SUMMARY OF PRODUCT CHARACTERISTICS

1 NAME OF THE MEDICINAL PRODUCT

Imipramine 10 mg Tablets

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

Each tablet contains Imipramine Hydrochloride 10 mg.

Excipients with known effect
Each tablet contains lactose 40.5 mg, sucrose 0.56 mg and sunset yellow FCF (E110) 0.26 mg.

For the full list of excipients, see section 6.1.

3. PHARMACEUTICAL FORM

Coated tablet.
Biconvex sugar-coated orange tablets.

4 CLINICAL PARTICULARS

4.1 Therapeutic indications

Adults
For the treatment of depressive illness.

Children and adolescents:
For the treatment of nocturnal enuresis in children over 6 years.

4.2 Posology and method of administration

Posology

Adults:

In depressive illness, initially 75 mg daily given in divided doses, and increased gradually to 150-200 mg daily. This dose to be reached by the end of the first week of treatment. Once improvement has occurred a maintenance dose should be calculated, on an individual basis and the dose gradually reduced (normally to approx. 50 – 100 mg daily).

Hospitalized patients: The dose can be increased to 100 mg three times daily, until significant improvement occurs. Again a maintenance dose should then be calculated, on an individual basis and the dose reduced (normally to approx. 100 mg daily).

Special populations:

Elderly:
Patients over 60 years of age may be responsive to lower doses than those detailed above. Initially 10 mg daily, gradually increasing the dose to 30-50 mg daily. This dose should be reached approximately 10 days after starting treatment and continued for the length of treatment.

Paediatric population:
In the treatment of nocturnal enuresis only:

Do not use in children under 6 years of age (see section 4.3).
6-7 years (weight 20-25 kg or 44-55 lbs): 25 mg at bedtime.
8-11 years (weight 25-35 kg or 55-77 lbs): 25 – 50 mg at bedtime.
11 years and over (weight 35-45 kg or 77-119 lbs): 50 – 75 mg at bedtime.

Do not exceed a daily dose of 2.5 mg/kg. Treatment should not exceed three months and the dose should be gradually withdrawn. Should a relapse occur, no further treatment with imipramine should be started until a full physical examination has been made.

Method of administration
For oral administration.

4.3 Contraindications

- Hypersensitivity to the active substance imipramine or to any of the excipients listed in section 6.1
- Cross-sensitivity to other tricyclic antidepressants of the dibenzazepine group.
- Concurrent use in patients receiving or within 3 weeks of stopping treatment with MAO inhibitors
- Concomitant treatment with selective, reversible MAO-A inhibitors such as moclobemide.
- Patients with any degree of heart block or other cardiac arrhythmias; recent myocardial infarction.
- Mania
- Severe liver disease
- Porphyria.

- Narrow angle glaucoma
- Urine retention
- Children under 6 years of age.

4.4 Special warnings and precautions for use

Improvement in depression may not occur during the first two to four weeks of treatment and hence patients should be closely monitored during this period.

Hyponatraemia (usually in the elderly) has been associated with all types of antidepressants and should be considered in all patients who develop symptoms such as drowsiness, confusion or convulsions.

Suicide/suicidal thoughts or clinical worsening
Depression is associated with an increased risk of suicidal thoughts, self-harm and suicide (suicide-related events). This risk persists until significant remission occurs. As improvement may not occur during the first few weeks or more of treatment, patients should be closely monitored until such improvement occurs. It is general clinical experience that the risk of suicide may increase in the early stages of recovery.

Patients with a history of suicide-related events, or those exhibiting a significant degree of suicidal ideation prior to commencement of treatment are known to be at greater risk of suicidal thoughts or suicide attempts, and should receive careful monitoring during treatment. A meta-analysis of placebo-controlled clinical trials of antidepressant drugs in adult patients with psychiatric disorders showed an increased risk of suicidal behaviour with anti-depressants compared to placebo in patients less than 25 years old.

Close supervision of patients and in particular those at high risk should accompany drug therapy especially in early treatment and following dose changes. Patients (and caregivers of patients) should be alerted about the need to monitor for any clinical worsening, suicidal behaviour or thoughts and unusual changes in behaviour and to seek medical advice immediately if these symptoms present.

Other psychiatric effects
Many patients with panic disorders experience intensified anxiety symptoms at the start of treatment with tricyclic antidepressants. This paradoxical initial increase in anxiety is most pronounced during the first few days of treatment, usually subsiding within two weeks.

