

SUMMARY OF PRODUCT CHARACTERISTICS

1 NAME OF THE MEDICINAL PRODUCT

Adalat LA 30 mg prolonged-release tablets

2 QUALITATIVE AND QUANTITATIVE COMPOSITION

Each prolonged-release tablet contains 30 mg nifedipine.

Each tablet contains a 10% overage of nifedipine to deliver the label claim.

Excipient with known effect: Sodium chloride, each 30 mg tablet contains 9.4 mg of sodium (see section 4.4).

For the full list of excipients, see section 6.1.

3 PHARMACEUTICAL FORM

Prolonged-release film-coated tablet.

Pink, round, convex tablet with a laser hole on one side and marked with Adalat 30.

4. CLINICAL PARTICULARS

4.1. Therapeutic indications

For the treatment of all grades of hypertension.

For the prophylaxis of chronic stable angina pectoris either as monotherapy or in combination with a beta-blocker.

4.2 Posology and method of administration

Posology

In mild to moderate hypertension, the recommended initial dose is one 20 mg tablet once-daily. In severe hypertension, the recommended initial dose is one 30 mg tablet once-daily. If necessary, the dosage can be increased according to individual requirements up to a maximum of 90 mg once-daily.

For the prophylaxis of angina pectoris, the recommended initial dose is one 30 mg tablet once-daily. The dosage can be increased according to individual requirements up to a maximum of 90 mg once-daily.

Patients in whom hypertension or anginal symptoms are controlled on Adalat capsules or Adalat retard may be safely switched to Adalat LA. Prophylactic anti-anginal efficacy is maintained when patients are switched from other calcium antagonists such as diltiazem or verapamil to Adalat LA. Patients switched from other calcium antagonists should initiate therapy at the recommended initial dose of 30 mg Adalat LA once-daily. Subsequent titration to a higher dose may be initiated as warranted clinically.

Co-administration with CYP 3A4 inhibitors or CYP 3A4 inducers may result in the recommendation to adapt the nifedipine dose or not to use nifedipine at all (see section 4.5).

Duration of treatment

Treatment may be continued indefinitely.

Additional information on special populations

Paediatric population

The safety and efficacy of Adalat LA in children below 18 years has not been established. Currently available data for the use of nifedipine in hypertension are described in section 5.1

Elderly

Based on pharmacokinetic data for Adalat LA no dose adaptation in elderly people above 65 years is necessary.

Renal impairment

Based on pharmacokinetic data, no dosage adjustment is required in patients with renal impairment (see section 5.2).

Method of administration

Oral use.

The tablets should be swallowed whole with a glass of water, either with or without food. The tablets should be taken at approximately 24-hour intervals, i.e. at the same time each day, preferably during the morning. Adalat LA tablets must be swallowed whole; under no circumstances should they be bitten, chewed or broken up.

Adalat LA should not be taken with grapefruit juice (see section 4.5).

4.3 Contraindications

Adalat LA should not be administered to patients with known hypersensitivity to the active substance, or to other dihydropyridines because of the theoretical risk of cross-reactivity, or to any of the excipients listed in section 4.4 and 6.1.

Adalat LA should not be used in cases of cardiogenic shock, clinically significant aortic stenosis, unstable angina, or during or within one month of a myocardial infarction.

Adalat LA should not be used for the treatment of acute attacks of angina.

The safety of Adalat LA in malignant hypertension has not been established.

Adalat LA should not be used for secondary prevention of myocardial infarction.

Owing to the duration of action of the formulation, Adalat LA should not be administered to patients with hepatic impairment.

Adalat LA should not be administered to patients with a history of gastro-intestinal obstruction, oesophageal obstruction, or any degree of decreased lumen diameter of the gastro-intestinal tract.

Adalat LA must not be used in patients with a Kock pouch (ileostomy after proctocolectomy).

Adalat LA is contra-indicated in patients with inflammatory bowel disease or Crohn's disease.

