SUMMARY OF PRODUCT CHARACTERISTICS

1. NAME OF THE MEDICINAL PRODUCT

Gyrablock 400 mg, film-coated tablets.

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

Each tablet contains 400 mg of norfloxacin.
For the full list of excipients, see section 6.1.

3. PHARMACEUTICAL FORM

Film-coated tablet.
Yellow, capsule shaped, convex, scored on one side, film-coated tablet.

4. CLINICAL PARTICULARS

4.1. Therapeutic indications

- Complicated urinary tract infections (except complicated pyelonephritis)
- Uncomplicated acute pyelonephritis
- Complicated acute cystitis
- Urethritis, including cases due to sensitive *Neisseria gonorrhoeae*
- Epididymorchitis, including cases due to sensitive *Neisseria gonorrhoeae*
- Bacterial prostatitis
- Uncomplicated acute cystitis
  In uncomplicated acute cystitis Gyrablock should be used only when it is considered inappropriate to use other antibacterial agents that are commonly recommended for the treatment of these infections.
- Gonococcal urethritis and cervicitis due to sensitive *Neisseria gonorrhoeae*
- Gastrointestinal tract infections (e.g., traveler's diarrhea)
- Typhoid fever
- Prophylaxis of bacterial infections in neutropenic patients.

Consideration should be given to official guidance on the appropriate use of antibacterial agents.

4.2. Posology and method of administration

Posology

Unless medically indicated otherwise, the recommended dose for adults is 400 mg twice a day.

Dosage and duration of treatment are dependent on the location and severity of the infection.

The Table below specifies the dosage and duration in the usual indications.

In some clinical situations, a test for the susceptibility of the pathological agent to the antibiotic may be indicated.

Indication	*Dosage*	*Duration*
Acute uncomplicated cystitis	400 mg every 12 hours	3-7 days
Acute bacterial prostatitis	400 mg every 12 hours	14-28 days
Chronic bacterial prostatitis	400 mg every 12 hours	4-6 weeks
Epididymorchitis*	400 mg every 12 hours	10-14 days
Complicated urinary tract infections**	400 mg every 12 hours	7-21 days
Gastrointestinal tract infections (e.g., traveler's diarrhea)	400 mg every 12 hours	5 days
Gonococcal urethritis and cervicitis due to sensitive *Neisseria gonorrhoeae****	800 mg	Single dose
Typhoid fever*****	400 mg every 8 hours	14 days
Prophylaxis of bacterial infections in neutropenic patients	400 mg every 8 hours	The duration of neutropenia******

*Not to be used if *Chlamydia trachomatis* infection is suspected due to lack of *in vitro* activity.

**Except complicated pyelonephritis.

***Given the increasing prevalence of quinolone-resistant *Neisseria gonorrhoeae*, norfloxacin is not indicated as empirical therapy for gonococcal infection.

In situations of urethritis, not to be used if *Chlamydia trachomatis* infection is suspected.

****Warning: Unlike other fluoroquinolones, norfloxacin has low oral bioavailability which makes it unsuitable for systemic infections.

*****Data to support treatment beyond 8 weeks are currently not available.

Renal impairment

The recommended dosage is one 400 mg tablet once a day.

Hepatic impairment

No studies have been performed in patients with hepatic impairment.

Method of administration

Swallow the tablet whole and with a large amount of liquid one hour before or two hours after meals. It is recommended to take the tablet at approximately the same time.

4.3. Contraindications

- Hypersensitivity to the active substance , chemically related quinolone antibacterials or to any of the excipients listed in section 6.1

It should not be administered to children under 18 years of age as there are insufficient data to ensure its safe use in this age group and data from preclinical studies do not allow the risk of injury to immature cartilage to be excluded.

History of quinolone-induced tendon injuries.

4.4. Special warnings and precautions for use

Current European and national recommendations for the treatment of urinary infections advise the empirical use of fluoroquinolones with predominant urinary excretion (such as norfloxacin) as an alternative to first-line antibiotics or in circumstances where the epidemiological context of the infection is one of resistance (from *Escherichia coli*) overall less than 20%.

The use of norfloxacin should be avoided in patients who have experienced serious adverse reactions in the past when using quinolone or fluoroquinolone containing products (see section 4.8). Treatment of these patients with norfloxacin should only be initiated in the absence of alternative treatment options and after careful benefit/risk assessment (see also section 4.3).

