

## **SUMMARY OF PRODUCT CHARACTERISTICS**

### **1 NAME OF THE MEDICINAL PRODUCT**

Mefenamic Acid 250mg Capsules

MEFLAM 250mg Capsules

OPUSTAN 250mg Capsules

CONTRAFLAM 250mg Capsules

### **2 QUALITATIVE AND QUANTITATIVE COMPOSITION**

Each Capsule contains 250mg of mefenamic acid

Excipient(s) with known effect

Each 250mg Capsules contains 38.700 mg of lactose

For the full list of excipients, see section 6.1.

### **3 PHARMACEUTICAL FORM**

Hard gelatine capsule with a blue cap and yellow body and intended for oral administration to human beings

### **4 CLINICAL PARTICULARS**

#### **4.1 Therapeutic indications**

1. As an anti-inflammatory analgesic for the symptomatic relief of rheumatoid arthritis (including Still's Disease), osteoarthritis and pain including muscular, traumatic and dental pain, headaches of most aetiology, post-operative and post-partum pain.

2. Primary dysmenorrhoea

3. Menorrhagia due to dysfunctional causes and presence of IUD when other pelvic pathology has been ruled out.

## 4.2 Posology and method of administration

### Posology

*Adults:* The usual dosage is 500mg three times daily.

In menorrhagia to be administered on the first day of excessive bleeding and continued according to the judgement of the physician. In dysmenorrhoea to be administered at the onset of menstrual pain and continued according to the judgement of the physician.

*Elderly (over 65 years):* As for adults. Whilst no pharmacokinetic or clinical studies specific to the elderly have been undertaken, it has been used at normal dosage in trials which include many elderly patients.

However, it should be used with caution in elderly patients suffering from dehydration and renal failure. Non-oliguric renal failure and proctocolitis have been reported mainly in elderly patients who have not discontinued mefenamic acid after the development of diarrhoea.

The elderly are at increased risk of the serious consequences of adverse reactions. If an NSAID is considered necessary, the lowest effective dose should be used and for the shortest possible duration. The patient should be monitored regularly for GI bleeding during NSAID therapy.

*Paediatric population (under the age of 12)*

Not Recommended.

### Method of administration

For oral administration.

To be taken preferably with or after food.

Undesirable effects may be minimised by using the lowest effective dose for the shortest duration necessary to control the symptoms (see section 4.4).

## 4.3 Contraindications

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

Because the potential exists for cross-sensitivity to aspirin, ibuprofen, or other non-steroidal anti-inflammatory drugs, mefenamic acid must not be given to patients who have previously shown hypersensitivity reaction (e.g. asthma, bronchospasm, rhinitis, angioedema or urticaria) to these medicines.

Mefenamic acid is also contra-indicated in patients with inflammatory bowel disease, intestinal ulceration and history of gastrointestinal bleeding or perforation, related to previous NSAIDs therapy.

Active or history of recurrent peptic ulcer/haemorrhage (two or more distinct episodes of proven ulceration or bleeding).

Severe heart failure, hepatic failure and renal failure (see section 4.4).

During the last trimester of pregnancy (see section 4.6).

Treatment of pain after coronary artery bypass graft (CABG) surgery.

#### **4.4 Special warnings and precautions for use**

Undesirable effects may be minimised by using the lowest effective dose for the shortest duration necessary to control symptoms (see section 4.2, and GI and cardiovascular risks below).

Patients on prolonged therapy should be kept under regular surveillance with particular attention to liver dysfunction, rash, blood dyscrasias or development of diarrhoea.

Appearance of any of these symptoms should be regarded as an indication to stop therapy immediately (see section 4.8).

Use with concomitant NSAIDs including cyclooxygenase 2 selective inhibitors (see section 4.5).

Prolonged use of any type of painkiller for headaches can make them worse. If this situation is experienced or suspected, medical advice should be obtained and treatment should be discontinued. The diagnosis of 'Medication Overuse Headache' should be suspected in patients who have frequent or daily headaches despite (or because of) the regular use of headache medications.

Precaution should be taken in patients suffering from dehydration and renal disease, particularly the elderly.

##### **Elderly**

The elderly have an increased frequency of adverse reactions to NSAIDs especially gastrointestinal bleeding and perforation which may be fatal (see section 4.2).

