually to minimise symptoms of withdrawal. Tapering from a high dose may take in excess of weeks or months. Patients should be informed of this when the medication is first prescribed.

The reduction schedule for a patient should be tailored to the individual and should be modified to allow intolerable withdrawal symptoms to improve before making the next reduction. If using a published withdrawal schedule, apply it flexibly to accommodate the person's preferences, changes to their circumstances and the response to dose reductions.

Suggest a slow stepwise rate of reduction proportionate to the existing dose, so that decrements become smaller as the dose is lowered, unless clinical risk is such that rapid withdrawal is needed.

If a patient develops withdrawal reactions, consider pausing the taper or increasing the dosage to the previous tapered dosage level.

If women take this drug during pregnancy, there is a risk that their newborn infants will experience neonatal withdrawal syndrome.

Symptoms such as headaches, muscle pain, extreme anxiety, restlessness, confusion, depression, nervousness, rebound insomnia, irritability, sweating and diarrhoea have been reported following abrupt cessation of treatment in patients receiving even normal therapeutic doses for short periods of time. In severe cases the following symptoms may occur: derealisation (a feeling of unreality or of being separated from the body), depersonalisation, hyperacusis, numbness and tingling of the extremities, hypersensitivity to light, noise and physical contact, hallucinations, psychotic manifestations or epileptic seizures.

Abuse of benzodiazepines has been reported

Rebound insomnia and anxiety

This is a transient syndrome whereby the symptoms that led to treatment with a benzodiazepine recur in an enhanced form, may occur on withdrawal of treatment. It may be accompanied by other reactions including mood changes, anxiety or sleep disturbances and restlessness. Since the risk of withdrawal phenomena/rebound phenomena is greater after abrupt discontinuation of treatment, it is recommended that the dosage is decreased gradually. (see section

4.2).

Duration of treatment

The duration of treatment should be as short as possible (see Section 4.1) depending on the indication, but should not exceed 4 weeks including tapering off process. Extension beyond these periods should not take place without re-evaluation of the situation. Routine repeat prescriptions should be avoided.

It may be useful to inform the patient when treatment is started that it will be of limited duration and to explain precisely how the dosage will be progressively decreased.

Moreover, it is important that the patient should be made aware of the possibility of rebound phenomena, thereby minimising anxiety over such symptoms should they occur while the product is being discontinued.

There are indications that, in the case of benzodiazepines with a short duration of action, withdrawal phenomena can become manifest within the dosage interval, especially when the dosage is high.

When benzodiazepines with a long duration of action are being used it is important not to change to a benzodiazepine with a short duration of action, as withdrawal symptoms may develop.

Amnesia

Amnesia may accur. Chlordiazepoxide may induce anterograde amnesia. The condition occurs most often several hours after ingesting the product and therefore to reduce the risk, patients should ensure that they will be able to have an uninterrupted sleep of 7-8 hours (see Section 4.8).

Psychiatric and 'paradoxical' reactions

Extreme caution should be used in prescribing benzodiazepines to patients with marked personality disorders.

Rare behavioural effects including restlessness, agitation, irritability, aggressiveness, delusion, rages, nightmares, hallucinations, psychoses, inappropriate behaviour and other adverse behavioural effects are known to occur when using benzodiazepines. Should these effects occur, use of the medicinal product should be discontinued. They are more likely to occur in children and the elderly.

Bereavement/loss

In cases of bereavement, psychological adjustment may be inhibited by benzodiazepines.

Specific patient groups

The elderly should be given a reduced dose (see section 4.2).

A lower dose is also recommended for patients with chronic respiratory insufficiency due to the risk of respiratory depression.

Benzodiazepines are contraindicated to treat patients with severe hepatic insufficiency as they may precipitate encephalopathy and reduced doses should be given to patients with renal or hepatic disease.

Patients with phobias and/or chronic psychoses: Benzodiazepines are not recommended for the primary treatment of psychotic illness, phobia or obsessive-compulsive diseases
Patients with depression: Benzodiazepines should not be used alone to treat depression or anxiety associated with depression since it may uncover depression with suicidal tendencies. *Patients with a history of alcohol and drug abuse*: Benzodiazepines should be used with extreme caution in patients with a history of alcohol or drug abuse

Extreme caution should be used in prescribing benzodiazepines to patients with personality disorders.

Due to myorelaxant effect there is a risk of falls and consequently fractures in the elderly.

