Summary of Product Characteristics

1 NAME OF THE MEDICINAL PRODUCT

Montelair 4 mg Chewable Tablets

2 QUALITATIVE AND QUANTITATIVE COMPOSITION

One chewable tablet contains montelukast sodium, which is equivalent to 4 mg montelukast.

Excipient(s) with known effect
Each chewable tablet contains 4.8 mg of aspartame (E951) and 0.45 mg sodium.

For the full list of excipients, see section 6.1.

3 PHARMACEUTICAL FORM

Chewable tablet. Pink, oval, biconvex-shaped tablets with 'M4' engraved on one side

4 CLINICAL PARTICULARS

4.1 Therapeutic Indications

Montelairis indicated in the treatment of asthma as add-on therapy in those 2 to 5 year old patients with mild to moderate persistent asthma who are inadequately controlled on inhaled corticosteroids and in whom 'as-needed' short-acting β-agonists provide inadequate clinical control of asthma.

Montelair may also be an alternative treatment option to low-dose inhaled corticosteroids for 2 to 5 year old patients with mild persistent asthma who do not have a recent history of serious asthma attacks that required oral corticosteroid use, and who have demonstrated that they are not capable of using inhaled corticosteroids (see section 4.2)

Montelair is also indicated in the prophylaxis of asthma for 2 to 5 year old patients in which the predominant component is exercise-induced bronchoconstriction.

4.2 Posology and method of administration

Method of administration:
For oral use.

This medicinal product is to be given to a child under adult supervision. For children who have problems consuming a chewable tablet, a granule formulation is available (see montelukast sodium 4 mg granule SmPC).The dosage for paediatric patients 2-5 years of age is one 4 mg chewable tablet daily to be taken in the evening. The tablet should be chewed. If taken in connection with food, Montelair should be taken 1 hour before or 2 hours after food. No dosage adjustment within this age group is necessary. Montelair 4 mg chewable tablet formulation is not recommended for use in children below 2 years of age due to lack of insufficient data on safety and efficacy.

General recommendations:
The therapeutic effect of Montelair on parameters of asthma control occurs within one day. Patients should be advised to continue taking Montelair even if their asthma is under control, as well as during periods of worsening asthma.

No dosage adjustment is necessary for patients with renal insufficiency, or mild to moderate hepatic impairment. There are no data on patients with severe hepatic impairment. The dosage is the same for both male and female patients.

Montelair as an alternative treatment option to low-dose inhaled corticosteroids for mild persistent asthma:
Montelukast is not recommended as monotherapy in patients with moderate persistent asthma. The use of montelukast as an alternative treatment option to low-dose inhaled corticosteroids for children with mild persistent asthma should only be considered for patients who do not have a recent history of serious asthma attacks that required oral corticosteroid use and who have demonstrated that they are not capable of using inhaled corticosteroids (see section 4.1). Mild persistent asthma is

defined as asthma symptoms more than once a week but less than once a day, nocturnal symptoms more than twice a month but less than once a week, normal lung function between episodes. If satisfactory control of asthma is not achieved at follow-up (usually within one month), the need for an additional or different anti-inflammatory therapy based on the step system for asthma therapy should be evaluated. Patients should be periodically evaluated for their asthma control.

Montelair as prophylaxis of asthma for 2 to 5 year old patients in whom the predominant component is exercise-induced bronchoconstriction.
In 2 to 5 year old patients, exercise-induced bronchoconstriction may be the predominant manifestation of persistent asthma that requires treatment with inhaled corticosteroids. Patients should be evaluated after 2 to 4 weeks of treatment with montelukast. If satisfactory response is not achieved, an additional or different therapy should be considered.

Therapy with Montelair in relation to other treatments for asthma.
When treatment with Montelair is used as add-on therapy to inhaled corticosteroids, Montelair should not be abruptly substituted for inhaled corticosteroids (see section 4.4).