Adalat LA should not be administered concomitantly with rifampicin since effective plasma levels of nifedipine may not be achieved owing to enzyme induction (see section 4.5).

4.4 Special warnings and precautions for use

Adalat LA tablets must be swallowed whole; under no circumstances should they be bitten, chewed or broken up.

Caution should be exercised in patients with hypotension as there is a risk of further reduction in blood pressure and care must be exercised in patients with very low blood pressure (severe hypotension with systolic blood pressure less than 90 mm Hg).

Adalat LA should not be used during pregnancy unless the clinical condition of the woman requires treatment with nifedipine. Adalat LA should be reserved for women with severe hypertension who are unresponsive to standard therapy (see section 4.6).

Careful monitoring of blood pressure must be exercised when administering nifedipine with I.V. magnesium sulfate, owing to the possibility of an excessive fall in blood pressure, which could harm both mother and foetus. For further information regarding use in pregnancy, refer to section 4.6.

In patients with impaired liver function careful monitoring and, in severe cases, a dose reduction may be necessary.

Adalat LA may be used in combination with beta-blocking drugs and other antihypertensive agents but the possibility of an additive effect resulting in postural hypotension should be borne in mind. Adalat LA will not prevent possible rebound effects after cessation of other antihypertensive therapy.

Adalat LA should be used with caution in patients whose cardiac reserve is poor. Deterioration of heart failure has occasionally been observed with nifedipine.

Diabetic patients taking Adalat LA may require adjustment of their control.

In dialysis patients with malignant hypertension and hypovolaemia, a marked decrease in blood pressure can occur.

Nifedipine is metabolised via the cytochrome P450 3A4 system. Drugs that are known to either inhibit or to induce this enzyme system may therefore alter the first pass or the clearance of nifedipine (see section 4.5).

Drugs, which are known inhibitors of the cytochrome P450 3A4 system, and which may therefore lead to increased plasma concentrations of nifedipine include, for example:

- macrolide antibiotics (e.g., erythromycin)
- anti-HIV protease inhibitors (e.g., ritonavir)
- azole antimycotics (e.g., ketoconazole)
- the antidepressants, nefazodone and fluoxetine
- quinupristin/dalfopristin
- valproic acid
- cimetidine

Upon co-administration with these drugs, the blood pressure should be monitored and, if necessary, a reduction of the nifedipine dose should be considered.

As the outer membrane of the Adalat LA tablet is not digested, what appears to be the complete tablet may be seen in the toilet or associated with the patient's stools. Also, as a result of this, care should be exercised when administering Adalat LA to patients, as obstructive symptoms may occur. Bezoars can occur in very rare cases and may require surgical intervention.

In single cases, obstructive symptoms have been described without known history of gastrointestinal disorders.

A false positive effect may be experienced when performing a barium contrast x-ray.

For use in special populations see section 4.2.

Adalat LA contains sodium

Adalat LA 30 contains 9.4 mg of sodium. Increasing the daily dose to 90 mg nifedipine results in an intake of 28.2 mg sodium. This is equivalent to 1.41 % of the WHO recommended maximum daily dietary intake of 2 g sodium for an adult.

4.5. Interactions with other medicinal products and other forms of interaction

Drugs that affect nifedipine

Nifedipine is metabolised via the cytochrome P450 3A4 system, located both in the intestinal mucosa and in the liver. Drugs that are known to either inhibit or to induce this enzyme system may therefore alter the first pass (after oral administration) or the clearance of nifedipine.

The extent as well as the duration of interactions should be taken into account when administering nifedipine together with the following drugs:

Rifampicin: Rifampicin strongly induces the cytochrome P450 3A4 system. Upon co-administration with rifampicin, the bioavailability of nifedipine is distinctly reduced and thus its efficacy weakened. The use of nifedipine in combination with rifampicin is therefore contraindicated (see Section 4.3).