### **Respiratory disorders**

Caution is required if administered to patients suffering from, or with a previous history of, bronchial asthma since NSAIDs have been reported to precipitate bronchospasm in such patients.

### **Cardiovascular, Renal and Hepatic impairment**

The administration of an NSAID may cause a dose dependant reduction in prostaglandin formation and precipitate renal failure. Patients at greatest risk of this reaction are those with impaired renal function, cardiac impairment, liver dysfunction, those taking diuretics and the elderly. Renal function should be monitored in these patients (see also section 4.3).

### **Cardiovascular and cerebrovascular effects**

Appropriate monitoring and advice are required for patients with a history of hypertension and/or mild to moderate congestive heart failure as fluid retention and oedema have been reported in association with NSAID therapy.

Clinical trial and epidemiological data suggest that use of some NSAIDs (particularly at high doses and in long term treatment) may be associated with a small increased risk of arterial thrombotic events (for example myocardial infarction or stroke). There are insufficient data to exclude such a risk for Mefenamic acid.

Patients with uncontrolled hypertension, congestive heart failure, established ischaemic heart disease, peripheral arterial disease, and/or cerebrovascular disease should only be treated with Mefenamic acid after careful consideration. Similar consideration should be made before initiating longer-term treatment of patients with risk factors for cardiovascular disease (e.g. hypertension, hyperlipidaemia, diabetes mellitus, smoking).

As NSAIDs can interfere with platelet function, they should be used in caution in patients with intracranial haemorrhage and bleeding diathesis.

### **Gastrointestinal**

GI bleeding, ulceration or perforation, which can be fatal, has been reported with all NSAIDs at any time during treatment, with or without warning symptoms or a previous history of serious GI events. Smoking and alcohol use are added risk factors.

The risk of GI bleeding, ulceration or perforation is higher with increasing NSAID doses, in patients with a history of ulcer, particularly if complicated with haemorrhage or perforation (see section 4.3), and in the elderly. These patients should commence treatment on the lowest dose available. Combination therapy with protective agents (e.g. misoprostol or proton pump inhibitors) should be considered for these patients, and also for patients requiring concomitant low dose aspirin, or other drugs likely to increase gastrointestinal risk (see below and section 4.5)

Patients with a history of GI toxicity, particularly when elderly, should report any unusual abdominal symptoms (especially GI bleeding) particularly in the initial stages of treatment.

Caution should be advised in patients receiving concomitant medications which could increase the risk of ulceration or bleeding, such as oral corticosteroids anticoagulants such as warfarin, selective serotonin-reuptake inhibitors or anti-platelet agents; such as aspirin (see section 4.5).

When GI bleeding or ulceration occurs in patients receiving mefenamic acid, the treatment should be withdrawn.

NSAIDs should be given with care to patients with a history of gastrointestinal disease (ulcerative colitis, Crohn's disease) as these conditions may be exacerbated (see section 4.8).

Diarrhoea occasionally occurs following the use of mefenamic acid. Although this may occur soon after starting treatment, it may also occur after several months of continuous use.

The diarrhoea has been investigated in some patients, who have continued the drug in spite of its continued presence; these patients were found to have associated proctocolitis. If diarrhoea does develop, the drug should be withdrawn immediately, and the patient should not receive mefenamic acid again.

#### **SLE and mixed connective tissue disease**

In patients with systemic lupus erythematosus (SLE) and mixed connective tissue disorders there may be an increased risk of aseptic meningitis (see section 4.8).

#### **Skin reactions**

Serious skin reactions, some of them fatal, including exfoliative dermatitis, Stevens Johnson syndrome and toxic epidermal necrolysis, have been reported very rarely in association with the use of NSAIDs (see section 4.8). Patients appear to be at high risk for these reactions, early in the course of therapy; the onset of the reaction occurring in the majority of cases within the first month of treatment. Mefenamic acid should be discontinued at the first appearance of skin rash, mucosal lesions, or any other sign of hypersensitivity.

#### **Blood dyscrasias**

Blood dyscrasias have been reported in association with mefenamic acid. Blood studies should be carried out during long term administration and the appearance of any dyscrasia is an indication to discontinue therapy.

#### **Liver function tests**

Borderline elevations of one or more liver function tests may occur in some patients receiving mefenamic acid. A patient with symptoms and/or signs suggesting liver dysfunction, or in whom an abnormal liver function test has occurred, should have their therapy discontinued. Patients on prolonged therapy

should be kept under surveillance with particular attention to the possibility of liver dysfunction.