Other available strength/pharmaceutical forms:
5 mg chewable tablets are available for paediatric patients 6 to 14 years of age.
10 mg film-coated tablets are available for adults 15 years of age and older.

4.3 Contraindications

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

4.4 Special warnings and precautions for use

Patients should be advised never to use oral montelukast to treat acute asthma attacks and to keep their usual appropriate rescue medication for this purpose readily available. If an acute attack occurs, a short-acting inhaled β-agonist should be used. Patients should seek their doctor's advice as soon as possible if they need more inhalations of short-acting β-agonists than usual.

Montelukast should not be abruptly substituted for inhaled or oral corticosteroids.

There are no data demonstrating that oral corticosteroids can be reduced when montelukast is given concomitantly.

In rare cases, patients on therapy with anti-asthma agents including montelukast may present with systemic eosinophilia, sometimes presenting with clinical features of vasculitis consistent with Churg-Strauss syndrome, a condition which is often treated with systemic corticosteroid therapy. These cases usually, but not always, have been associated with the reduction or withdrawal of oral corticosteroid therapy. The possibility that leukotriene receptor antagonists may be associated with emergence of Churg-Strauss syndrome can neither be excluded nor established. Physicians should be alert to eosinophilia, vasculitic rash, worsening pulmonary symptoms, cardiac complications, and/or neuropathy presenting in their patients. Patients who develop these symptoms should be reassessed and their treatment regimens evaluated.

Neuropsychiatric events have been reported in adults, adolescents, and children taking montelukast (see section 4.8). Patients and physicians should be alert for neuropsychiatric events. Patients and/or caregivers should be instructed to notify their physician if these changes occur. Prescribers should carefully evaluate the risks and benefits of continuing treatment with montelukast if such events occur.

Excipients
This medicinal product contains aspartame (E951), a source of phenylalanine. May be harmful for people with phenylketonuria.

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

4.5 Interaction with other medicinal products and other forms of interactions

Montelukast may be administered with other therapies routinely used in the prophylaxis and chronic treatment of asthma. In drug-interactions studies, the recommended clinical dose of montelukast did not have clinically important effects on the pharmacokinetics of the following medicinal products: theophylline, prednisone, prednisolone, oral contraceptives (ethinyl estradiol/norethindrone 35/1), terfenadine, digoxin and warfarin.

The area under the plasma concentration curve (AUC) for montelukast was decreased approximately 40 % in subjects with co-administration of phenobarbital. Since montelukast is metabolised by CYP 3A4, 2C8, and 2C9, caution should be exercised, particularly in children, when montelukast is co-administered with inducers of CYP 3A4, 2C8, and 2C9, such as phenytoin, phenobarbital and rifampicin.

In vitro studies have shown that montelukast is a potent inhibitor of CYP 2C8. However, data from a clinical drug-drug interaction study involving montelukast and rosiglitazone (a probe substrate representative of medicinal products primarily metabolised by CYP 2C8) demonstrated that montelukast does not inhibit CYP 2C8 *in vivo*. Therefore, montelukast is not anticipated to markedly alter the metabolism of medicinal products metabolised by this enzyme (e.g., paclitaxel, rosiglitazone and repaglinide).

In vitro studies have shown that montelukast is a substrate of CYP 2C8, and to a less significant extent, of 2C9, and 3A4. In a clinical drug-drug interaction study involving montelukast and gemfibrozil (an inhibitor of both CYP 2C8 and 2C9) gemfibrozil increased the systemic exposure of montelukast by 4.4-fold. No routine dosage adjustment of montelukast is required upon co-administration with gemfibrozil or other potent inhibitors of CYP 2C8, but the physician should be aware of the potential for an increase in adverse reactions.

Based on *in vitro* data, clinically important drug interactions with less potent inhibitors of CYP 2C8 (e.g., trimethoprim) are not anticipated. Co-administration of montelukast with itraconazole, a strong inhibitor of CYP 3A4, resulted in no significant increase in the systemic exposure of montelukast.