Use in patients with epilepsy and other CNS disorders

Norfloxacin can cause CNS side effects (e.g., vertigo). The occurrence of these effects is rare. It should be used with caution in patients with a history of seizures.

Photosensitivity

There have been reports of photosensitivity reactions in patients exposed to excessive sunlight while on therapy with quinolones. Patients should avoid excessive sunlight, should photosensitivity reactions occur norfloxacin should be discontinued.

Peripheral neuropathy

Cases of sensory or sensorimotor polyneuropathy resulting in paresthesia, hypoesthesia, dysesthesia, or weakness have been reported in patients receiving quinolones and fluoroquinolones. Patients under treatment with norfloxacin should be advised to inform their doctor prior to continuing treatment if symptoms of neuropathy such as pain, burning, tingling, numbness, or weakness develop in order to prevent the development of potentially irreversible condition (see section 4.8).

Tendinitis and tendon rupture

Tendinitis and tendon rupture (especially but not limited to Achilles tendon), sometimes bilateral, may occur as early as within 48 hours of starting treatment with quinolones and fluoroquinolones and have been reported to occur even up to several months after discontinuation of treatment. The risk of tendinitis and tendon rupture is increased in older patients, patients with renal impairment, patients with solid organ transplants, and those treated concurrently with corticosteroids. Therefore, concomitant use of corticosteroids should be avoided.

At the first sign of tendinitis (e.g., painful swelling, inflammation) the treatment with norfloxacin should be discontinued and alternative treatment should be considered. The affected limb(s) should be appropriately treated (e.g., immobilization). Corticosteroids should not be used if signs of tendinopathy occur.

Aortic aneurysm and dissection, and heart valve regurgitation/incompetence

Epidemiologic studies report an increased risk of aortic aneurysm and dissection, particularly in elderly patients, and of aortic and mitral valve regurgitation after intake of fluoroquinolones. Cases of aortic aneurysm and dissection, sometimes complicated by rupture (including fatal ones), and of regurgitation/incompetence of any of the heart valves have been reported in patients receiving fluoroquinolones (see section 4.8).

Therefore, fluoroquinolones should only be used after careful benefit-risk assessment and after consideration of other therapeutic options in patients with positive family history of aneurysm disease or congenital heart valve disease, or in patients diagnosed with pre-existing aortic aneurysm and/or aortic dissection or heart valve disease, or in presence of other risk factors or conditions predisposing

- for both aortic aneurysm and dissection and heart valve regurgitation/incompetence (e.g., connective tissue disorders such as Marfan syndrome or Ehlers-Danlos syndrome, Turner syndrome, Behcet's disease, hypertension, rheumatoid arthritis) or additionally
- for aortic aneurysm and dissection (e.g., vascular disorders such as Takayasu arteritis or giant cell arteritis, or known atherosclerosis, or Sjögren's syndrome) or additionally
- for heart valve regurgitation/incompetence (e.g., infective endocarditis).

The risk of aortic aneurysm and dissection, and their rupture may also be increased in patients treated concurrently with systemic corticosteroids.

In case of sudden abdominal, chest or back pain, patients should be advised to immediately consult a physician in an emergency department.
Patients should be advised to seek immediate medical attention in case of acute dyspnea, new onset of heart palpitations, or development of oedema of the abdomen or lower extremities.

Cardiac disorders

Caution should be taken when using fluoroquinolones, including Gyrablock, in patients with known risk factors for prolongation of the QT interval such as, for example:
congenital long QT syndrome, concomitant use of drugs that are known to prolong the QT interval (e.g., Class IA and III antiarrhythmics, tricyclic antidepressants, macrolides, antipsychotics), uncorrected electrolyte imbalance (e.g., hypokalemia, hypomagnesaemia),
cardiac disease (e.g., heart failure, myocardial infarction, bradycardia).
Elderly patients and women may be more sensitive to QTc-prolonging medications. Therefore, caution should be taken when using fluoroquinolones, including Gyrablock, in these populations (see section 4.5, section 4.8, section 4.9).

G6PD-(Glucose-6-phosphate-Dehydrogenase) deficiency

Patients with latent or actual glucose-6-phosphate dehydrogenase activity defects taking quinolones, including norfloxacin, have experienced rare hemolytic reactions.