### **Female fertility**

The use of Mefenamic acid may impair female fertility and is not recommended in women attempting to conceive. In women who have difficulties conceiving or who are undergoing investigation of infertility, withdrawal of Mefenamic acid should be considered.

In dysmenorrhoea and menorrhagia lack of response to mefenamic acid should alert the physician to investigate other causes.

### **Epilepsy**

Caution should be exercised when treating patients suffering from epilepsy.

In patients who are known or suspected to be poor CYP2C9 metabolisers based on previous history/experience with other CYP2C9 substrates, mefenamic acid should be administered with caution as they may have abnormally high plasma levels due to reduced metabolic clearance (see section 5.2)

### Excipients

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

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

## **4.5 Interaction with other medicinal products and other forms of interaction**

Concurrent therapy with other plasma protein binding drugs may necessitate a modification in dosage.

Other analgesics including cyclooxygenase—2 selective inhibitors: Avoid concomitant use of two or more NSAIDs (including aspirin) as this may increase the risk of adverse effects (see section 4. 4)

Care should be taken in patients treated with an NSAID and any of the following drugs, as interactions have been reported in some patients:

*Anticoagulants:* NSAIDs may enhance the anticoagulant effect such as warfarin (see section 4.4) and the dose of the anticoagulant may need to be reduced. Concurrent administration of mefenamic acid with oral anti-coagulant drugs requires careful prothrombin time monitoring.

It is considered unsafe to take NSAIDs in combination with Warfarin or Heparin unless under direct medical supervision.

The following interactions have been reported with NSAIDs but have not necessarily been associated with Mefenamic Acid 250mg Capsules:

*Lithium:* Decreased elimination of lithium and increased risk of lithium toxicity.

*Anti-platelet agents and selective serotonin reuptake inhibitors (SSRIs):* Increased risk of gastrointestinal bleeding (see section 4.4).

*Antihypertensives and diuretics:* a reduction in antihypertensive and diuretic effect has been observed. Diuretics can increase the nephrotoxicity of NSAIDs.

*ACE inhibitors and angiotensin-II-receptor antagonists:* a reduction in antihypertensive effect and an increased risk of renal impairment especially in elderly patients. Patients should be adequately hydrated and the renal function assessed in the beginning and during concomitant therapy.

*Aminoglycosides:* reduction in renal function in susceptible individuals, decreased elimination of aminoglycoside and increased plasma concentrations.

*Cardiac glycosides:* NSAIDs may exacerbate cardiac failure, reduce GFR and increase plasma of cardiac glycoside levels.

*Ciclosporin:* the risk of nephrotoxicity of ciclosporin may be increased with NSAIDs.

*Corticosteroids:* Increased the risk of gastro-intestinal ulceration or bleeding (see section 4.4)

*Oral hypoglycaemic agents:* inhibition of metabolism of sulfonylurea drugs, prolonged half-life and increased risk of hypoglycaemia.

*Methotrexate:* elimination of the drug can be reduced, resulting in increased plasma levels.

*Mifepristone:* NSAIDs should not be used for 8-12 days after mifepristone administration as NSAIDs can reduce the effect of mifepristone.

*Probenecid:* reduction in metabolism and elimination of NSAIDs and metabolites.

*Quinolone antibiotics:* Animal data indicate that the NSAIDs can increase the risk of convulsions associated with quinolone antibiotics. Patients taking NSAIDs and quinolone may have an increased risk of developing convulsions.

*Tacrolimus:* Possible increased risk of nephrotoxicity when NSAIDs are given with tacrolimus

*Zidovudine*: Increased risk of haematological toxicity when NSAIDs are given with zidovudine. There is evidence of an increased risk of haemarthroses and haematoma in HIV (+) haemophiliacs receiving concurrent treatment with zidovudine

#### **4.6 Fertility, pregnancy and lactation**

##### Pregnancy

NSAIDs should not be used during the third trimester of pregnancy.

