SUMMARY OF PRODUCT CHARACTERISTICS

1 NAME OF THE MEDICINAL PRODUCT

Omeprazole 10 mg Gastro-resistant Capsules

2 QUALITATIVE AND QUANTITATIVE COMPOSITION

Each gastro-resistant capsule, hard contains 10mg of omeprazole.

Excipient with known effect:

Each gastro-resistant capsule, hard contains up to 19.9 mg of sucrose.

For the full list of excipients, see section 6.1.

3 PHARMACEUTICAL FORM

Gastro-resistant capsule, hard

Hard gelatin capsules with light brown cap and light brown body, containing almost white to light brown pellets.

4 CLINICAL PARTICULARS

4.1 Therapeutic indications

Omeprazole are indicated for the treatment of reflux symptoms (e.g. heartburn, acid regurgitation) in adults.

4.2 Posology and method of administration

Posology in adults

The recommended dose is 20 mg once daily for 14 days.

It might be necessary to take the capsules for 2-3 consecutive days to achieve improvement of symptoms.

The majority of patients achieve complete relief of heartburn within 7 days. Once complete relief of symptoms has occurred, treatment should be discontinued.

Special populations

Renal impairment
Dose adjustment is not needed in patients with impaired renal function (see section 5.2).

Hepatic impairment
Patients with impaired hepatic function should be advised by a doctor before taking Omeprazole (see section 5.2).

Elderly Dose adjustment is not needed in the elderly (see section 5.2).

Paediatric population
This medicinal product should not be used in children and adolescents under the age of 18 years.

Method of administration
It is recommended to take Omeprazole in the morning, swallowed whole with half a glass of water. The capsules must not be chewed or crushed.

For patients with swallowing difficulties
Patients can open the capsule and swallow the contents with half a glass of water or after mixing the contents in a slightly acidic fluid e.g., fruit juice or applesauce, or in non-carbonated water. Patients should be advised that the dispersion should be taken immediately (or within 30 minutes) and always be stirred just before drinking and rinsed down with half a glass of water.
Alternatively patients can suck the capsule and swallow the pellets with half a glass of water. The enteric-coated pellets must not be chewed.

4.3 Contraindications

Hypersensitivity to the active substance, substituted benzimidazoles or to any of the excipients listed in section 6.1.

Omeprazole like other proton pump inhibitors must not be used concomitantly with nelfinavir (see section 4.5).

4.4 Special warnings and precautions for use

In the presence of any alarm symptom (e.g. significant unintentional weight loss, recurrent vomiting, dysphagia, haematemesis or melena) and when gastric ulcer is suspected or present, malignancy should be excluded, as treatment may alleviate symptoms and delay diagnosis.

Co-administration of atazanavir with proton pump inhibitors is not recommended (see section 4.5). If the combination of atazanavir with a proton pump inhibitor is judged unavoidable, close clinical monitoring (e.g virus load)

is recommended in combination with an increase in the dose of atazanavir to 400 mg with 100 mg of ritonavir; omeprazole 20 mg should not be exceeded.

Omeprazole, as all acid-blocking medicinal products, may reduce the absorption of vitamin B12 (cyanocobalamin) due to hypo- or achlorhydria. This should be considered in patients with reduced body stores or risk factors for reduced vitamin B12 absorption on long-term therapy.

Omeprazole is a CYP2C19 inhibitor. When starting or ending treatment with omeprazole, the potential for interactions with medicinal products metabolised through CYP2C19 should be considered. An interaction is observed between clopidogrel and omeprazole (see section 4.5). The clinical relevance of this interaction is uncertain. As a precaution, concomitant use of omeprazole and clopidogrel should be discouraged.

Hypomagnesaemia
Severe hypomagnesaemia has been reported in patients treated with proton pump inhibitors (PPIs) like omeprazole for at least three months, and in most cases for a year. Serious manifestations of hypomagnesaemia such as fatigue, tetany, delirium, convulsions, dizziness and ventricular arrhythmia can occur but they may begin insidiously and be overlooked. In most affected patients, hypomagnesaemia improved after magnesium replacement and discontinuation of the PPI.
For patients expected to be on prolonged treatment or who take PPIs with digoxin or drugs that may cause hypomagnesaemia (e.g. diuretics), healthcare professionals should consider measuring magnesium levels before starting PPI treatment and periodically during treatment.

