SUMMARY OF PRODUCT CHARACTERISTICS

1 NAME OF THE MEDICINAL PRODUCT

Co-codamol 15/500mg Film-coated Tablets

2 QUALITATIVE AND QUANTITATIVE COMPOSITION

Each film-coated tablet contains 15 mg codeine phosphate hemihydrate and 500 mg Paracetamol.

For the full list of excipients, see section 6.1

3 PHARMACEUTICAL FORM

Film-coated tablet

Co-codamol film-coated tablets are light yellow, oval, 8.5 x 17 mm, biconvex tablets, marked ’5 15’ on one side with a score line.

The score line is only to facilitate breaking for ease of swallowing and not to divide into equal doses.

4 CLINICAL PARTICULARS

4.1 Therapeutic indications

For the relief of moderate to severe pain in adults and children above 12 years.

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

Treatment goals and discontinuation

Before initiating treatment with Co-codamol, a treatment strategy including treatment duration and treatment goals, and a plan for end of the treatment, should be agreed together with the patient, in accordance with pain management guidelines. During treatment, there should be frequent contact between the physician and the patient to evaluate the need for continued treatment, consider discontinuation and to adjust dosages if needed. When a patient no longer requires therapy with codeine, it may be advisable to taper the dose gradually to prevent symptoms of withdrawal. In absence of adequate pain control, the possibility of hyperalgesia, tolerance and progression of underlying disease should be considered (see section 4.4).

The duration of treatment should be as short as possible, 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.

Adults over 18 years

One or two tablets not more frequently than every 4 to 6 hours, up to a maximum of 8 tablets in any 24 hour period.

Maximum daily dose

- The maximum daily dose of Paracetamol must not exceed 4000 mg.
- Maximum single dose is 1000 mg (2 tablets).

Elderly

As adults, however a reduced dose may be required. See section 4.4.

Renal insufficiency

In case of renal insufficiency the dose should be reduced due to available data on the paracetamol component:

Glomerulal filtration	Dose
10 – 50 ml/min	One Co-codamol 15 mg / 500 mg tablet every 6 hours
< 10 ml/min	One Co-codamol 15 mg / 500 mg tablet every 8 hours

Hepatic insufficiency

As adults, however a reduced dose may be required. See section 4.4.

Chronic alcoholism

Chronic alcohol consumption may lower the paracetamol toxicity threshold. In these patients, the dosing interval should be a minimum of 8 hours. The maximum daily dose of paracetamol should be 2 g per day.

Paediatric population

Children below 12 years of age

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 (see sections 4.3 and 4.4).

Children 12 – 15 years of age

One tablet every 6 hours, up to a maximum of 4 tablets in any 24 hour period.

Adolescents aged 16 years or above and over 50kg of body weight
One or two tablets every 6 hours, up to a maximum of 8 tablets in any 24 hour period.

Method of administration

Co-codamol film-coated tablets are for oral use.

4.3 Contraindications

Hypersensitivity to the active substances, to any of the excipients listed in section 6.1 or soya or peanut.

Conditions where morphine and opioids are contraindicated e.g:
• Acute asthma
• Respiratory depression
• Acute alcoholism
• Head injuries
• Raised intra-cranial pressure
• Following biliary tract surgery
• Breast-feeding (see Section 4.6)

Monoamine oxidase inhibitor therapy, concurrent or within 14 days.
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 (see section 4.4).

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

4.4 Special warnings and precautions for use

Tolerance and opioid use disorder (abuse and dependence)
Tolerance, physical and psychological dependence, and opioid use disorder (OUD) may develop upon repeated administration of opioids such as Co-codamol. Repeated use of Co-codamol can lead to OUD. A higher dose and longer duration of opioid treatment can increase the risk of developing OUD. Abuse or intentional misuse of Co-codamol may result in overdose and/or death. The risk of developing OUD is increased in patients with a personal or a family history (parents or siblings) of substance use disorders (including alcohol use disorder), in current tobacco users or in patients with a personal history of other mental health disorders (e.g. major depression, anxiety and personality disorders).

Before initiating treatment with Co-codamol and during the treatment, treatment goals and a discontinuation plan should be agreed with the patient (see section 4.2). Before and during treatment the patient should also be

informed about the risks and signs of OUD. If these signs occur, patients should contact their physician.