Inhibition of prostaglandin synthesis may adversely affect the pregnancy and/or the embryo/foetal development. Data from epidemiological studies suggest an increased risk of miscarriage and of cardiac malformation and gastroschisis after use of a prostaglandin synthesis inhibitor in early pregnancy. The absolute risk for cardiovascular malformation was increased from less than 1%, up to approximately 1.5 %. The risk is believed to increase with dose and duration of therapy. In animals, administration of a prostaglandin synthesis inhibitor has been shown to result in increased pre- and post-implantation loss and embryo-foetal lethality. In addition, increased incidences of various malformations, including cardiovascular, have been reported in animals given a prostaglandin synthesis inhibitor during the organogenetic period.

From the 20th week of pregnancy onward, Mefenamic acid use may cause oligohydramnios resulting from foetal renal dysfunction. This may occur shortly after treatment initiation and is usually reversible upon discontinuation. In addition, there have been reports of ductus arteriosus constriction following treatment in the second trimester, most of which resolved after treatment cessation. Therefore, during the first and second trimester of pregnancy, Mefenamic acid should not be given unless clearly necessary. If Mefenamic acid is used by a woman attempting to conceive, or during the first and second trimester of pregnancy, the dose should be kept as low and duration of treatment as short as possible. Antenatal monitoring for oligohydramnios and ductus arteriosus constriction should be considered after exposure to Mefenamic acid for several days from gestational week 20 onward. Mefenamic acid should be discontinued if oligohydramnios or ductus arteriosus constriction are found.

During the third trimester of pregnancy, all prostaglandin synthesis inhibitors may expose the foetus to:

- cardio pulmonary toxicity (premature constriction/ closure of the ductus arteriosus and pulmonary hypertension);
- renal dysfunction, which may progress to renal failure with oligohydroamniosis (see above);

the mother and the neonate, at the end of pregnancy, to:

- possible prolongation of bleeding time, an anti-aggregating effect which may occur even at very low doses.
- inhibition of uterine contractions resulting in delayed or prolonged labour.

Consequently, Mefenamic acid is contraindicated during the third trimester of pregnancy (see sections 4.3).

#### Breast-feeding

Trace amounts of mefenamic acid may be present in breast milk and transmitted to the nursing infant. Therefore, mefenamic acid should not be taken by nursing mothers.

#### Fertility

*No data available*

See section 4.4 Special warnings and precautions for use, regarding female fertility.

### **4.7 Effects on ability to drive and use machines**

Undesirable effects such as dizziness, drowsiness, fatigue and visual disturbances are possible after taking NSAIDs. If affected, patients should not drive or operate machinery.

### **4.8 Undesirable effects**

General description

The most frequently reported side effects associated with mefenamic acid involve the gastrointestinal tract. Diarrhoea appears to be the most common side effect and is usually dose-related. It generally subsides on dosage reduction, and rapidly disappears on termination of therapy. Some patients may not be able to continue therapy.

Adverse reactions are listed below according to system organ class and frequency. Frequencies are defined according to the following convention:

Very common ( $\geq 1/10$ ), Common ( $\geq 1/100$  to  $< 1/10$ ), Uncommon ( $\geq 1/1,000$  to  $< 1/100$ ), Rare ( $\geq 1/10,000$  to  $< 1/1,000$ ), Very rare ( $< 1/10,000$ ) and Not known (cannot be estimated from the available data)

#### *Blood and the lymphatic system disorders:*

Frequency not known: Haemolytic anaemia<sup>†</sup>, anaemia, hypoplasia bone marrow, haematocrit decreased, thrombocytopenic purpura, leukopenia with a risk of infection, sepsis, disseminated intravascular coagulation, agranulocytosis, aplastic anaemia, eosinophilia, neutropenia, pancytopenia, thrombocytopenia.

<sup>†</sup> Haemolytic anaemia reversible when mefenamic acid is stopped. Reports are associated with 12 months of mefenamic acid therapy.

*Immune system disorders:*

Frequency not known: Hypersensitivity†, fixed drug eruption

† Hypersensitivity reactions have been reported following treatment with NSAIDs. These may consist of (a) non-specific allergic reaction and anaphylaxis, (b) respiratory tract reactivity or (c) assorted skin disorders

*Metabolism and nutrition disorders:*

Frequency not known: Glucose intolerance impaired†, hyponatraemia.

† in diabetic patients

*Psychiatric disorders:*

Frequency not known: Confusion, depression, hallucinations, nervousness.

*Nervous system disorders:*

Frequency not known: Optic neuritis, headaches, paraesthesia, dizziness, drowsiness, meningitis aseptic†, blurred vision, convulsions, insomnia.