4.6 Fertility, pregnancy and lactation

Use during pregnancy
Animal studies do not indicate harmful effects with respect to effects on pregnancy or embryonal/foetal development.

Limited data from available pregnancy databases do not suggest a causal relationship between montelukast and malformations (i.e. limb defects) that have been rarely reported in worldwide post marketing experience.

Montelukast may be used during pregnancy only if it is considered to be clearly essential.

Use during breastfeeding
Studies in rats have shown that montelukast is excreted in milk (see section 5.3). It is not known if montelukast is excreted in human milk.

Montelukast may be used in breastfeeding mothers only if it is considered to be clearly essential.

4.7 Effects on ability to drive and use machines

No studies on the effects on the ability to drive and use machines have been performed.
Montelukast is not expected to affect a patient's ability to drive a car or operate machinery. However, in very rare cases, individuals have reported drowsiness or dizziness.

4.8 Undesirable effects

Montelukast has been evaluated in clinical studies with persistent asthma as follows:

- 10 mg film-coated tablets in approximately 4,000 adult patients 15 years of age and older.
- 5 mg chewable tablets in approximately 1,750 paediatric patients 6 to 14 years of age.
- 4 mg chewable tablets in 851 paediatric patients 2 to 5 years of age.

Montelukast has been evaluated in a clinical study in patients with intermittent asthma as follows:

- 4 mg granules and chewable tablets in 1,038 paediatric patients 6 months to 5 years of age

The following drug-related adverse reactions in clinical studies were reported commonly (≥ 1/100 to < 1/10) in patients treated with montelukast and at a greater incidence than in patients treated with placebo:

Body System Class	Adult Patients 15 years and	Paediatric	Paediatric

	older (two 12-week studies; n=795)	Patients 6 to 14 years old (one 8-week study; n=201) (two 56-week studies; n=615)	Patients 2 to 5 years old (one 12-week study; n=461) (one 48-week study; n=278)
Nervous system disorders	headache	headache	
Gastrointestinal disorders	abdominal pain		abdominal pain
General disorders and administration site conditions			thirst

With prolonged treatment in clinical trials with a limited number of patients for up to 2 years for adults, and up to 12 months for paediatric patients 6 to 14 years of age, the safety profile did not change.

Cumulatively, 502 paediatric patients 2 to 5 years of age were treated with montelukast for at least 3 months, 338 for 6 months or longer, and 534 patients for 12 months or longer. With prolonged treatment, the safety profile did not change in these patients either.

Post-marketing experience
Adverse reactions reported in post-marketing use are listed, by System Organ Class and specific Adverse Experience Term, in the table below. Frequency Categories were estimated based on relevant clinical trials.

System Organ Class	**Adverse Experience Term**	**Frequency Category***
Infections and infestations	upper respiratory infection[†]	very common
Blood and lymphatic system disorders	increased bleeding tendency	rare
Immune system disorder	hypersensitivity reactions including anaphylaxis	uncommon
	hepatic eosinophilic infiltration	very rare
Psychiatric disorders	dream abnormalities including nightmares, insomnia, somnambulism, irritability, anxiety, restlessness, agitation including aggressive behaviour or hostility, depression	uncommon
	tremor	rare
	hallucinations, disorientation, suicidal thinking and behaviour (suicidality), dysphemia	very rare
Nervous system disorder	dizziness, drowsiness, paraesthesia/hypoaesthesia, seizure	uncommon
Cardiac disorders	palpitations	rare
Respiratory, thoracic and mediastinal disorders	epistaxis	uncommon
	Churg-Strauss Syndrome (CSS) have been reported during montelukast treatment in asthmatic patients (see section 4.4)	very rare
Gastrointestinal disorders	diarrhoea[‡], nausea[‡], vomiting[‡]	common
	dry mouth, dyspepsia	uncommon
Hepatobiliary disorders	elevated levels of serum transaminases (ALT, AST)	common
	Hepatitis (including cholestatic, hepatocellular, and mixed pattern liver injury).	very rare
Skin and subcutaneous	rash[‡]	common

tissue disorders	bruising, urticaria, pruritus	uncommon
	angio-oedema	rare
	erythema nodosum, erythema multiforme	very rare
Musculoskeletal and connective tissue disorders	arthralgia, myalgia including muscle cramps	uncommon
General disorders and administration site conditions	pyrexia[‡]	common
	asthenia/fatigue, malaise, oedema	uncommon