Patients will require monitoring for signs of drug-seeking behaviour (e.g. too early requests for refills). This includes the review of concomitant opioids and psycho-active drugs (like benzodiazepines). For patients with signs and symptoms of OUD, consultation with an addiction specialist should be considered.

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 pain control as initially experienced. Patients may also supplement their treatment with additional pain relievers. 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.

Drug withdrawal syndrome
Prior to starting treatment with any opioids, a discussion should be held with patients to put in place a withdrawal strategy for ending treatment with Co-codamol.

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 weeks to months.

The opioid drug withdrawal syndrome is characterised by some or all of the following: restlessness, lacrimation, rhinorrhoea, yawning, perspiration, chills, myalgia, mydriasis and palpitations. Other symptoms may also develop including irritability, agitation, anxiety, hyperkinesia, tremor, weakness, insomnia, anorexia, abdominal cramps, nausea, vomiting, diarrhoea, increased blood pressure, increased respiratory rate or heart rate.
If women take this drug during pregnancy, there is a risk that their newborn infants will experience neonatal withdrawal syndrome.

Hyperalgesia
As with other opioids, in case of insufficient pain control in response to an increased dose of codeine, the possibility of opioid-induced hyperalgesia should be considered. This might be qualitatively and anatomically distinct from pain related to disease progression or to breakthrough pain resulting from development of opioid tolerance. Pain associated with hyperalgesia tends to be more diffuse than the pre-existing pain and less defined in quality. A dose

reduction or treatment review may be indicated to resolve symptoms of hyperalgesia.

CYP2D6 metabolism

Codeine is partially metabolised by CYP2D6. If a patient has a deficiency or is completely lacking this enzyme they will not obtain adequate analgesic effects. 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 nausea, vomiting, constipation, lack of appetite, somnolence, shallow breathing, small pupils and confusion. 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%

Risk from concomitant use of sedative medicines such as benzodiazepines or related drugs

Concomitant use of 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 with these sedative medicines 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, the lowest effective dose should be used, and the duration of treatment should be as short as possible.

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 caregivers to be aware of these symptoms (see section 4.5).

Sleep-related breathing disorders

Opioids can cause sleep-related breathing disorders including central sleep apnoea (CSA) and sleep-related hypoxemia. Opioid use increases the risk of CSA in a dose-dependent fashion. In patients who present with CSA, consider decreasing the total opioid dosage.

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).

Care should be observed in administering the product to any patient whose condition may be exacerbated by opioids, including the elderly, who may be sensitive to their central and gastro-intestinal effects, those on concurrent CNS depressant drugs, those with prostatic hypertrophy, hypothyroidism and those with inflammatory or obstructive bowel disorders, Addison's disease or myasthenia gravis. Care should also be observed if prolonged therapy is contemplated.

Cases of high anion gap metabolic acidosis (HAGMA) due to pyroglutamic acidosis have been reported in patients with severe illness such as severe renal impairment and sepsis, or in patients with malnutrition or other sources of glutathione deficiency (e.g. chronic alcoholism) who were treated with paracetamol at therapeutic dose for a prolonged period or a combination of paracetamol and flucloxacillin. If HAGMA due to pyroglutamic acidosis is suspected, prompt discontinuation of paracetamol and close monitoring is recommended. The measurement of urinary 5-oxoproline may be useful to identify pyroglutamic acidosis as underlying cause of HAGMA in patients with multiple risk factors.

Hepatobiliary disorders
Codeine may cause dysfunction and spasm of the sphincter of Oddi, thus increasing the risk of biliary tract symptoms and pancreatitis. Therefore, codeine/paracetamol has to be administered with caution in patients with pancreatitis and diseases of the biliary tract.

Care is advised in the administration of paracetamol to patients with severe renal or severe hepatic impairment. The hazards of overdose are greater in those with alcoholic liver disease.

Patients should be advised not to exceed the recommended dose and not take other paracetamol containing products concurrently.

Patients should be advised to consult a doctor should symptoms persist and to keep the product out of the reach and sight of children.

Caution is advised in patients with underlying sensitivity to aspirin and/or to non-steroidal anti-inflammatory drugs (NSAIDs).

The risk-benefit of continued use should be assessed regularly by the prescriber.

Paediatric population
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 (see also section 4.3). 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.