Activation of psychosis has occasionally been observed in schizophrenic patients taking tricyclic antidepressants.

Hypomanic and manic episodes have also been reported during a depressive phase in patients with cyclic affective disorders receiving treatment with a tricyclic antidepressant. In such cases, it may be necessary to reduce the dosage of imipramine or to withdraw it and administer an antipsychotic agent. After such episodes have subsided, low dose therapy with imipramine may be resumed, if required.

In predisposed or elderly patients, tricyclic antidepressants can cause pharmacogenic (delirious) psychoses, particularly at night which disappear without treatment within a few days of withdrawing the drug.

Imipramine may cause anxiety, feelings of unrest and hyperexcitation in agitated patients and patients with accompanying schizophrenic symptoms.

Behavioural disturbances may occur in children receiving treatment with imipramine for the treatment of nocturnal enuresis.

Monitoring of cardiac function is indicated in the elderly.

Before starting treatment with Imipramine, it is advisable to check the patients' blood pressure, as patients with hypotension or a labile circulation may react to the drug with a fall in blood pressure.

Serotonin syndrome
Concomitant administration of imipramine and buprenorphine/opioids may result in serotonin syndrome, a potentially life-threatening condition (see section 4.5).

If concomitant treatment with buprenorphine containing medicinal products is clinically warranted, careful observation of the patient is advised, particularly during treatment initiation and dose increases.

Symptoms of serotonin syndrome may include mental-status changes, autonomic instability, neuromuscular abnormalities, and/or gastrointestinal symptoms.

If serotonin syndrome is suspected, a dose reduction or discontinuation of therapy should be considered depending on the severity of the symptoms.

Convulsions
As tricyclic antidepressants are known to lower the convulsion threshold, Imipramine should be used with extreme caution in patients with epilepsy and other predisposing factors, e.g. brain damage of varying aetiology, concomitant use of neuroleptics, withdrawal from alcohol or drugs with anti-convulsive properties (e.g. benzodiazepines). Occurrence of seizures appears to be dose dependant.

As with related tricyclic antidepressants, concomitant treatment of imipramine and electroconvulsive therapy should only be resorted to under careful supervision.

Anticholinergic effects
Because of its anticholinergic properties, imipramine should be used with caution in patients with a history of increased intra-ocular pressure, narrow angle glaucoma or urinary retention (e.g. prostate disease).

Decreased lacrimation (tear production) and accumulation of mucoid secretions due to the anticholinergic properties of tricyclic antidepressants may cause damage to the corneal epithelium in patients with contact lenses.

Special treatment populations

Caution is required when giving tricyclic antidepressants to patients with:
- severe renal disease
- adrenal medulla tumours (e.g. phaeochromocytoma, neuroblastoma), as hypertensive crisis may be provoked.
- hyperthyroidism or during concomitant treatment with thyroid preparations which may aggravate unwanted cardiac effects.

Periodic monitoring of liver enzyme levels is recommended in individuals with liver disease.

Caution is needed in patients with chronic constipation. Tricyclic antidepressants can cause paralytic ileus especially in elderly or bedridden patients.

An increase in the number of dental caries has been reported during long-term treatment with tricyclic antidepressants. It is therefore recommended to carry out regular dental checks during long-term therapy.

Monitoring of cardiac function is indicated in elderly patients.

White blood cell count
Although changes in the white blood cell count have been reported with Imipramine only in isolated cases, periodic blood cell counts should be performed and monitoring for symptoms such as fever and sore throat, particularly during the first few months of treatment and during prolonged treatment (see Section 4.8).

Anaesthesia
Before general or local anaesthesia, the anaesthetist should be aware that the patient has been receiving Imipramine. Anaesthetics given during tri/tetracyclic anti-depressants therapy may increase the risk of arrhythmias and hypotension (see section 4.5).

Therapy discontinuation
Abrupt withdrawal should be avoided because of possible adverse reactions (see section 4.8).

This medicine contains lactose and sucrose
Patients with rare hereditary problems of fructose or galactose intolerance, total lactase deficiency, glucose-galactose malabsorption or sucrase-isomaltase insufficiency should not take this medicine.

This medicine contains sunset yellow FCF (E110) which may cause allergic reactions.