Myasthenia gravis

Use quinolones with caution in patients with myasthenia gravis. They may exacerbate the signs of myasthenia gravis and lead to life threatening weakness of the respiratory muscles.

Antibiotic-associated diarrhea including colitis

Associated with the use of broad-spectrum antibiotics, including norfloxacin, antibiotic-associated diarrhea (AAD) and antibiotic-associated colitis (AAC), including pseudomembranous colitis and Clostridium difficile-associated diarrhea, have been reported, the severity of which can range from mild to severe diarrhea. fatal colitis. For this reason, it is important to consider this diagnosis in patients who develop severe diarrhea during or after the use of norfloxacin.
If AAD or AAC is suspected or confirmed, ongoing treatment with antibacterial agents, including norfloxacin, should be discontinued and appropriate therapeutic measures initiated immediately. In addition, adequate infection control measures should be taken to reduce the risk of transmission.

Hypersensitivity reactions

Severe and sometimes fatal (anaphylactic) hypersensitivity reactions have been reported after the first dose of quinolone antibiotics, including norfloxacin. Clinical manifestations may include:

- fever, rash or severe skin reaction (e.g., toxic epidermal necrolysis, Stevens-Johnson syndrome)
- vasculitis, arthralgia, myalgia, serum sickness
- hypersensitivity pneumonitis
- interstitial nephritis, acute renal failure or failure
- hepatitis, jaundice, acute liver necrosis
- anemia, including aplastic and hemolytic, thrombocytopenia, including thrombotic thrombocytopenic purpura, leukopenia, agranulocytosis, pancytopenia and other hematological disorders.

Renal insufficiency

Norfloxacin is suitable for the treatment of patients with impaired renal function. However, since norfloxacin is primarily excreted by the kidneys, urinary levels can be seriously affected by kidney failure.

Pediatric population

In common with other quinolones, norfloxacin has been demonstrated to cause arthropathy in immature animals. Safety of norfloxacin has not been adequately investigated in children and use in pre-pubertal children or growing adolescents is contraindicated.

Vision disorders

If vision becomes impaired or any effects on the eyes are experienced, an eye specialist should be consulted immediately.

Prolonged, disabling and potentially irreversible serious adverse drug reactions

Very rare cases of prolonged (continuing months or years), disabling and potentially irreversible serious adverse drug reactions affecting different, sometimes multiple, body systems (musculoskeletal, nervous, psychiatric and senses) have been reported in patients receiving quinolones and fluoroquinolones irrespective of their age and pre-existing risk factors. Norfloxacin should be discontinued immediately at the first signs or symptoms of any serious adverse reaction and patients should be advised to contact their prescriber for advice.

Dysglycaemia

As with all quinolones, disturbances in blood glucose, including both hypoglycaemia and hyperglycaemia have been reported (see section 4.8), usually in diabetic patients receiving concomitant treatment with an oral hypoglycaemic agent (e.g., glibenclamide) or with insulin. Cases

of hypoglycaemic coma have been reported. In diabetic patients, careful monitoring of blood glucose is recommended.

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

Antacids and sucralfate: Should not be administered concomitantly or within two hours before or two hours after norfloxacin as they interfere with absorption resulting in lower serum/urine levels of norfloxacin.

Caffeine: Norfloxacin interferes with caffeine metabolism resulting in reduced caffeine clearance and prolongation of caffeine half-life.

Cyclosporin: Norfloxacin concomitantly administered results in elevation of cyclosporin plasma levels. Cyclosporin plasma levels should be monitored and the dosage adjusted as required.

Didanosine: Should not be administered concomitantly or within two hours before or two hours after norfloxacin as they interfere with absorption resulting in lower serum/urine levels of norfloxacin.

Fenbufen: Use in combination with quinolones can lead to convulsions in animals. Use in combination should be avoided.

Glibenclamide: Concomitant use of norfloxacin and glibenclamide has, on occasions, resulted in severe hypoglycaemia. In this case monitoring of blood glucose is recommended.

Iron: Products containing iron should not be administered concomitantly or within two hours before or two hours after norfloxacin as they interfere with absorption resulting in lower serum/urine levels of norfloxacin.