† Especially in patients with existing auto-immune disorders, such as systemic lupus erythematosus, mixed connective tissue disease) with symptoms such as stiff neck, headache, nausea, vomiting, fever or disorientation (see section 4.4).

*Eye disorders:* Frequency not known: Eye irritation, colour blindness, visual impairment.

*Ear and labyrinth disorders:*

Frequency not known: Ear pain, tinnitus, vertigo.

*Cardiac disorders:*

Frequency not known: Palpitations, dyspnoea, oedema, hypertension, hypotension and cardiac failure.†

†Clinical trial and epidemiological data suggest that use of some NSAIDs (particularly at high doses and in long term treatment) may be associated with an increased risk of arterial thrombotic events (for example myocardial infarction or stroke) (see section 4.4)

*Respiratory, thoracic and mediastinal disorders:*

Frequency not known: Asthma, dyspnoea.

*Gastrointestinal disorders:*

Frequency not known: Peptic ulcer†, gastrointestinal perforation, gastrointestinal haemorrhage††, nausea, vomiting, diarrhoea†††, flatulence, constipation, dyspepsia, abdominal pain, melaena, haematemesis, mouth ulceration, colitis, Crohn's disease (See section 4.4), gastritis, anorexia nervosa, enterocolitis, pancreatitis and steatorrhea.

† Gastric ulceration with or without haemorrhage,

†† Gastrointestinal perforation or GI bleeding, sometimes fatal, particularly in the elderly, may occur (see section 4.4). Elderly or debilitated patients seem to tolerate gastrointestinal ulceration or bleeding less well than other individuals and most spontaneous reports of fatal GI events are in this population.

††† Diarrhoea occasionally occurs following the use of mefenamic acid. Although this may occur soon after starting treatment, it may also occur after several months of continuous use. The diarrhoea has been investigated in some patients who have continued this drug in spite of its continued presence. These patients were found to have associated proctocolitis. If diarrhoea does develop the drug should be withdrawn immediately and this patient should not receive mefenamic acid again.

#### *Hepatobiliary disorders:*

Frequency not known: liver function test abnormal, jaundice cholestatic, hepatotoxicity, hepatitis, hepatorenal syndrome.

#### *Skin and subcutaneous tissue disorders:*

Frequency not known: Angioedema, laryngeal oedema, erythema multiforme, face oedema, toxic epidermal necrolysis, Stevens-Johnson syndrome, erythema multiforme, rash, photosensitivity reaction, pruritus and urticaria.

#### *Renal and urinary disorders:*

Frequency not known: glomerulonephritis, Tubulointerstitial nephritis, dysuria, haematuria, nephrotic syndrome, acute renal failure†, proteinuria, renal failure including renal papillary necrosis.

† Non oliguric renal failure particularly in dehydration. Renal toxicity has been seen in patients with pre-renal conditions leading to a reduction in renal blood flow or blood volume. Patients at greatest risk of this reaction are those with impaired renal function, heart failure, liver dysfunction, those taking diuretics and the elderly.

#### *General disorders and administration site conditions:*

Frequency not known: Fatigue, malaise, multi-organ failure, pyrexia, hyperhydrosis.

#### *Investigations:*

Frequency not known: Total bile acids increased†

† A positive reaction in certain tests for bile in the urine of patients receiving Mefenamic acid has been demonstrated to be due to the presence of the drug and its metabolites and not to the presence of bile.

#### 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](http://www.mhra.gov.uk/yellowcard) or search for MHRA Yellow Card in the Google Play or Apple App Store.

## **4.9 Overdose**

It is important that the recommended dose is not exceeded, and the regime adhered to since some reports have involved daily dosages under 3g.

#### Symptoms

Symptoms include headache, nausea, vomiting, epigastric pain, gastrointestinal bleeding, rarely diarrhoea, disorientation, excitation, coma, drowsiness, dizziness, tinnitus, fainting, occasionally convulsions. In cases of significant poisoning acute renal failure and liver damage are possible.

Mefenamic acid has a tendency to induce tonic-clonic (grand mal) convulsion in overdose.

#### Management

Patients should be treated symptomatically as required.

Within one hour of ingestion of a potentially toxic amount, activated charcoal should be considered.