4.5 Interaction with other medicinal products and other forms of interaction

MAO inhibitors (MAOIs): Imipramine should not be administered for at least 3 weeks after discontinuation of treatment with MAO inhibitors (there is a risk of severe symptoms such as hypertensive crisis, hyperpyrexia, myoclonus, agitation, seizures, delirium and coma). This also applies when giving an MAO inhibitor after previous treatment with Imipramine. In both cases,

Imipramine or the MAO inhibitor should initially be given in small, gradually increasing doses, and its effects monitored. There is evidence to suggest that tricyclic antidepressants may be given as little as 24 hours after a reversible MAO inhibitor such as moclobemide, but the 3-week washout period must be observed if the MAO inhibitor is given after using a tricyclic antidepressant.

Selective serotonin reuptake inhibitor (SSRIs): Concomitant administration with imipramine may lead to additive effects on the serotonergic system. Fluoxetine and fluvoxamine may also increase plasma concentrations of imipramine with corresponding adverse effects, resulting in increased plasma levels of tricyclic antidepressants, a lowered convulsion threshold and seizures.

CNS depressants: Tricyclic antidepressants may also potentiate the CNS depressant effects of alcohol and central depressant drugs (e.g. barbiturates, benzodiazepines or general anaesthetics).

Neuroleptics: Concomitant administration may cause an increase in plasma concentrations of tricyclic antidepressants, a lowered convulsion threshold and seizures. Combination with thioridazine may cause severe cardiac arrhythmias.

Alprazolam and disulfiram: It may be necessary to reduce the dose of imipramine if it is administered concomitantly with alprazolam or disulfiram.

Adrenergic neurone blockers: Imipramine, may diminish or abolish the antihypertensive effects of guanethidine, bethanidine, reserpine, clonidine and α-methyldopa. Patients requiring concomitant administration of medicines for hypertension should therefore be given antihypertensives of a different type, e.g. vasodilators.

Beta-blockers: Blood concentrations of imipramine may be increased by drugs such as labetalol and propranolol. The clinical importance of these interactions is uncertain.

Diuretics: Concurrent use of a tricyclic antidepressant and a diuretic may increase the risk of postural hypotension.

Alpha$_2$-adrenoceptor stimulants: Concomitant use of apraclonidine or brimonidine should be avoided.

Anticoagulants: Tricyclic antidepressants may potentiate the anticoagulant effect of coumarin drugs by inhibiting hepatic metabolism of these anticoagulants. Careful monitoring of plasma prothrombin is therefore advised.

Anticholinergic drugs: Tricyclic antidepressants may potentiate the effects of these drugs (e.g. phenothiazine, anti-parkinsonism agents, antihistamines, atropine, biperiden) on the eye, CNS, bowel and bladder.

Sympathomimetic drugs: Imipramine may potentiate the cardiovascular effects of adrenaline (epinephrine), noradrenaline (norepinephrine), ephedrine, isoprenaline, phenylephrine and phenylpropanolamine (e.g. as contained in local anaesthetic preparations and nasal decongestants).

Quinidine: Tricyclic antidepressants should not be employed in combination with anti-arrhythmic agents of the quinidine type.

Liver enzyme inducers: Drugs which activate the hepatic mono-oxygenase enzyme system (such as barbiturates, carbamazepine, phenytoin, nicotine and oral contraceptives) may accelerate metabolism and lower plasma concentrations of imipramine, resulting in decreased efficacy. Phenytoin and carbamazepine plasma levels may increase with corresponding adverse effects. It may be necessary to adjust the dosage of these drugs.

Cimetidine and methylphenidate: These drugs may increase plasma concentrations of tricyclic antidepressants, whose dosage should therefore be reduced.

Oestrogens: There is evidence that oestrogens can sometimes paradoxically reduce the effects of imipramine and at the same time induce toxicity by imipramine.

Tricyclic antidepressants may also interact with the following drug classes:

- Analgesics: Possible increase in risk of side effects (nefopam), convulsions (tramadol), sedation (opioid analgesics) or ventricular arrhythmias.
- Anti-arrhythmics: Increased risk of ventricular arrhythmias with drugs which prolong the QT interval.
- Muscle relaxants: Enhanced muscle relaxant effect of baclofen.

Imipramine should be used cautiously when co-administered with: Buprenorphine/opioids as the risk of serotonin syndrome, a potentially life-threatening condition is increased. (see section 4.4).

Calcium channel blockers: Verapamil and diltiazem can increase the plasma imipramine concentration as a result of interference with the metabolisation of imipramine.

Antiviral agents: Drugs such as ritonavir have been reported to increase plasma concentrations of antidepressant drugs.

Nitrates: Reduced salivary secretion may lessen the effectiveness of sublingual nitrate preparations.