The leaflet will state in the "pregnancy and breast-feeding" subsection of the section 2 "Before taking your medicine":
Do not take Co-codamol while you are breastfeeding as codeine passes into breast milk and will affect your baby.

The leaflet will state in section 3:
Do not take for longer than your doctor or pharmacist tells you to.

The leaflet will state in a prominent position in section 4 ' Important side effects you should know about ':
Taking codeine regularly for a long time can lead to addiction, which might cause you to feel restless and irritable when you stop the tablets.
Taking a pain killer for headaches too often or for too long can make them worse.

The label will state (To be displayed prominently on outer pack (not boxed):
Do not take for longer than directed by your prescriber as taking codeine regularly for a long time can lead to addiction.

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

4.5 Interaction with other medicinal products and other forms of interaction

Paracetamol may increase the elimination half-life of chloramphenicol. Oral contraceptives may increase its rate of clearance. The speed of absorption of paracetamol may be increased by metoclopramide or domperidone and absorption reduced by colestyramine.

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

Sedative medicines such as benzodiazepines or related drugs

The concomitant use of opioids with sedative medicines such as benzodiazepines or related drugs, gabapentinoids (gabapentin and pregabalin) may result in respiratory depression, hypotension, profound sedation, coma or death because of additive CNS depressant effect. The dose 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).

CYP2D6 inhibitors
Codeine is metabolised by the liver enzyme CYP2D6 to its active metabolite morphine. Medicines that inhibit CYP2D6 activity may reduce the analgesic effect of codeine.

Patients taking codeine and moderate to strong CYP2D6 inhibitors (such as quinidine, fluoxetine, paroxetine, bupropion, cinacalcet, methadone) should be adequately monitored for reduced efficacy and withdrawal signs and symptoms. If necessary, an adjustment of the treatment should be considered.

CYP3A4 inducers
Medicines that induce CYP3A4 activity may reduce the analgesic effect of codeine. Patients taking codeine and rifampicin should be adequately monitored for reduced efficacy and withdrawal signs and symptoms. If necessary, an adjustment of the treatment should be considered.

Flucloxacillin
Caution should be taken when paracetamol is used concomitantly with flucloxacillin as concurrent intake has been associated with high anion gap metabolic acidosis due to pyroglutamic acidosis, especially in patients with risks factors (see section 4.4).

4.6 Fertility, pregnancy and lactation

Careful consideration should be given before prescribing the product for pregnant patients. Regular use during pregnancy may cause dependence in the foetus, leading to withdrawal symptoms in the neonate.

If opioid use is required for a prolonged period in a pregnant woman, advise the patient of the risk of neonatal opioid withdrawal syndrome and ensure that appropriate treatment will be available.

Administration during labour may depress respiration in the neonate and an antidote for the child should be readily available.

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.

As a precautionary measure, use of Co-codamol tablets should be avoided during the third trimester of pregnancy and during labour.

Breastfeeding
Paracetamol is excreted in breast milk but not in a clinically significant amount. Administration to nursing women is not recommended as codeine may be secreted in breast milk and may cause respiratory depression in the infant. If the patient is an ultra-rapid metaboliser of CYP2D6, higher levels of the active metabolite, morphine, 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

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

Codeine can produce typical opioid effects including constipation, nausea, vomiting, dizziness, light-headedness, confusion, drowsiness and urinary retention. The frequency and severity are determined by dosage, duration of treatment and individual sensitivity. Tolerance and dependence can occur, especially with prolonged high dosage of codeine.

• Regular prolonged use of codeine is known to lead to addiction and tolerance. Symptoms of restlessness and irritability may result when treatment is then stopped.

• Prolonged use of a painkiller for headaches can make them worse.

The frequency of undesirable effects is classified as follows: 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 (cannot be estimated from the available data).