Severe cutaneous adverse reactions (SCARs) including Stevens-Johnson syndrome (SJS), toxic epidermal necrolysis (TEN), drug reaction with eosinophilia and systemic symptoms (DRESS) and acute generalized exanthematous pustulosis (AGEP), which can be life-threatening or fatal, have been reported very rarely and rarely, respectively in association with omeprazole treatment.

Proton pump inhibitors, especially if used in high doses and over long durations (>1 year), may modestly increase the risk of hip, wrist and spine fracture, predominantly in the elderly or in presence of other recognised risk factors. Observational studies suggest that proton pump inhibitors may increase the overall risk of fracture by 10-40%. Some of this increase may be due to other risk factors. Patients at risk of osteoporosis should receive care according to current clinical guidelines and they should have an adequate intake of vitamin D and calcium.

Subacute cutaneous lupus erythematosus (SCLE)
Proton pump inhibitors are associated with very infrequent cases of SCLE. If lesions occur, especially in sun-exposed areas of the skin, and if accompanied by arthralgia, the patient should seek medical help promptly and the health care professional should consider stopping Omeprazole. SCLE after previous

treatment with a proton pump inhibitor may increase the risk of SCLE with other proton pump inhibitors.

Interference with laboratory tests

Increased Chromogranin A (CgA) level may interfere with investigations for neuroendocrine tumours. To avoid this interference, omeprazole treatment should be stopped for at least 5 days before CgA measurements (see section 5.1). If CgA and gastrin levels have not returned to reference range after initial measurement, measurements should be repeated 14 days after cessation of proton pump inhibitor treatment.

Patients with long-term recurrent symptoms of indigestion or heartburn should see their doctor at regular intervals. Especially, patients over 55 years taking any 'over-the-counter' (OTC, non-prescription) indigestion or heartburn remedy on a daily basis should inform their pharmacist or doctor.

Patients should be instructed to consult a doctor if:

- They have had previous gastric ulcer or gastrointestinal surgery
- They are on continuous symptomatic treatment of indigestion or heartburn for 4 or more weeks
- They have jaundice or severe liver disease.
- They are aged over 55 years with new or recently changed symptoms.

Patients should not take omeprazole as a preventative medicinal product.

Treatment with proton pump inhibitors may lead to slightly increased risk of gastrointestinal infections such as *Salmonella* and *Campylobacter* (see section 5.1) and, in hospitalised patients, possibly also *Clostridium difficile*.

Omeprazole contains sucrose and sodium

Patients with rare hereditary problems of fructose intolerance, glucose-galactose malabsorption or sucrase-isomaltase insufficiency should not take this medicinal product.

This medicinal product contains less than 1 mmol (23 mg) sodium per gastro-resistant hard capsule, that is to say essentially 'sodium-free'.

4.5 Interaction with other medicinal products and other forms of interaction

Effects of omeprazole on the pharmacokinetics of other active substances

Active substances with pH dependent absorption

The decreased intragastric acidity during treatment with omeprazole might increase or decrease the absorption of active substances with a gastric pH dependent absorption.

Nelfinavir, atazanavir

The plasma levels of nelfinavir and atazanavir are decreased in case of co-administration with omeprazole.

Concomitant administration of omeprazole with nelfinavir is contraindicated (see section 4.3). Co-administration of omeprazole (40 mg once daily) reduced mean nelfinavir exposure by ca. 40% and the mean exposure of the pharmacologically active metabolite M8 was reduced by ca. 75-90%. The interaction may also involve CYP2C19 inhibition.

Concomitant administration of omeprazole with atazanavir is not recommended (see section 4.4). Concomitant administration of omeprazole (40 mg once daily) and atazanavir 300 mg/ritonavir 100 mg to healthy volunteers resulted in a 75% decrease of the atazanavir exposure. Increasing the atazanavir dose to 400 mg did not compensate for the impact of omeprazole on atazanavir exposure. The co-administration of omeprazole (20 mg once daily) with atazanavir 400 mg/ritonavir 100 mg to healthy volunteers resulted in a decrease of approximately 30% in the atazanavir exposure as compared to atazanavir 300 mg/ritonavir 100 mg once daily.