Intolerance to sugars

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

4.5 Interaction with other medicinal products and other forms of interaction

Not recommended:

Alcohol: Chlordiazepoxide should not be used together with alcohol. The sedative effect may be enhanced when this product is used in combination with alcohol. This affects the ability to drive or use machines.
Sodium oxybate: avoid concomitant use (enhanced effects of sodium oxybate)

Take into account:

Centrally acting drugs: If chlordiazepoxide is combined with centrally-acting drugs such as neuroleptics, tranquilisers, antidepressants, hypnotics, analgesics, anaesthetics, and sedative antihistamines the central depressive effects are likely to be intensified. In the case of narcotic analgesics, enhancement of the euphoria may also occur leading to an increase in psychic dependence. The elderly require special supervision.

Chlordiazepoxide in combination with 4-hydroxybutanoic acid (sodium oxybate) may cause an increased respiratory depression.

Concurrent treatment with tranquilisers may increase the effects of relaxing the muscles – especially elderly patients receiving higher doses of chlordiazepoxide should be well monitored (higher risk of falling).

Anti-epileptic drugs: When chlordiazepoxide is used in conjunction with anti-epileptic drugs, side effects and toxicity may be more evident, particularly with hydantoins (e.g. phenytoin) and/or barbiturates, or combinations using them. This requires extra care in adjusting dosage in the initial stages of treatment.

Compounds which affect certain hepatic enzymes (particularly cytochrome P450):

- inhibitors (e.g. cimetidine, omeprazole, macrolide antibiotics (erythromycin) and disulfiram) reduce clearance and may enhance the activity of benzodiazepines. The same applies to the use of contraceptive agents. To a lesser degree this also applies to benzodiazepines that are metabolised only by conjugation
- know inducers (e.g. rifampicin) may increase clearance of benzodiazepines

Other drugs which enhance the sedative effects of chlordiazepoxide: cisapride, lofexidine, nabilone, disulfiram and the muscle-relaxants baclofen and tizanidine.

In patients receiving long-term treatment with other medicines (such as centrally acting antihypertensive agents, beta receptor blockers, anticoagulant agents and cardiac glycosides), nature and extent of interactions cannot safely be foreseen.

Sedative effects are possibly increased when benzodiazepines are given with moxonidine.

Dopaminergics: Benzodiazepines possibly antagonise the effects of levadopa.

Effect of benzodiazepines are possibly reduced by theophylline.

4.6 Fertility, pregnancy and lactation

Pregnancy:

Chlordiazepoxide crosses the placenta. There is a limited amount of data from the use of chlordiazepoxide in pregnant women. Studies in animals have shown reproductive toxicity (see section 5.3).

Do not use during pregnancy, especially during the first and last trimesters, unless for compelling medical reasons.

An increased risk of congenital malformations in humans has been associated with its use, particularly in the first and second trimesters. If the product is prescribed to a woman of childbearing potential, she should be warned to contact her physician regarding discontinuance of the product if she intends to become, or suspects that she is, pregnant.

If the product is administered at high doses or prolonged administration of low doses of benzodiazepines in the last trimester of pregnancy or during labour, effects on the neonate, such as irregularities in the foetal heart rate, hypothermia, hypotonia, poor suckling and moderate respiratory depression can be expected, due to the pharmacological action of the compound.

Moreover, infants born to mothers who took benzodiazepines chronically during the latter stages of pregnancy may have developed physical dependence and may be at some risk for developing withdrawal symptoms in the postnatal period.

Breast-feeding:

Since benzodiazepines are found in breast milk, benzodiazepines should be avoided if possible by breast-feeding mothers.

4.7 Effects on ability to drive and use machines

Chlordiazepoxide can impair cognitive function and may modify patients performance at skilled tasks such as the ability to drive safely. Sedation, amnesia, impaired concentration, dizziness, blurred vision and impaired muscular function may adversely affect the ability to drive or use machines, or take part in any activities where they would put themselves or others at risk. 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

If insufficient sleep duration occurs, the likelihood of impaired alertness may be increased. Concurrent medication may increase these effects (see also Interactions).

Patients should be advised that alcohol may intensify any impairment, and should therefore be avoided during treatment.

4.8 Undesirable effects

Common adverse effects include; Drowsiness and light-headedness during the day, sedation, fatigue, balance disorder, unsteadiness, ataxia, these are dose-related and may persist into the following day, even after a single dose. However, these phenomena accur predominantly at the start of therapy and usually disappear with repeated administration. The elderly are particularly sensitive to the effects of central depressant drugs and may experience confusion, especially if organic brain changes are present; the dosage of chlordiazepoxide should not exceed one-half that recommended for other adults, (see section 4.2).

Evaluation of undesirable effects is based on the following frequency information: 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); not known (frequency cannot be estimated from available data).