Blood and lymphatic system disorders	Thrombocytopaenia, neutropenia,

Very rare Not known	leucopenia. Agranulocytosis.
Immune system disorders Not known	 Hypersensitivity including skin rash may occur. Anaphylactic shock, angioedema.
Metabolism and nutrition disorders Not known	High anion gap metabolic acidosis.
Psychiatric disorders Not known	 Drug dependence (see section 4.4).
Vascular disorders Not known	 Hypotension (with high doses).
Respiratory, thoracic and mediastinal disorders Not known	 Bronchospasm (see section 4.4).
Hepatobiliary disorders Not known	 Sphincter of Oddi dysfunction.
Skin and subcutaneous tissue disorders Very rare	 Stevens-Johnson syndrome (SJS), toxic epidermal necrolysis (TEN), acute generalized exanthematous pustulosis (AGEP), fixed drug eruption.
General disorders and administration site conditions Uncommon Very rare	 Drug withdrawal syndrome. Panreatitis.

Description of selected adverse reactions

Drug dependence

Repeated use of Co-codamol can lead to drug dependence, even at therapeutic doses. The risk of drug dependence may vary depending on a patient's individual risk factors, dosage, and duration of opioid treatment (see section 4.4).

High anion gap metabolic acidosis

Cases of high anion gap metabolic acidosis due to pyroglutamic acidosis have been observed in patients with risk factors using paracetamol (see section 4.4). Pyroglutamic acidosis may occur as a consequence of low glutathione levels in these patients.

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 help if they occur.

Codeine
The effects of codeine overdosage 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
Management 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 350 mg or a child more than 5 mg/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 4 hours after ingestion, or 8 hours if a sustained release preparation has been taken.

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 overdosage 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, coma, gastrointestinal bleeding, disseminated intravascular coagulation 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, pancreatitis and pancytopenia have been reported.

Management
Immediate treatment is essential in the management of Paracetamol overdose. Despite lack of significant early symptoms, patients should be referred to hospital urgently for immediate 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 concentrations 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. General supportive measures must be available.

Management of patients who present with serious hepatic dysfunction beyond 24 hours from ingestion should be discussed with the NPIS or a liver unit.

5 PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: codeine and paracetamol.
ATC Code: N02AJ06

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 a low affinity to μ opioid receptors and its analgesic effect is due to its conversion to morphine. It can potentiate the effect of other analgesics. Codeine, particularly in combination with other analgesics such as paracetamol, has been shown to be effective in acute nociceptive pain.

5.2 Pharmacokinetic properties

Absorption
Following oral administration of two capsules (ie, a dose of paracetamol 1000mg and codeine phosphate 60mg) the mean maximum plasma concentrations of paracetamol and codeine phosphate were 15.96µg/ml and 212.4ng/ml respectively. The mean times to maximum plasma concentrations were 0.88 hours for paracetamol and 1.05 hours for codeine phosphate.

Distribution
The mean $AUC_{(0-10)}$ for the 9 hours following administration was 49.05µg/ml per hour for paracetamol and 885.0ng/ml per hour for codeine.

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

Biotransformation
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 after both O- and N-demethylation formation of normorphine. Morphine and norcodeine are further transformed in glucuroconjugates. 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

There are no preclinical data of relevance which are additional to that already included in other sections of the SPC.

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

6 PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Tablet core:
Povidone K29/32
Magnesium stearate
Silica colloidal anhydrous
Talc

Sodium croscarmellose
Copovidone (25.2-30.8)
Cellulose microcrystalline

Tablet coating:
Hypromellose
Macrogol 3350
Talc
Titanium dioxide (E171)
Iron oxide yellow (E172)

6.2 Incompatibilities

Not applicable.

6.3 Shelf life

2 years

Shelf life after first opening of the HDPE container: 100 days

6.4 Special precautions for storage

This medicinal product does not require any special storage conditions.

6.5 Nature and contents of container

White PVC/Aluminium blisters
or white PVC/Aluminium/PE/paper child resistant blisters
or white HDPE tablet container with a white PP child-resistant screw cap.
or white PVC/Aluminium/paper child resistant blisters

Pack Sizes:
Blisters: 8, 10, 16, 20, 24, 30, 40, 50 and 100 film-coated tablets

Tablet containers: 100 and 200 film-coated tablets

Not all pack sizes may be marketed.

6.6 Special precautions for disposal

No special requirements.

7 MARKETING AUTHORISATION HOLDER

Accord-UK Ltd
(Trading style: Accord)
Whiddon Valley
Barnstaple
Devon
EX32 8NS

8 MARKETING AUTHORISATION NUMBER(S)

PL 0142/0921

9 DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUTHORISATION

23/01/2025

10 DATE OF REVISION OF THE TEXT

21/05/2026