Digoxin
Concomitant treatment with omeprazole (20 mg daily) and digoxin in healthy subjects increased the bioavailability of digoxin by 10%. Digoxin toxicity has been rarely reported. However caution should be exercised when omeprazole is given at high doses in elderly patients. Therapeutic drug monitoring of digoxin should be then be reinforced.

Clopidogrel
Results from studies in healthy subjects have shown a pharmacokinetic (PK)/pharmacodynamic (PD) interaction between clopidogrel (300 mg loading dose/75 mg daily maintenance dose) and omeprazole (80 mg p.o. daily) resulting in a decreased exposure to the active metabolite of clopidogrel by an average of 46% and a decreased maximum inhibition of (ADP induced) platelet aggregation by an average of 16%.

Inconsistent data on the clinical implications of a PK/PD interaction of omeprazole in terms of major cardiovascular events have been reported from both observational and clinical studies. As a precaution, concomitant use of omeprazole and clopidogrel should be discouraged (see section 4.4).

Other active substances
The absorption of posaconazole, erlotinib, ketoconazole and itraconazole is significantly reduced and thus clinical efficacy may be impaired. For posaconazole and erlotinib concomitant use should be avoided.

Active substances *metabolised by CYP2C19*
Omeprazole is a moderate inhibitor of CYP2C19, the major omeprazole metabolising enzyme. Thus, the metabolism of concomitant active substances also metabolised by CYP2C19, may be decreased and the systemic exposure to these substances increased. Examples of such medicinal products are R-warfarin and other vitamin K antagonists, cilostazol, diazepam and phenytoin.

Cilostazol
Omeprazole, given in doses of 40 mg to healthy subjects in a cross-over study, increased Cmax and AUC for cilostazol by 18% and 26% respectively, and one of its active metabolites by 29% and 69% respectively.

Phenytoin
Monitoring phenytoin plasma concentration is recommended during the first two weeks after initiating omeprazole treatment and, if a phenytoin dose adjustment is made, monitoring and a further dose adjustment should occur upon ending omeprazole treatment.

Unknown mechanism

Saquinavir
Concomitant administration of omeprazole with saquinavir/ritonavir resulted in increased plasma levels up to approximately 70% for saquinavir associated with good tolerability in HIV-infected patients.

Tacrolimus
Concomitant administration of omeprazole has been reported to increase the serum levels of tacrolimus. A reinforced monitoring of tacrolimus concentrations as well as renal function (creatinine clearance) should be performed, and dosage of tacrolimus adjusted if needed.

Methotrexate
When given together with proton pump inhibitors, methotrexate levels have been reported to increase in some patients. In high-dose methotrexate administration a temporary withdrawal of omeprazole may need to be considered.

Effects of other active substances on the pharmacokinetics of omeprazole

Inhibitors of CYP2C19 and/or CYP3A4
Since omeprazole is metabolised by CYP2C19 and CYP3A4, active substances known to inhibit CYP2C19 or CYP3A4 (such as clarithromycin and voriconazole) may lead to increased omeprazole serum levels by decreasing omeprazole's rate of metabolism. Concomitant voriconazole treatment resulted in more than doubling of the omeprazole exposure. As high doses of omeprazole have been well-tolerated adjustment of the omeprazole dose is not generally required. However, dose adjustment should be considered in patients with severe hepatic impairment and if long-term treatment is indicated.

Inducers of CYP2C19 and/or CYP3A4
Active substances known to induce CYP2C19 or CYP3A4 or both (such as rifampicin and St John's wort) may lead to decreased omeprazole serum levels by increasing omeprazole's rate of metabolism.

4.6 Fertility, pregnancy and lactation

Pregnancy
Results from three prospective epidemiological studies (more than 1000 exposed outcomes) indicate no adverse events of omeprazole on pregnancy or on the health of the foetus/newborn child. Omeprazole can be used during pregnancy.

Breast-feeding
Omeprazole is excreted in breast milk but is not likely to influence the child when therapeutic doses are used.

Fertility
Animal studies with the racemic mixture omeprazole, given by oral administration do not indicate effects with respect to fertility.