Blood and lymphatic system disorders:
Rare: Bone marrow depression (e.g. thrombocytopenia, leukopenia, agranulocytosis, pancytopenia)

Immune system disorders:
Very rare: Anaphylactic reaction,
angioedema Frequency not known:
Hypersensitivity

Metabolism and nutrition disorders:

Frequency not known: Increased appetite

Psychiatric disorders:
Frequency not known: Amnesia, hallucinations, Drug dependence (see section 4.4), depression, restlessness, agitation, irritability, depressed level of consciousness, aggression, delusion, nightmares, psychotic disorder, abnormal behaviour, emotional disturbances, paradoxical drug reaction (e.g. anxiety, sleep disorders, insomnia, suicide attempt, suicidal ideation)

Nervous system disorders:
Common: Sedation, dizziness, unsteadiness, somnolence, ataxia, balance disorder, confusional states

Rare: Headache, vertigo
Frequency not known: Dysarthria, gait disturbance, extrapyramidal disorder (e.g. tremor, dyskinesia)

Eye disorders:
Rare: Visual impairment including diplopia

Vascular disorders:
Rare: Hypotension

Respiratory, thoracic and mediastinal disorders:
Frequency not known: Respiratory depression

Gastrointestinal disorders:
Rare: Gastrointestinal upsets

Hepatobiliary disorders:
Frequency not known: Jaundice, blood bilirubin increased, transaminases increased, blood alkaline phosphatase increased

Skin and subcutaneous tissue disorders:
Rare: Skin reaction (e.g. rash)

Musculoskeletal and connective tissue disorders:
Due to the myorelaxant effect there is a risk of falls and consequently fractures in the elderly
Frequency not known: Muscle weakness

Renal and urinary disorders:
Rare: Urinary retention, incontinence

Reproductive system and breast disorders:
Rare: Libido disorders, erectile dysfunction, menstrual disorder

General disorders and administration site conditions:
Common: Fatigue
Frequency not known: Changes in salivation

Amnesia

Anterograde amnesia may occur using therapeutic dosages, the risk increasing at

higher dosages. Amnesic affects may be associated with inappropriate behaviour. (See warnings and precautions).

Depression

Pre-existing depression may be unmasked during benzodiazepine use.

Psychiatric and paradoxical reactions

Reactions like restlessness, agitation, irritability, aggressiveness, delusion, rages, nightmares, hallucinations, psychoses, inappropriate behaviour and other adverse behavioural effects are known to occur when using benzodiazepines or benzodiazepine- like agents. They may be quite severe with this product. They are more likely to occur in children and the elderly.

Drug dependence

Use (even therapeutic doses) may lead to the development of physical dependence: discontinuation of the therapy may result in withdrawal or rebound phenomena (see Warnings and precautions). Psychic dependence may occur. Abuse of benzodiazepines has been reported, (see sections 4.2 and 4.4).

General disorders and administration site conditions:

Drug withdrawal symptoms (see 4.4 Special warnings and precautions).

Symptoms reported following discontinuation of benzodiazepines include headaches, muscle pain, anxiety, tension, depression, insomnia, restlessness, confusion, irritability, sweating, and the occurrence of "rebound" phenomena whereby the symptoms that led to treatment with benzodiazepines recur in an enhanced form. These symptoms may be difficult to distinguish from the original symptoms for which the drug was prescribed.

In severe cases the following symptoms may occur: derealisation; depersonalisation; hyperacusis; tinnitus; numbness and tingling of the extremities; hypersensitivity to light, noise, and physical contact; involuntary movements; hyperreflexia, tremor, nausea, vomiting; diarrhoea, abdominal cramps, loss of appetite, agitation, palpitations, tachycardia, panic attacks, vertigo, short-term memory loss, hallucinations/delirium; catatonia; hyperthermia, convulsions. Convulsions may be more common in patients with pre-existing seizure disorders or who are taking other drugs that lower the convulsive threshold such as antidepressants.

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

4.9 Overdose

Patients should be informed of the signs and symptoms of overdose and to ensure that family and friends are also aware of these signs and to seek immediate medical help if they occur.

When taken alone in overdosage, Chlordiazepoxide presents few problems in management. When taken with centrally-acting drugs, especially alcohol, the effects of overdose are likely to be more severe and in the absence of supportive measures may prove fatal.

Symptoms:
Overdose of benzodiazepines is usually manifested by degrees of central nervous system depression ranging from drowsiness to coma. In mild cases, symptoms include drowsiness, mental confusion and lethargy, in more serious cases, symptoms may include ataxia, hypotonia, hypotension, respiratory depression, rarely coma and very rarely death.,

Management:
In the management of overdose with any medicinal product, it should be borne in mind that multiple agents may have been taken.