Activated charcoal has been shown to be a powerful adsorbent for mefenamic acid and its metabolites. Studies in experimental animals and humans showed that a 5 to 1 ratio of charcoal to mefenamic acid resulted in considerable suppression of absorption of the drug. Alternatively, in adults, gastric lavage should be considered within one hour of ingestion of a potentially life-threatening overdose. Gastric lavage in the conscious patient and intensive supportive therapy where necessary.

Good urine output should be ensured.

Renal and liver function should be closely monitored.

Patients should be observed for at least four hours after ingestion of potentially toxic amounts.

Frequent or prolonged convulsions should be treated with Intravenous diazepam. Other measures may be indicated by the patient's clinical condition.

Haemodialysis is of little value since mefenamic acid and its metabolites are firmly bound to plasma proteins.

## **5 PHARMACOLOGICAL PROPERTIES**

### **5.1 Pharmacodynamic properties**

Pharmacotherapeutic group: Non-steroidal anti-inflammatory agent with analgesic and anti-pyretic properties, ATC code: M01AG01

Prostaglandins are implicated in a number of disease processes including inflammation, modulation of the pain response, dysmenorrhoea, menorrhagia and pyrexia.

#### Mechanism of action

In common with most NSAIDs mefenamic acid inhibits the action of prostaglandin synthetase (cyclo oxygenase). This results in a reduction in the rate of prostaglandin synthesis and reduced prostaglandin levels.

#### Pharmacodynamic effects

The anti-inflammatory activity of NSAIDs in the rat paw oedema test has been correlated with their ability to inhibit prostaglandin synthetase. When mefenamic acid is ranked in both these tests it falls between indomethacin and phenylbutazone and it is probable that inhibition of prostaglandin synthesis contributes to the pharmacological activity and clinical efficacy of mefenamic acid.

There is also considerable evidence that the fenamates inhibit the action of prostaglandins after they have been formed. They therefore both inhibit the synthesis and response to prostaglandins. This double blockade may well be important in their mode of action.

### **5.2 Pharmacokinetic properties**

Following oral administration, mefenamic acid is absorbed rapidly and is excreted both in urine and faeces, the half life in plasma is approximately 2 to 4 hours.

#### Absorption and Distribution

Mefenamic acid is absorbed from the gastro intestinal tract. Peak levels of 10 mg/l occur two hours after the administration of a 1g oral dose to adults.

### Biotransformation

Mefenamic acid is extensively metabolised, first to A3 hydroxymethyl derivative (metabolite I) and then A3 carboxyl derivative (metabolite II). Both metabolites undergo secondary conjugation to form glucuronides.

Therefore in patients who are known or suspected to be poor CYP2C9 metabolisers based on previous history/experience with other CYP2C9 substrates, mefenamic acid should be administered with caution as they may have abnormally high plasma levels due to reduced metabolic clearance.

### Elimination

Fifty two percent of a dose is recovered from the urine, 6% as mefenamic acid, 25% as metabolite I and 21% as metabolite II. Assay of stools over a 3 day period accounted for 10-20% of the dose chiefly as unconjugated metabolite II.

The plasma levels of unconjugated mefenamic acid decline with a half life of approximately two hours.

### **5.3 Preclinical safety data**

No further relevant information other than that which is included in other sections of the Summary of Product Characteristics.

## **6 PHARMACEUTICAL PARTICULARS**

### **6.1 List of excipients**

Maize Starch

Lactose

Purified Water

Magnesium Stearate

Sodium Starch Glycollate

Sodium Lauryl Sulphate

### **6.2 Incompatibilities**

Not applicable

### **6.3 Shelf life**

3 years.

**6.4 Special precautions for storage**

Store below 25°C.

Protect from light

**6.5 Nature and contents of container**

Polypropylene securitainers with tamper evident polypropylene caps.

Pack size: 50, 84, 100, 168 and 500 capsules.

Not all pack sizes may be marketed.

**6.6 Special precautions for disposal**

No special requirements for disposal.

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

**7 MARKETING AUTHORISATION HOLDER**

Mercury Pharmaceuticals Ltd,  
Dashwood House, 69 Old Broad Street, London,  
EC2M 1QS, United Kingdom

**8 MARKETING AUTHORISATION NUMBER(S)**

PL 12762/0121

**9 DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUTHORISATION**

Date of first authorisation: 25/07/2001

Date of latest renewal: 12/03/2009

**10 DATE OF REVISION OF THE TEXT**

09/09/2024