4.7 Effects on ability to drive and use machines

Omeprazole is not likely to affect the ability to drive or use machines. Adverse reactions such as dizziness and visual disturbances may occur (see section 4.8). If affected, patients should not drive or operate machinery.

4.8 Undesirable effects

Summary of the safety profile

The most common adverse reactions (1-10% of patients) are headache, abdominal pain, constipation, diarrhoea, flatulence and nausea/vomiting.

Severe cutaneous adverse reactions (SCARs), including Stevens-Johnson syndrome (SJS), toxic epidermal necrolysis (TEN), drug reaction with eosinophilia and systemic symptoms (DRESS) and acute generalized exanthematous pustulosis (AGEP) have been reported in association with omeprazole treatment (see section 4.4).

Tabulated list of adverse reactions

The following adverse reactions have been identified or suspected in the clinical trials programme for omeprazole and post-marketing. None was found to be dose-related. Adverse reactions listed below are classified according to frequency and System Organ Class (SOC). Frequency categories are defined according to the following convention: 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).

SOC/frequency	**Adverse reaction**
Blood and lymphatic system disorders	

Rare:	Leukopenia, thrombocytopenia
Very rare:	Agranulocytosis, pancytopenia
Immune system disorders	
Rare:	Hypersensitivity reactions e.g. fever, angioedema and anaphylactic reaction/shock
Metabolism and nutrition disorders	
Rare:	Hyponatraemia
Not known:	Hypomagnesaemia. Severe hypomagnesaemia may result in hypocalcaemia. Hypomagnesaemia may also be associated with hypokalaemia.
Psychiatric disorders	
Uncommon:	Insomnia
Rare:	Agitation, confusion, depression
Very rare:	Aggression, hallucinations
Nervous system disorders	
Common:	Headache
Uncommon:	Dizziness, paraesthesia, somnolence
Rare:	Taste disturbance
Eye disorders	
Rare:	Blurred vision
Ear and labyrinth disorders	
Uncommon:	Vertigo
Respiratory, thoracic and mediastinal disorders	
Rare:	Bronchospasm
Gastrointestinal disorders	
Common:	Abdominal pain, constipation, diarrhoea, flatulence, nausea/vomiting, fundic gland polyps (benign)
Rare:	Dry mouth, stomatitis, gastrointestinal candidiasis,
Not known	Microscopic colitis
Hepatobiliary disorders	
Uncommon:	Increased liver enzymes
Rare:	Hepatitis with or without jaundice
Very rare:	Hepatic failure, encephalopathy in patients with pre-existing liver disease
Skin and subcutaneous tissue disorders	
Uncommon:	Dermatitis, pruritus, rash, urticaria
Rare:	Alopecia, photosensitivity, acute generalized exanthematous pustulosis (AGEP), drug reaction with eosinophilia and systemic symptoms (DRESS)
Very rare:	Erythema multiforme, Stevens-Johnson syndrome, toxic epidermal necrolysis (TEN)
Not known:	Subacute cutaneous lupus erythematosus (see section 4.4)
Musculoskeletal and connective tissue disorders	
Uncommon:	Fracture of the hip, wrist or spine
Rare:	Arthralgia, myalgia

Very rare:	Muscular weakness
Renal and urinary disorders	
Rare:	Interstitial nephritis
Reproductive system and breast disorders	
Very rare:	Gynaecomastia
General disorders and administration site conditions	
Uncommon:	Malaise, peripheral oedema
Rare:	Increased sweating

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 (www.mhra.gov.uk/yellowcard).

4.9 Overdose

There is limited information available on the effects of overdoses of omeprazole in humans. In the literature, doses of up to 560 mg have been described, and occasional reports have been received when single oral doses have reached up to 2,400 mg omeprazole (120 times the usual recommended clinical dose). Nausea, vomiting, dizziness, abdominal pain, diarrhoea and headache have been reported. Also apathy, depression and confusion have been described in single cases.

The symptoms described have been transient, and no serious outcome has been reported. The rate of elimination was unchanged (first order kinetics) with increased doses. Treatment, if needed, is symptomatic.