Treatment is symptomatic

Following overdose with oral benzodiazepines;

- Maintain clear airway and adequate ventilation, if indicated
- Gastric lavage – unnecessary if only benzodiazepine taken
- The value of gastric decontaminants is uncertain. Consider activated charcoal (50 g for an adult, 1g/kg for a child) in adults or children who have taken more than a potentially toxic amount within 1 hour, provided the airway can be protected.
- The value of dialysis has not been determined.
- Supportive measures as indicated by the patient's clinical condition
- Special attention should be paid to respiratory and cardiovascular functions in intensive care. Rarely, flumazenil may be useful as an antidote. It may be required in children who are naïve to benzodiazepines or patients with COPD as an alternative to ventilation. Flumazenil has a short half-life (about 1 hour) and in this situation an infusion may therefore be required. Flumazenil should not normally be used in patients with history of seizures, head injury, chronic benzodiazepine use, co-ingestion of benzodiazepine and tricyclic antidepressant or other proconvulsant.
- If excitation accurs, barbiturates should not be used.

5 PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeiutic group: Psycholeptics, anxiolytics, benzodiazepine derivatives.

ATC code: N05BA02

Chlordiazepoxide is a psychotropic substance from the class of 1,4-benzodiazepines with tension, excitement, anxiety attenuating properties and and sedative and hypnotic effects depending on the dose. It also has a muscle relaxant function in cases of muscular spasticity and is an anti-convulsant.

Chlordiazepoxide has low affinity as an agonist at specific benzodiazepine receptors located on GABA-ergic neurones. Stimulation of benzodiazepine receptors potentates the actions of GABA. GABA-ergic neurones are inhibitory in the nervous system. This results in diminution of various 5-HT, dopamine and noradrenergic neurotransmitter system effects.

5.2 Pharmacokinetic properties

Absorption:
Chlordiazepoxide is well absorbed, with peak blood levels being achieved one or two hours after administration.
Steady-state levels are usually reached within three days.

Distribution:
Chlordiazepoxide is metabolised to desmethyl-chlordiazepoxide. Demoxepam and desmethyldiazepam are also found in the plasma of patients on continuous treatment. The active metabolite desmethyl-chlordiazepoxide has an accumulation half-life of 10 – 18 hours; that of demoxepam has been recorded as 21 – 78 hours

Steady-state levels of these active metabolites are reached after 10-15 days, with metabolite concentrations which are similar to those of the parent drug.

Elimination:
The drug has a half-life is of 6 - 30 hours.

Pharmacokinetic / pharmacodynamic relationship:
No clear correlation has been demonstrated between the blood levels of chlordiazepoxide and its clinical effects.

5.3 Preclinical safety data

Mutagenic and tumourigenic potential:

In in-vivo and in-vitro studies with chlordiazepoxide, there are indications for a mutagenic effect. Nevertheless, in similar test systems results are negative.

The relevance of the positive findings is currently unclear.

In carcinogenicity studies in mice an increase of liver tumours was seen at high doses, especially in males, whereas no increase of tumour incidence was seen in rats.

Reproductive toxicity:

In animal studies increased resorption rates, increased incidence of stillbirth and neonatal death, malformation of the scull (exencephaly, cleft palate), lung anomalies and changes in the urogenital tract as well as behavioural disorders and neurochemical changes have been observed in the offspring.

6 PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Capsule contents:
Lactose monohydrate
Maize starch
Sodium starch glycollate
Magnesium stearate

Capsule shell:
Erythrosine (E127)
Quinoline yellow (E104)
Titanium dioxide (E171)
Gelatin
Black iron oxide (E172)
Opacode white (shellac glaze, titanium dioxide, lecithin (soya), antifoam DC 1510)

6.2 Incompatibilities

Not Applicable.

6.3 Shelf life

Capsule containers: 36 months
Blister packs: 24 months

6.4 Special precautions for storage

Capsule containers: Do not store above 25ºC. Keep the container tightly closed and protect from light.

Blister packs: Do not store above 25°C. Store in the original package and protect from light.

6.5 Nature and contents of container

Polypropylene or polyethylene capsule containers with polyethylene or polypropylene lids and polyurethane, polyethylene or polypropylene inserts
PVC/Aluminium blister packs

Capsule container and blister pack sizes: 28, 30, 50, 56, 60, 84, 100, 250, 500 and 1000.

Not all pack sizes may be marketed.

6.6 Special precautions for disposal

Not Applicable

7 MARKETING AUTHORISATION HOLDER

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8. MARKETING AUTHORISATION NUMBER(S)

PL 42976/0001

9 DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUTHORISATION

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10 DATE OF REVISION OF THE TEXT

23/12/2025