Multivitamins: Should not be administered concomitantly or within two hours before or two hours after norfloxacin as they interfere with absorption resulting in lower serum/urine levels of norfloxacin.

Nitrofurantoin: in vitro antagonism has been shown.

Probenecid: Norfloxacin serum concentrations are not affected by co-administration of probenecid but urinary excretion of norfloxacin is decreased.

Theophylline: Concomitant therapy may lead to elevation of theophylline plasma levels and side effects, theophylline plasma levels should be monitored and the dose adjusted if required.

Norfloxacin inhibits CYP1A2 which may lead to increased serum concentrations of other substances administered concomitantly and also metabolized by this enzyme (e.g., theophylline, clozapine, tacrine, ropinirole, tizanidine). Patients taking these substances concomitantly with norfloxacin should be closely monitored for clinical signs of overdose and serum monitoring may be necessary, especially for theophylline.

Warfarin or its derivatives: Norfloxacin may enhance significantly the anticoagulant effects of warfarin or its derivatives due to displacement from serum binding sites. If concomitant therapy is needed, prothrombin time should be monitored and dosage adjusted if required.

Zinc: Products containing zinc should not be administered concomitantly or within two hours before or two hours after norfloxacin as it interferes with absorption resulting in lower serum/urine levels of norfloxacin.

Drugs known to prolong QT interval: Gyrablock, like other fluoroquinolones, should be used with caution in patients receiving drugs known to prolong the QT interval (e.g. Class IA and III antiarrhythmics, tricyclic antidepressants, macrolides, antipsychotics) (see section 4.4).

4.6. Fertility, pregnancy and lactation

Norfloxacin has been found in cord blood and amniotic fluid.
When 200 mg doses were given to nursing mothers, no norfloxacin was found in breast milk. However, and because the dose studied was small, care must be taken when administering norfloxacin to mothers during lactation.
In pregnant or breastfeeding women, the potential benefits must be weighed against the possible risks, as norfloxacin has been shown to cause arthropathy in young animals.

4.7. Effects on ability to drive and use machines

No effects on the ability to drive and use machines have been observed, except in rare cases where adverse CNS effects (e.g., dizziness) occur.

4.8. Undesirable effects

The adverse reactions are presented taking into consideration MedDRA frequency and system organ class database 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)

System Organ Class	*Frequency*	*Adverse reactions*
Blood and lymphatic system disorders	Very rare	Leukopenia, eosinophilia, thrombocytopenia
	Not known	Hemolytic anemia, sometimes associated with glucose-6-phosphate dehydrogenase deficiency
Immune system disorders	Rare	Hypersensitivity reactions including anaphylaxis, angioedema, dyspnea, vasculitis, urticaria, arthritis, myalgia, arthralgia and interstitial nephritis
Endocrine disorders	Not known	Syndrome of inappropriate secretion of antidiuretic hormone (SIADH)
Nervous system disorders*	Very common	Headache
	Not known	Convulsions, tremors, myoclonus, polyneuropathy including Guillaume-Barre syndrome, paresthesia
Psychiatric disorders	Uncommon	Anorexia, sleep disturbances, depression, anxiety/nervousness, irritability, euphoria, disorientation, hallucination, epiphora
	Not known	Confusion, psychic disturbances including psychotic reactions
Ear and labyrinth disorders*	Very common	Dizziness
	Uncommon	Tinnitus
Eye disorders*	Not known	Visual disturbances (see section 4.4)
Cardiac disorders**	Not known	Ventricular arrhythmia and torsade de pointes (reported predominantly in patients with risk factors for QT prolongation), prolonged QT interval on ECG (see sections 4.4 and 4.9)

System Organ Class	*Frequency*	*Adverse reactions*
Gastrointestinal disorders	Very common	Nausea, dyspepsia, abdominal pain/cramps, diarrhea
	Rare	Pseudomembranous colitis, hepatitis, jaundice including cholestatic jaundice and elevated liver function test results. Dysgeusia. Pancreatitis.
Hepatobiliary disorders	Very rare	Cytolytic hepatitis Cholestatic hepatitis
Skin and subcutaneous tissue disorders	Very common	Rash, pruritus
	Very rare	Photosensitivity, Stevens-Johnson syndrome, toxic epidermal necrolysis, exfoliative dermatitis, erythema multiforme
Musculoskeletal and connective tissue disorders*	Rare	Achilles tendon injury, with tendinitis, which can lead to its rupture
	Not known	Exacerbation of myasthenia gravis, elevated levels of creatinine kinase (CK)
Renal and urinary disorders	Very rare	Nephrotic syndrome, acute renal failure
	Not known	Vaginal candidiasis
Investigations	Very rare	Increased transaminases (AST and ALT) Alkaline phosphatase increase Increased lactic dehydrogenase (LDH) Increase in bilirubinemia