Dopaminergic agents: CNS toxicity may be enhanced when tricyclic antidepressants are used in conjunction with dopaminergic drugs such as selegiline and entacapone.

Centrally acting appetite suppressants: Concomitant use is not recommended due to the increased risk of CNS toxicity.

Antineoplastic drugs: Concomitant use of altretamine should be avoided due to the risk of severe postural hypotension.

4.6 Fertility, pregnancy and lactation

Pregnancy
There is no evidence of the safety of the drug in human pregnancy. There have been isolated reports of a possible connection between the use of tricyclic antidepressants and adverse effects (development disorders) on the foetus. Treatment with imipramine should be avoided during pregnancy unless the anticipated benefits justify the potential risk to the foetus.

Neonates whose mothers had taken imipramine until delivery have developed dyspnoea, lethargy, colic, irritability, hypotension or hypertension, tremor or spasms during the first few hours or days. If possible, imipramine should be gradually withdrawn at least 7 weeks before the expected date of delivery.

Breast-feeding
As imipramine is excreted in breast milk it should not be administered to nursing mothers unless considered essential when the mother should be advised to stop breastfeeding.

Fertility
No data available.

4.7 Effects on ability to drive and use machines

Patients taking imipramine should be advised that they may experience blurred vision, drowsiness and other CNS symptoms (see section 4.8) and should not drive, operate machinery, or perform any other tasks requiring alertness or quick actions if affected. Patients should also be advised that alcohol and other drugs may potentiate these effects (see section 4.5).

4.8 Undesirable effects

Treatment with imipramine should be withdrawn if severe neurological and psychiatric reactions occur.

Elderly patients are particularly sensitive to the anticholinergic, neurological, psychiatric and cardiovascular effects. Their ability to metabolise and eliminate drugs may be reduced, leading to a risk of elevated plasma concentrations at therapeutic doses.

The following undesirable effects have been reported with tricyclic antidepressant drugs, not necessarily reported with imipramine. The adverse reactions are presented according to the following convention: very common (≥1/10); common (≥1/100, <1/10); uncommon (≥1/1,000, <1/100); rare

(≥1/10,000, <1/1,000); very rare (< 1/10,000); not known (frequency cannot be estimated from the available data).

Blood and the lymphatic system disorders:
Very rare: bone marrow depression including eosinophilia, with leucopenia, agranulocytosis, thrombocytopenia. It is advisable to perform blood counts during treatment with tri/tetracyclic antidepressants, especially if the patient develops fever, sore throat or other signs of infection. (See section 4.4).

Immune system disorders:
Very rare: allergic alveolitis (pneumonitis) with or without eosinophilia, systemic anaphylactic/anaphylactoid reactions including hypotension.

Endocrine disorders:
Very common: weight gain.
Common: changes to libido & potency.
Very rare: enlarged mammary glands, galactorrhoea, increase/decrease in blood sugar, SIADH (syndrome of inappropriate antidiuretic hormone secretion) and weight loss.

Metabolism and nutrition disorders:
Hyponatraemia, usually in the elderly, has been associated with all types of antidepressants (see section 4.4).

Psychiatric disorders:
Common: fatigue, drowsiness, sleep disturbance, increased anxiety, restlessness/agitation, confusion, delirium, swings from depression to hypomania/mania, hallucinations and disorientation (mainly in geriatric patients or those suffering from Parkinson's disease).
Rare: psychotic symptoms have been activated.
Very rare: aggressiveness.
Not known: Paranoid delusion may be exacerbated during treatment with tricyclic antidepressants. These are more frequently seen in elderly patients or those on high doses. Cases of ideation and suicidal behaviour have been reported during imipramine therapy or shortly after treatment discontinuation (see section 4.4).

Nervous system disorders:
Very common: tremor.
Common: dizziness, headache and paresthesias.
Rare: epileptic seizures.
Very rare: ataxia, drug fever, EEG changes, extrapyramidal symptoms, myoclonus, problems with speech and weakness.

Eye disorders:
Very common: blurred vision, disorders of visual accommodation.
Very rare: glaucoma, mydriasis.

Ear and labyrinth disorders:
Not knowns: tinnitus.

Cardiac disorders:
Very common: sinus tachycardia and clinically irrelevant ECG changes (T and ST changes) in patients with normal cardiac status, postural hypotension. Cardiac arrhythmias and severe hypotension are likely to occur with high dosage or in deliberate overdosage. They may also occur in patients with pre-existing heart disease taking normal dosage.
Common: arrhythmias, conduction disorders (widening of the QRS complex, and PR interval, bundle-branch block) and palpitations.
Very rare: increases in blood pressure, cardiac decompensation and peripheral vasospastic reactions.