5 PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: Drugs for acid related disorders, drugs for peptic ulcer and gastro-oesophageal reflux disease (GORD), proton pump inhibitors, ATC code: A02BC01

Mechanism of action
Omeprazole, a racemic mixture of two enantiomers reduces gastric acid secretion through a highly targeted mechanism of action. It is a specific inhibitor of the acid pump in the parietal cell. It is rapidly acting and provides control through reversible inhibition of gastric acid secretion with once-daily dosing.

Omeprazole is a weak base and is concentrated and converted to the active form in the highly acidic environment of the intracellular canaliculi within the parietal cell, where it inhibits the enzyme H+ K+-ATPase - the acid pump. This effect on the final step of the gastric acid formation process is dose-dependent and provides for highly effective inhibition of both basal acid secretion and stimulated acid secretion, irrespective of stimulus.

Pharmacodynamic effects

All pharmacodynamic effects observed can be explained by the effect of omeprazole on acid secretion.

Effect on gastric acid secretion

Oral dosing with omeprazole once daily provides for rapid and effective inhibition of daytime and night-time gastric acid secretion with maximum effect being achieved within 4 days of treatment. With omeprazole 20 mg, a mean decrease of at least 80% in 24-hour intragastric acidity is then maintained in duodenal ulcer patients, with the mean decrease in peak acid output after pentagastrin stimulation being about 70% 24 hours after dosing.

Oral dosing with omeprazole 20 mg maintains an intragastric pH of ≥ 3 for a mean time of 17 hours of the 24-hour period in duodenal ulcer patients.

As a consequence of reduced acid secretion and intragastric acidity, omeprazole dose-dependently reduces/normalizes acid exposure of the oesophagus in patients with gastro-oesophageal reflux disease.

The inhibition of acid secretion is related to the area under the plasma concentration-time curve (AUC) of omeprazole and not to the actual plasma concentration at a given time.

No tachyphylaxis has been observed during treatment with omeprazole.

Other effects related to acid inhibition

During long-term treatment gastric glandular cysts have been reported in a somewhat increased frequency. These changes are a physiological consequence of pronounced inhibition of acid secretion, are benign and appear to be reversible.

Decreased gastric acidity due to any means including proton pump inhibitors, increases gastric counts of bacteria normally present in the gastrointestinal tract. Treatment with acid-reducing medicinal products may lead to slightly increased risk of gastrointestinal infections such as *Salmonella and Campylobacter* and, in hospitalised patients, possibly also *Clostridium difficile.*

During treatment with antisecretory medicinal products serum gastrin increases in response to the decreased acid secretion. Also CgA increases due to decreased gastric acidity. The increased CgA level may interfere with investigations for neuroendocrine tumours. Available published evidence suggests that proton pump inhibitors should be discontinued between 5 days and 2 weeks prior to CgA measurements. This is to allow CgA levels that might be spuriously elevated following PPI treatment to return to reference range. An increased number of ECL cells possibly related to the

increased serum gastrin levels, have been observed in some patients (both children and adults) during long term treatment with omeprazole. The findings are considered to be of no clinical significance.

5.2 Pharmacokinetic properties

Absorption

Omeprazole and omeprazole magnesium are acid labile and are therefore administered orally as enteric-coated granules in capsules. Absorption of omeprazole is rapid, with peak plasma levels occurring approximately 1-2 hours after dose. Absorption of omeprazole takes place in the small intestine and is usually completed within 3-6 hours. Concomitant intake of food has no influence on the bioavailability. The systemic availability (bioavailability) from a single oral dose of omeprazole is approximately 40%. After repeated once-daily administration, the bioavailability increases to about 60%.

Distribution

The apparent volume of distribution in healthy subjects is approximately 0.3 l/kg body weight. Omeprazole is 97% plasma protein bound.

Biotransformation

Omeprazole is completely metabolised by the cytochrome P450 system (CYP). The major part of its metabolism is dependent on the polymorphically expressed CYP2C19, responsible for the formation of hydroxyomeprazole, the major metabolite in plasma. The remaining part is dependent on another specific isoform, CYP3A4, responsible for the formation of omeprazole sulphone. As a consequence of high affinity of omeprazole to CYP2C19, there is a potential for competitive inhibition and metabolic drug-drug interactions with other substrates for CYP2C19. However, due to low affinity to CYP3A4, omeprazole has no potential to inhibit the metabolism of other CYP3A4 substrates. In addition, omeprazole lacks an inhibitory effect on the main CYP enzymes.