*Very rare cases of prolonged (up to months or years), disabling and potentially irreversible serious drug reactions affecting several, sometimes multiple, system organ classes and senses (including reactions such as tendonitis, tendon rupture, arthralgia, pain in extremities, gait disturbance, neuropathies associated with paresthesia, depression, fatigue, memory impairment, sleep disorders, and impairment of hearing, vision, taste and smell) have been reported in association with the use of quinolones and fluoroquinolones in some cases irrespective of pre-existing risk factors (see Section 4.4).

**Cases of aortic aneurysm and dissection, sometimes complicated by rupture (including fatal ones), and of regurgitation/incompetence of any of the heart valves have been reported in patients receiving fluoroquinolones (see section 4.4).

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 national reporting system.

4.9. Overdose

No cases of overdose were observed. However, an overdose of norfloxacin can cause symptoms of central arousal (including seizures). Symptoms of gastrointestinal irritation can be severe.

There is no specific antidote. In case of overdose, symptomatic treatment should be instituted. Gastric lavage may be performed. In all cases, intensive hydration should be carried out, as the ingestion of high doses of norfloxacin can cause crystalluria.
ECG monitoring should be performed due to the possibility of QT interval prolongation. The drug is not removed by hemodialysis.

5. PHARMACOLOGICAL PROPERTIES

5.1. Pharmacodynamic properties

Pharmacotherapeutic group: Fluoroquinolones, ATC code: J01MA06

Mechanism of action

The antibacterial effect is bactericidal and is essentially due to the inhibition of the A subunit of the DNA gyrase enzyme, a type II topoisomerase. Generally, norfloxacin is active against a wide variety of aerobic Gram-positive and Gram-negative bacteria. Resistance to quinolones is not mediated by plasmids but by mutation. Cross-resistance with other antibiotics is often low. Strains resistant to nalidixic acid remain sensitive to norfloxacin.

Susceptibility data

Norfloxacin has been shown to have in vitro and in vivo activity against a range of Gram-positive and Gram-negative aerobic bacteria. The breakpoints defined by the European Committee on Antimicrobial Susceptibility Testing (EUCAST) for norfloxacin are:

Organism	*MIC breakpoint (mg/L)*	
	Susceptible ≤	*Resistant* >
Enterobacteriaceae	0.5	1
Non-species related breakpoints	0.5	1
*Non-species related breakpoints were primarily determined based on pharmacokinetic/pharmacodynamic data and are independent of species-specific MIC distributions.		

Organism	*MIC breakpoint (mg/L)*	
	Susceptible ≤	*Resistant >*
They are intended to be used only for species that have not been assigned species breakpoints and are not for use with species where the criteria for interpretation remain to be determined. MIC: minimum inhibitory concentration		

The prevalence of acquired resistance may vary geographically and over time for selected species.

Bacteria for which there have been higher rates of acquired resistance to norfloxacin:

Pseudomonas aeruginosa

Klebsiella pneumoniae

Enterococcus spp.

Acinetobacter spp.

Bacteria naturally resistant to norfloxacin (almost all anaerobes):

Actinomyces spp.

Fusobacterium spp.

Bacteroides spp.

Clostridium spp., apart from *C. perfringens*

Bacteria found in urinary tract infections generally susceptible to norfloxacin:

Enterobacteriaceae

Citrobacter spp.

Citrobacter koseri (initially known as *Citrobacter diversus*)

Citrobacter freundii

Edwarsiella tarda

Enterobacter spp.

Enterobacter aerogenes

Enterobacter agglomerans

Enterobacter cloacae

Escherichia coli

Hafnia alvei

Klebsiella spp.