Upon co-administration of known inhibitors of the cytochrome P450 3A4 system, the blood pressure should be monitored and, if necessary, a reduction in the nifedipine dose considered (see Sections 4.2 and 4.4). In the majority of these cases, no formal studies to assess the potential for a drug interaction between nifedipine and the drug(s) listed have been undertaken, thus far.

Drugs increasing nifedipine exposure:

- *macrolide antibiotics (e.g. erythromycin)*
- *anti-HIV protease inhibitors (e.g. ritonavir)*
- *azole anti-mycotics (e.g., ketoconazole)*
- *fluoxetine*
- *nefazodone*
- *quinupristin/dalfopristin*
- *cisapride*
- *valproic acid*
- *cimetidine*
- *diltiazem*

Upon co-administration of inducers of the cytochrome P450 3A4 system, the clinical response to nifedipine should be monitored and, if necessary, an increase in the nifedipine dose considered. If the dose of nifedipine is increased during co-administration of both drugs, a reduction of the nifedipine dose should be considered when the treatment is discontinued.

Drugs decreasing nifedipine exposure:

- *rifampicin (see above)*
- *phenytoin*
- *carbamazepine*
- *phenobarbital*

Effects of nifedipine on other drugs

Nifedipine may increase the blood pressure lowering effect of concomitant applied antihypertensives.

When nifedipine is administered simultaneously with β -receptor blockers the patient should be carefully monitored, since deterioration of heart failure is also known to develop in isolated cases.

Digoxin: The simultaneous administration of nifedipine and digoxin may lead to reduced digoxin clearance and, hence, an increase in the plasma digoxin level. The patient should therefore be subjected to precautionary checks for symptoms of digoxin overdosage and, if necessary, the glycoside dose should be reduced.

Quinidine: Co-administration of nifedipine with quinidine may lower plasma quinidine levels, and after discontinuation of nifedipine, a distinct increase in plasma quinidine levels may be observed in individual cases. Consequently, when nifedipine is either additionally administered or discontinued, monitoring of the quinidine plasma concentration, and if necessary, adjustment

of the quinidine dose are recommended. Blood pressure should be carefully monitored and, if necessary, the dose of nifedipine should be decreased.

Tacrolimus: Tacrolimus is metabolised via the cytochrome P450 3A4 system. Published data indicate that the dose of tacrolimus administered simultaneously with nifedipine may be reduced in individual cases. Upon co-administration of both drugs, the tacrolimus plasma concentrations should be monitored and, if necessary, a reduction in the tacrolimus dose considered.

Drug food interactions

Grapefruit juice inhibits the cytochrome P450 3A4 system. Administration of nifedipine together with grapefruit juice thus results in elevated plasma concentrations and prolonged action of nifedipine due to a decreased first pass metabolism or reduced clearance. As a consequence, the blood pressure lowering effect of nifedipine may be increased. After regular intake of grapefruit juice, this effect may last for at least three days after the last ingestion of grapefruit juice. Ingestion of grapefruit/grapefruit juice is therefore to be avoided while taking nifedipine (see Section 4.2).

Other forms of interaction

Nifedipine may increase the spectrophotometric values of urinary vanillylmandelic acid, falsely. However, HPLC measurements are unaffected.

4.6 Fertility, pregnancy and lactation

Pregnancy

Nifedipine should not be used during pregnancy unless the clinical condition of the woman requires treatment with nifedipine (see section 4.4).

In animal studies, nifedipine has been shown to produce embryotoxicity, foetotoxicity and teratogenicity (see section 5.3).

There are no adequate well controlled studies in pregnant women.

From the clinical evidence available a specific prenatal risk has not been identified, although an increase in perinatal asphyxia, caesarean delivery, as well as prematurity and intrauterine growth retardation have been reported. It is unclear whether these reports are due to the underlying hypertension, its treatment, or to a specific drug effect.