Approximately 3% of the Caucasian population and 15-20% of Asian populations lack a functional CYP2C19 enzyme and are called poor metabolisers. In such individuals the metabolism of omeprazole is probably mainly catalysed by CYP3A4. After repeated once-daily administration of 20 mg omeprazole, the mean AUC was 5 to 10 times higher in poor metabolisers than in subjects having a functional CYP2C19 enzyme (extensive metabolisers). Mean peak plasma concentrations were also higher, by 3 to 5 times. These findings have no implications for the posology of omeprazole.

Elimination

The plasma elimination half-life of omeprazole is usually shorter than one hour both after single and repeated oral once-daily dosing. Omeprazole is completely eliminated from plasma between doses with no tendency for accumulation during once-daily administration. Almost 80% of an oral dose of omeprazole is

excreted as metabolites in the urine, the remainder in the faeces, primarily originating from bile secretion.

Linearity/non-linearity

The AUC of omeprazole increases with repeated administration. This increase is dose-dependent and results in a non-linear dose-AUC relationship after repeated administration. This time- and dose-dependency is due to a decrease of first pass metabolism and systemic clearance probably caused by an inhibition of the CYP2C19 enzyme by omeprazole and/or its metabolites (e.g. the sulphone).
No metabolite has been found to have any effect on gastric acid secretion.

Special populations

Hepatic impairment
The metabolism of omeprazole in patients with liver dysfunction is impaired, resulting in an increased AUC. Omeprazole has not shown any tendency to accumulate with once-daily dosing.

Renal impairment
The pharmacokinetics of omeprazole, including systemic bioavailability and elimination rate, are unchanged in patients with reduced renal function.

Elderly
The metabolism rate of omeprazole is somewhat reduced in elderly subjects (75-79 years of age).

5.3 Preclinical safety data

Gastric ECL-cell hyperplasia and carcinoids, have been observed in life-long studies in rats treated with omeprazole. These changes are the result of sustained hypergastrinaemia secondary to acid inhibition. Similar findings have been made after treatment with H2-receptor antagonists, proton pump inhibitors and after partial fundectomy. Thus, these changes are not from a direct effect of any individual active substance.

6 PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Capsule contents:
Sugar spheres (contain sucrose and maize starch)
Hypromellose
Sodium lauryl sulfate
Magnesium oxide heavy
Povidone K25

Talc
Methacrylic acid - ethyl acrylate copolymer 1:1 (dispersion 30%) Triethyl citrate

Capsule shell:
Gelatin

Titanium dioxide (E171)
Yellow iron oxide (E172)
Red iron oxide (E172)
May also contain:
Black iron oxide (E172)

6.2 Incompatibilities

Not applicable.

6.3 Shelf life

2 years

For HDPE bottle:

In – use shelf life after first opening:
100 days
Do not store above 25°C. Keep the bottle tightly closed in order to protect from light and moisture.

6.4 Special precautions for storage

Do not store above 25°C.

For blister:

Store in the original package, in order to protect from light and moisture.

For HDPE bottle:
Keep the bottle tightly closed in order to protect from light and moisture.
For storage conditions after first opening of the medicinal product, see section 6.3.

6.5 Nature and contents of container

Aluminum // Aluminium blister

White HDPE bottles with PP screw cap with child-resistant closure or tamper-evident closure and inserted desiccant (silica gel capsule).

Pack sizes:
Blister: 7, 14 and 28 gastro-resistant capsules, hard
Bottle: 7, 10, 14, 15, 20 and 28 gastro-resistant capsules, hard.

Not all pack sizes may be marketed.

6.6 Special precautions for disposal and other handling

Any unused medicinal product or waste material should be disposed of in accordance with local requirements.

7 MARKETING AUTHORISATION HOLDER

Sandoz Limited
Park View, Riverside Way
Watchmoor Park
Camberley, Surrey
GU15 3YL
United Kingdom

8 MARKETING AUTHORISATION NUMBER(S)

PL 04416/1224

9 DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUTHORISATION

02/03/2012

10 DATE OF REVISION OF THE TEXT

25/04/2024