Vascular disorders:
Very common: hot flushes.

Gastrointestinal disorders:
Very common: dry mouth, constipation.
Common: anorexia, nausea, vomiting.
Very rare: paralytic ileus, stomatitis, tongue lesions, abdominal disorders.

Hepato-biliary disorders:
Common: elevated transaminases
Rare: impaired liver function.
Very rare: hepatitis (with or without jaundice).

Skin and subcutaneous tissue disorders:
Very common: sweating.
Common: allergic reactions such as skin rash and urticaria.
Very rare: oedema (local or generalised), petechiae, pruritus, photosensitivity, alopecia.

Renal and urinary disorders:
Common: disturbances of micturition.

Withdrawal effects:
Although not indicative of addiction, withdrawal symptoms may occur on abrupt cessation of therapy and include nausea, vomiting, abdominal pain, diarrhoea, headache, insomnia, nervousness, anxiety, irritability and excessive perspiration (see section 4.4).
Respiratory depression, agitation and withdrawal symptoms have been reported in neonates whose mothers received imipramine during the last trimester of pregnancy.

Class effects:
Epidemiological data, particularly from studies conducted in patients 50 years and over, show an increased risk of bone fractures in patients taking selective serotonin reuptake inhibitors (SSRIs) and tricyclic antidepressants. The mechanism underlying this risk is still unknown.

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

4.9 Overdose

The signs and symptoms of imipramine overdose are similar to those observed with other tricyclic antidepressants. The main complications are cardiac abnormalities and neurological disturbances. In children, accidental ingestion of any amount should be regarded as serious and potentially fatal.

Signals and symptoms
Symptoms generally appear within four hours of ingestion and reach a maximum severity after 24 hours. Due to delayed absorption (increased anticholinergic effect due to overdose), long half-life and enterohepatic recycling of the drug, the patient may be at risk for up to 4-6 days.

Major symptoms of overdose include:

- *Effects on the central nervous system*: drowsiness, stupor, coma, ataxia, restlessness, agitation, enhanced reflexes, muscle rigidity, athetoid and chorieform movements, convulsions.
- *Effects on the cardiovascular system*: hypotension, tachycardia, arrhythmias, conduction disorders, heart failure and in very rare cases cardiac arrest.
- *Others:* respiratory depression, cyanosis, vomiting, fever, sweating, oliguria or anuria.

Treatment:
There is no specific antidote and treatment is essentially symptomatic and supportive. Anyone suspected of having taken an overdose of imipramine, particularly children, should be hospitalized and observed closely for at least 72 hours. If the patient is fully conscious, gastric lavage and enforced enuresis should be employed immediately. If the patient has impaired consciousness, the airway should be secured with a cuffed endotracheal tube before beginning lavage, and vomiting should not be induced. This can be carried out for up to 12 hours, or even longer after the overdose (the anticholinergic effect of the drug may delay gastric emptying). Administration of activated charcoal may help reduce drug absorption.

Patients presenting with major symptoms of overdosage, particularly children, should be nursed in an intensive care unit for at least 72 hours where full support of vital functions is possible.

Symptomatic treatment is based on modern intensive care methods, with continuous monitoring of cardiac function, blood gases and electrolyte levels and, if necessary, emergency measures such as anticonvulsive therapy, artificial respiration, insertion of temporary cardiac pacemaker, plasma

expanders, dopamine or dobutamine administered by intravenous infusion and resuscitation.

Any serious overdosage requires continuous cardiac monitoring for at least 48 hours and dysrhythmias must be treated on an individual basis. Respiratory insufficiency may necessitate intubation and ventilation, and convulsions may be controlled with intravenous diazepam.

Physostigmine should not be used in cases of imipramine overdose since it may cause bradycardia, asystole or seizures. Haemodialysis or peritoneal dialysis are ineffective due to the low plasma levels of imipramine.

5 PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic group:
ATC code: N06A A02 - Tricyclic antidepressant. Noradrenaline (NA) and serotonin (5HT) reuptake inhibitor.

Mechanism of action
Imipramine is a tricyclic antidepressant and has several pharmacological actions including α-adrenolytic, antihistamine, anticholinergic and 5-HT receptor blocking properties. However, the main therapeutic activity is believed to be the inhibition of the neuronal re-uptake of noradrenaline (NA) and serotonin (5-HT).
Imipramine is a so-called "mixed" reuptake blocker, i.e. it inhibits the reuptake of NA and 5-HT to about the same extent.