The available information is inadequate to rule out adverse drug effects on the unborn and newborn child. Therefore any use in pregnancy requires a very careful individual risk benefit assessment and should only be considered if all other treatment options are either not indicated or have failed to be efficacious.

Acute pulmonary oedema has been observed when calcium channel blockers, among others nifedipine, have been used as a tocolytic agent during pregnancy (see section 4.8), especially in cases of multiple pregnancy (twins or more), with the intravenous route and/or concomitant use of beta-2 agonists.

Breast-feeding

Nifedipine is excreted in the breast milk. Clinical evidence indicates that breastfed infants receive a small fraction of the maternal nifedipine dose. There are no safety and efficacy data from well-controlled studies in breastfeeding women. Limited clinical evidence suggests no specific safety concerns, but patients should be advised of signs of low blood pressure in the infant and to talk to their doctor if they have concerns. Decisions on whether to breastfeed during treatment or to abstain from nifedipine therapy should take into account the benefit of breastfeeding for the child and the benefit of therapy for the woman.

Fertility

In single cases of *in vitro* fertilisation calcium antagonists like nifedipine have been associated with reversible biochemical changes in the spermatozoa's head section that may result in impaired sperm function. In those men who are repeatedly unsuccessful in fathering a child by *in vitro* fertilisation, and where no other explanation can be found, calcium antagonists like nifedipine should be considered as possible causes.

4.7 Effects on ability to drive and use machines

Reactions to the drug, which vary in intensity from individual to individual, may impair the ability to drive or to operate machinery (see Section 4.8). This applies particularly at the start of treatment, on changing the medication and in combination with alcohol.

4.8 Undesirable effects

Adverse drug reactions (ADRs) based on placebo-controlled studies with nifedipine sorted by CIOMS III categories of frequency (clinical trial data base: nifedipine n = 2,661; placebo n = 1,486; status: 22 Feb 2006 and the ACTION study: nifedipine n = 3,825; placebo n = 3,840) are listed below:

ADRs listed under "common" were observed with a frequency below 3% with the exception of oedema (9.9%) and headache (3.9%).

The frequencies of ADRs reported with nifedipine-containing products are summarised in the table below. Within each frequency grouping, undesirable effects are presented in order of decreasing seriousness. Frequencies are defined as common ($\geq 1/100$ to $< 1/10$), uncommon ($\geq 1/1,000$ to $< 1/100$) and rare ($\geq 1/10,000$ to $< 1/1,000$). The ADRs identified only during the ongoing postmarketing surveillance, and for which a frequency could not be estimated, are listed under "Not known".

System Organ Class (MedDRA)	Common	Uncommon	Rare	Not Known
Blood and Lymphatic System Disorders				Agranulocytosis Leucopenia
Immune System Disorders		Allergic reaction Allergic oedema/angioedema (incl. larynx oedema*)	Pruritus Urticaria Rash	Anaphylactic/ anaphylactoid reaction
Psychiatric Disorders		Anxiety reactions Sleep disorders		Depression
Metabolism and				Hyperglycaemia

System Organ Class (MedDRA)	Common	Uncommon	Rare	Not Known
Nutrition Disorders				
Nervous System Disorders	Headache	Vertigo Migraine Dizziness Tremor	Par- /Dysaesthesia	Hypoaesthesia Somnolence
Eye Disorders		Visual disturbances		Eye pain
Cardiac Disorders		Tachycardia Palpitations		Chest pain (Angina pectoris)
Vascular Disorders	Oedema (incl. peripheral oedema) Vasodilatation	Hypotension Syncope		
Respiratory, Thoracic, and Mediastinal Disorders		Nosebleed Nasal congestion		Dyspnoea Pulmonary oedema**
Gastrointestinal Disorders	Constipation	Gastrointestinal and abdominal pain Nausea Dyspepsia Flatulence Dry mouth	Gingival hyperplasia	Bezoar Dysphagia Intestinal obstruction Intestinal ulcer Vomiting Gastroesophageal sphincter insufficiency
Hepatobiliary Disorders		Transient increase in liver enzymes		Jaundice
Skin and Subcutaneous Tissue Disorders		Erythema		Toxic Epidermal Necrolysis Photosensitivity allergic reaction Palpable purpura
Musculoskeletal and Connective Tissue Disorders		Muscle cramps Joint swelling		Arthralgia Myalgia
Renal and Urinary Disorders		Polyuria Dysuria		
Reproductive System and Breast Disorders		Erectile dysfunction		
General Disorders and Administration Site Conditions	Feeling unwell	Unspecific pain Chills		