Klebsiella oxytoca

Klebsiella pneumoniae

Morganella morganii

Proteus spp. (indole-positive)

Proteus mirabilis
Proteus vulgaris
Providencia spp.
Providencia rettgeri
Providencia stuartii
Serratia spp.
Serratia marcescens
Pseudomonadaceae
Pseudomonas aeruginosa
Pseudomonas cepacia
Pseudomonas fluorescens
Pseudomonas stutzeri

Other:
Flavobacterium spp.
Gram positive cocci
Enterococos faecalis
Group G *Streptococcus*
Staphylococcus spp.
Staphylococcus coagulase-negative
Staphylococcus aureus (including penicillinase-producing and most methicillin-resistant strains)
Staphylococcus epidermidis
Staphylococcus saprophyticus
Streptococcus agalactiae
Streptococcus of viridans group

Bacteria associated with acute gastroenteritis usually sensitive to norfloxacin:
Aeromonas hydrophila
Campylobacter fetus sub-spp. *jejuni*
Enterotoxic strains of *Escherichia coli*
Plesiomonas shigelloides
Salmonella spp.
Salmonella typhi
Shigella spp.
Shigella boydii
Shigella dysenteriae
Shigella flexneri

Shigella sonnei
Vibrio cholerae
Vibrio parahemolyticus
Yersinia enterocolitica

Other:
Bacillus cereus
Ureaplasma urealyticum
Haemophilus influenzae
Haemophilus ducreyi

5.2. Pharmacokinetic properties

The gastrointestinal absorption of norfloxacin is done quickly.
Absorption is at least 30-50% in healthy volunteers; the unabsorbed part contributes to high levels of the drug in the intestinal lumen.
Peak serum concentration is 2.4 µg/ml and is reached approximately 1-2 hours after oral administration of an 800 mg dose.
The mean plasma half-life is 2.3-4 hours. Plasma protein binding is less than 15%.
The concentrations observed in urine, prostatic fluid and tissue and renal parenchyma are very high, which contrasts with what is observed in other tissues of the body.
Six metabolites of norfloxacin were identified in the urine that show lower antimicrobial activity.
Norfloxacin is eliminated by biliary and renal excretion.
The unchanged compound represents more than 70% of the norfloxacin excreted in the urine. Renal excretion is by glomerular filtration and tubular secretion.
The pharmacokinetic parameters known in animals and in man are those necessary for a correct clinical use of the drug.

5.3. Preclinical safety data

The acute toxicity of norfloxacin is low; the LD50 for rats is greater than 4000 mg/kg orally. The LD50 of each of the 6 known metabolites of norfloxacin is greater than 2000 mg/kg.
Chronic toxicity has been studied in several animal species, the only undesirable effect occurring in some animals was crystalluria.
Toxicity during pregnancy was studied and arthropathy and lameness were observed in immature animals, days after the start of treatment, which disappeared in 8 weeks.

However, because the lameness was caused by erosion of the articular cartilage in some affected animals, it is therefore prudent to limit the use of fluoroquinolones to adults.
No teratogenic effects were observed in monkeys at daily doses of 200 or 300 mg/kg norfloxacin.
Peri and Postnatal Toxicity: No harmful effects on pregnancy or offspring were observed with very high doses.
No effects on fertility were observed in any of the animal species studied.
Mutagenic potential: several tests were carried out and all were negative.

6. PHARMACEUTICAL PARTICULARS

6.1. List of excipients

Croscarmellose sodium
Povidone
Microcrystalline cellulose
Magnesium stearate
Opadry Yellow 02B220005
Polyethylene glycol 6000

6.2. Incompatibilities

None known.

6.3. Shelf life

36 months.

6.4. Special precautions for storage

Store below 25°C in the original package in order to protect from light and moisture.

6.5. Nature and contents of container

Polypropelene securitainer packs, with a leaflet, in a carton. Securitainers of 14, 500 and 1000 tablets, blisters of 14, 20, 30, 50, 100 are available.
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

MEDOCHEMIE LTD, 1-10 Constantinoupoleos street, 3011 Limassol, Cyprus

8. MARKETING AUTHORISATION NUMBER

07685/08446/REN/2022

9. DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUTHORISATION

Date of first authorisation: 14/02/2002
Date of latest renewal: 08/08/2022

10. DATE OF REVISION OF THE TEXT

11/2022