5.2 Pharmacokinetic properties

Absorption
Imipramine hydrochloride is rapidly and almost completely absorbed following oral administration . Food intake has no affect on its absorption and bioavailability. During its first passage through the liver, orally administered imipramine is partially converted to desmethylimipramine, a metabolite which also exhibits antidepressant activity.

Following oral administration of 50 mg 3 times daily, for 10 days, the mean steady-state plasma concentrations recorded of imipramine and desmethylimipramine were 33-85 ng/mL and 43-109 ng/mL, respectively. Owing to lower clearance in the plasma, resulting in increased systemic availability, elderly patients require lower doses of imipramine than patients in intermediate age groups. Renal impairment is not expected to have any influence on the kinetics of unchanged imipramine and its desmethyl metabolite since both are excreted only in small amounts by the kidneys.

Distribution
About 86% of imipramine binds to plasma proteins. Concentrations of imipramine in the cerebrospinal fluid and the plasma are highly correlated. The mean distribution volume is about 21 L/kg of body weight.
Imipramine and its metabolite desmethylimipramine both pass into breast milk at similar concentrations to those found in plasma.

Biotransformation
Imipramine is extensively metabolised in the liver. It is cleared mainly by demethylation and to a lesser extent by hydroxylation. Both metabolic pathways are under genetic control.

Elimination
Imipramine is eliminated from the blood with a mean half-life of about 19 hours.
About 80% is excreted in the urine and 20% in the faeces, mainly as inactive metabolites. Urinary excretion of unchanged imipramine and the active metabolite, desmethylimipramine is about 5% and 6%, respectively. Only small amounts are excreted in the faeces.

Characteristics in patients
Owing to reduced metabolic clearance, imipramine plasma concentrations are higher in elderly patients than in younger patients.

In children, the mean clearance and elimination half-life do not differ significantly from adult controls, but the variability between patients is very high.

In patients with severe renal impairment, no change occurs in renal excretion of imipramine and its biologically active unconjugated metabolites. However, steady-state plasma concentrations of the conjugated metabolites which are considered biologically inactive are elevated. The clinical significance of this finding is unclear.

5.3 Preclinical safety data

Imipramine has no mutagenic or carcinogenic potential. Studies in four species (mouse, rat, rabbit, and monkey) led to the conclusion that orally administered imipramine has no teratogenic potential. Experiments with high doses of parenterally administered imipramine resulted mainly in severe maternal toxicity and embryotoxic effects; they were thus inconclusive with regard to teratogenic effects.

6. PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Tablet core
Lactose (spray dried)
Talc

Colloidal Anhydrous Silica
Stearic Acid

Tablet coating
Opadry SGR Translucent (containing Sucrose, Talc, Hypromellose, Polyethylene Glycol, Medium Chain Triglycerides, Glyceryl Monostearate)

Opadry SGR Orange (containing Sucrose, Hypromellose, Polyvinyl Alcohol, Polyethylene Glycol, FD& C Yellow/ Sunset Yellow FCF (E110) Aluminium Lake, Titanium Dioxide (E171), Talc, Medium Chain Triglycerides & Quinoline Yellow Aluminum Lake).

Opaglos 2 clear (containing Sodium Carboxymethylcellulose, Maltodextrin, Dextrose Monohydrate, Lecithin)

6.2 Incompatibilities

Not applicable.

6.3 Shelf life

5 years.

6.4 Special precautions for storage

Tablet containers: Do not store above 25°C. Keep the container tightly closed.

Blisters: Do not store above 25°C. Store in the original package.

6.5 Nature and contents of container

High density polypropylene containers with low density polyethylene caps of 28, 100, 250, 500 & 1000 tablets.

Al/ White opaque PVC/ blisters enclosed in an outer carton, containing 28 or 56 tablets.

Not all packs may be marketed.

6.6 Special precautions for disposal

Not applicable.

SUMMARY OF PRODUCT CHARACTERISTICS

7. MARKETING AUTHORISATION HOLDER

Crescent Pharma Limited
Key House, Sarum Hill,
Basingstoke, RG21 8SR, UK.

8 MARKETING AUTHORISATION NUMBER(S)

PL 20416/0195

9 DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUTHORISATION

14/01/2025

10 DATE OF REVISION OF THE TEXT

21/11/2025