* = may result in life-threatening outcome

**cases have been reported when used as tocolytic during pregnancy (see section 4.6)

In dialysis patients with malignant hypertension and hypovolaemia a distinct fall in blood pressure can occur as a result of vasodilation.

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 at: www.mhra.gov.uk/yellowcard.

4.9 Overdose

Symptoms

The following symptoms are observed in cases of severe nifedipine intoxication: Disturbances of consciousness to the point of coma, a drop in blood pressure, tachycardia, bradycardia, hyperglycaemia, metabolic acidosis, hypoxia, cardiogenic shock with pulmonary oedema.

Treatment

As far as treatment is concerned, elimination of nifedipine and the restoration of stable cardiovascular conditions have priority. Elimination must be as complete as possible, including the small intestine, to prevent the otherwise inevitable subsequent absorption of the active substance.

The benefit of gastric decontamination is uncertain.

1. Consider activated charcoal (50 g for adults, 1 g/kg for children) if the patient presents within 1 hour of ingestion of a potentially toxic amount.

Although it may seem reasonable to assume that late administration of activated charcoal may be beneficial for sustained release (SR, MR) preparations there is no evidence to support this.

2. Alternatively consider gastric lavage in adults within 1 hour of a potentially life-threatening overdose.
3. Consider further doses of activated charcoal every 4 hours if a clinically significant amount of a sustained release preparation has been ingested with a single dose of an osmotic laxative (e.g. sorbitol, lactulose or magnesium sulfate).
4. Asymptomatic patients should be observed for at least 4 hours after ingestion and for 12 hours if a sustained release preparation has been taken.

Haemodialysis serves no purpose as nifedipine is not dialysable, but plasmapheresis is advisable (high plasma protein binding, relatively low volume of distribution).

Hypotension as a result of cardiogenic shock and arterial vasodilatation can be treated with calcium (10-20 ml of a 10 % calcium gluconate solution administered intravenously over 5-10 minutes). If the effects are inadequate, the treatment can be continued, with ECG monitoring. If an insufficient increase in blood pressure is achieved with calcium, vasoconstricting sympathomimetics such as dopamine or noradrenaline should be administered. The dosage of these drugs should be determined by the patient's response.

Symptomatic bradycardia may be treated with atropine, beta-sympathomimetics or a temporary cardiac pacemaker, as required.

Additional fluids should be administered with caution to avoid cardiac overload.

5 PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: selective calcium channel blockers with mainly vascular effect, dihydropyridine derivatives, ATC code: C08CA05

Nifedipine is a calcium antagonist of the 1,4-dihydropyridine type. Calcium antagonists reduce the transmembranal influx of calcium ions through the slow calcium channel into the cell. As a specific and potent calcium antagonist, nifedipine acts particularly on the cells of the myocardium and the smooth muscle cells of the coronary arteries and the peripheral resistance vessels. The main action of nifedipine is to relax arterial smooth muscle, both in the coronary and peripheral circulation. The Adalat LA tablet is formulated to achieve controlled delivery of nifedipine in a release profile sufficient to enable once-daily administration to be effective in clinical use.

In hypertension, the main action of nifedipine is to cause peripheral vasodilatation and thus reduce peripheral resistance. Nifedipine administered once-daily provides 24-hour control of raised blood pressure. Nifedipine causes reduction in blood pressure such that the percentage lowering is proportional to its initial level. In normotensive individuals, nifedipine has little or no effect on blood pressure.

In angina, Adalat LA reduces peripheral and coronary vascular resistance, leading to an increase in coronary blood flow, cardiac output and stroke volume, whilst decreasing after-load. Additionally, nifedipine dilates submaximally both clear and atherosclerotic coronary arteries, thus protecting the heart against coronary artery spasm and improving perfusion to the ischaemic myocardium. Nifedipine reduces the frequency of painful attacks and the ischaemic ECG changes irrespective of the relative contribution from coronary artery spasm or atherosclerosis.

In a multi-national, randomised, double-blind, prospective study involving 6321 hypertensive patients with at least one additional risk factor followed over 3 to 4.8 years, Adalat LA 30 and 60 (nifedipine GITS) were shown to reduce blood pressure to a comparable degree as a standard diuretic combination.

Paediatric population

Limited information on comparison of nifedipine with other antihypertensives is available for both acute hypertension and long-term hypertension with different formulations in different dosages. Antihypertensive effects of nifedipine have been demonstrated but dose recommendations, long term safety and effect on cardiovascular outcome remain unestablished. Pediatric dosing forms are lacking.

5.2 Pharmacokinetic properties

General characteristics:

Adalat LA tablets are formulated to provide nifedipine at an approximately constant rate over 24 hours. Nifedipine is released from the tablet at a zero-order rate by a membrane-controlled, osmotic push-pull process. The pharmacokinetic profile of this formulation is characterized by low peak-trough fluctuation. 0-24 hour plasma concentration versus time profiles at steady state are plateau-like, rendering the Adalat LA tablet appropriate for once-a-day administration.

The delivery rate is independent of gastrointestinal pH or motility. Upon swallowing, the biologically inert components of the tablet remain intact during gastrointestinal transit and are eliminated in the faeces as an insoluble shell.

Absorption

Orally administered nifedipine is almost completely absorbed in the gastro-intestinal tract. The systemic availability of orally administered nifedipine immediate release formulations (nifedipine capsules) is 45–56% owing to a first pass effect. At steady-state, the bioavailability of Adalat LA tablets ranges from 68-86% relative to Adalat capsules. Administration in the presence of food slightly alters the early rate of absorption but does not influence the extent of drug availability.

Distribution

Nifedipine is about 95% bound to plasma protein (albumin). The distribution half-life after intravenous administration has been determined to be 5 to 6 minutes.

Biotransformation

After oral administration, nifedipine is metabolised in the gut wall and in the liver, primarily by oxidative processes. These metabolites show no pharmacodynamic activity. Nifedipine is eliminated in the form of its metabolites, predominantly via the kidneys, with approximately 5-15% being excreted via the bile in the faeces. Non-metabolised nifedipine can be detected only in traces (below 0.1%) in the urine.

Elimination

The terminal elimination half-life is 1.7 to 3.4 h in conventional formulations (nifedipine capsules). The terminal half-life following Adalat LA administration does not represent a meaningful parameter as a plateau-like plasma concentration is maintained during release from the tablets and absorption. After release and absorption of the last dose the plasma concentration finally declines with an elimination half-life as seen in conventional formulations.

Characteristics in patients:

There are no significant differences in the pharmacokinetics of nifedipine between healthy subjects and subjects with renal impairment. Therefore, dosage adjustment is not needed in these patients.

In patients with hepatic impairment, the elimination half-life is distinctly prolonged and the total clearance is reduced. Owing to the duration of action of the formulation, Adalat LA should not be administered in these patients.

5.3 Preclinical safety data

Preclinical data reveal no special hazards for humans based on conventional studies of single and repeated dose toxicity, genotoxicity and carcinogenic potential.

Following acute oral and intravenous administration of nifedipine in various animal species, the following LD₅₀ (mg/kg) values were obtained:

Mouse:	Oral: 494 (421-572)*;	i.v.: 4.2 (3.8-4.6)*.
Rat:	Oral: 1022 (950-1087)*;	i.v.: 15.5 (13.7-17.5)*.
Rabbit:	Oral: 250-500;	i.v.: 2-3.
Cat:	Oral: ~ 100;	i.v.: 0.5-8.
Dog:	Oral: > 250;	i.v.: 2-3.

* 95% confidence interval.

In subacute and subchronic toxicity studies in rats and dogs, nifedipine was tolerated without damage at doses of up to 50 mg/kg (rats) and 100 mg/kg (dogs) p.o. over periods of thirteen and four weeks, respectively. Following intravenous administration, dogs tolerated up to 0.1 mg/kg nifedipine for six days without damage. Rats tolerated daily intravenous administration of 2.5 mg/kg nifedipine over a period of three weeks without damage.

In chronic toxicity studies in dogs with treatment lasting up to one year, nifedipine was tolerated without damage at doses up to and including 100 mg/kg p.o. In rats, toxic effects occurred at concentrations above 100 ppm in the feed (approximately 5-7 mg/kg bodyweight).

In a carcinogenicity study in rats (two years), there was no evidence of a carcinogenic effect of nifedipine.

Nifedipine has been shown to produce teratogenic findings in rats, mice and rabbits, including digital anomalies, malformation of the extremities, cleft palates, cleft sternum and malformation of the ribs.

Digital anomalies and malformation of the extremities are possibly a result of compromised uterine blood flow, but have also been observed in animals treated with nifedipine solely after the end of the organogenesis period.

Nifedipine administration was associated with a variety of embryotoxic, placentotoxic and foetotoxic effects, including stunted foetuses (rats, mice, rabbits), small placentas and underdeveloped chorionic villi (monkeys), embryonic and foetal deaths (rats, mice, rabbits) and prolonged pregnancy/decreased neonatal survival (rats; not evaluated in other species). The risk to humans cannot be ruled out if a sufficiently high systemic exposure is achieved, however, all of the doses associated with the teratogenic, embryotoxic or foetotoxic effects in animals were maternally toxic and were several times the recommended maximum dose for humans.

In *in vitro* and *in vivo* tests, nifedipine has not been associated with mutagenic properties.

6 PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Tablet Core

Polyethylene oxide
Hypromellose (5 cp)
Magnesium stearate
Sodium chloride
Ferric oxide, red (E172)

Coating

Cellulose acetate
Macrogol (3350)
Hydroxypropylcellulose
Hypromellose (3 cp)
Propylene glycol
Hypromellose (5 cp)
Titanium dioxide (E171)
Ferric oxide, red (E172)

Polish and Print

Black ink for printing Opacode S-1-17823
(Contains: iron oxide black (E172) and Shellac)

6.2. Incompatibilities

Not applicable.

6.3 Shelf life

PP / Al foil blister packs: 4 years
PVC / PVDC / Al foil blister packs: 3 years

6.4. Special precautions for storage

Store in the original container. The tablets should be protected from strong light. Do not store above 30°C.

6.5 Nature and contents of container

Blister packs composed of PP or PVC / PVDC backed with aluminium foil, containing 28 tablets.

6.6. Instructions for use and handling

No additional information

7 MARKETING AUTHORISATION HOLDER

Bayer plc
400 South Oak Way
Reading
RG2 6AD

8. MARKETING AUTHORISATION NUMBER

PL 00010/0174

9. DATE OF FIRST AUTHORISATION / RENEWAL OF THE AUTHORISATION

Date of first authorisation:	16 March 1992
Date of last renewal:	22 April 1997

10 DATE OF REVISION OF THE TEXT

12/05/2026