*Frequency Category: Defined for each Adverse Experience Term by the incidence reported in the clinical trials data base: 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).

[†]This adverse experience, reported as very common in the patients who received montelukast, was also reported as very common in the patients who received placebo in clinical trials.

[‡]This adverse experience, reported as common in the patients who received montelukast, was also reported as common in the patients who received placebo in clinical trials.

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 HPRA Pharmacovigilance, Earlsfort Terrace, IRL - Dublin 2; Tel: +353 1 6764971; Fax: +353 1 6762517. Website: www.hpra.ie; E-mail: medsafety@hpra.ie.

4.9 Overdose

No specific information is available on the treatment of overdose with montelukast. In chronic asthma studies, montelukast has been administered at doses up to 200 mg/day to adult patients for 22 weeks and in short-term studies, up to 900 mg/day to patients for approximately one week without clinically important adverse experiences.

There have been reports of acute overdose in post-marketing experience and clinical studies with montelukast. These include reports in adults and children with a dose as high as 1000 mg (approximately 61 mg/kg in a 42 month old child). The clinical and laboratory findings observed were consistent with the safety profile in adults and paediatric patients. There were no adverse experiences in the majority of overdose reports. The most frequently occurring adverse experiences were consistent with the safety profile of montelukast and included abdominal pain, somnolence, thirst, headache, vomiting, and psychomotor hyperactivity.

It is not known whether montelukast is dialysable by peritoneal- or haemo-dialysis.

5 PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: Other systemic drugs for obstructive airway diseases. Leukotriene receptor antagonist
ATC Code: RO3D CO3

The cysteinyl leukotrienes (LTC_4, LTD_4, LTE_4) are potent inflammatory eicosanoids released from various cells including mast cells and eosinophils.
These important pro-asthmatic mediators bind to cysteinyl leukotriene receptors (CysLT) found in the human airway and cause airway actions, including bronchoconstriction, mucous secretion, vascular permeability, and eosinophil recruitment.

Montelukast is an orally active compound which binds with high affinity and selectivity to the $CysLT_1$ receptor.

In clinical studies, montelukast inhibits bronchoconstriction due to inhaled LTD_4 at doses as low as 5 mg. Bronchodilation was observed within 2 hours of oral administration. The bronchodilation effect caused by a β-agonist was additive to that caused by montelukast. Treatment with montelukast inhibited both early- and late-phase bronchoconstriction due to antigen challenge. Montelukast, compared with placebo, decreased peripheral blood eosinophils in adult and paediatric patients. In a separate study, treatment with montelukast significantly decreased eosinophils in the airways (as measured in sputum). In adult and paediatric patients 2 to 14 years of age, montelukast, compared with placebo, decreased peripheral blood eosinophils while improving clinical asthma control.

In studies in adults, montelukast, 10 mg once daily, compared with placebo, demonstrated significant improvements in morning FEV_1 (10.4 % vs. 2.7 % change from baseline), AM peak expiratory flow rate (PEFR) (24.5 L/min vs. 3.3 L/min change from baseline), and significant decrease in total β-agonist use (-26.1 % vs. -4.6 % change from baseline). Improvement in patient-reported daytime and night-time asthma symptoms scores was significantly better than placebo.

Studies in adults demonstrated the ability of montelukast to add to the clinical effect of inhaled corticosteroid (% change from baseline for inhaled beclomethasone plus montelukast vs. beclomethasone, respectively for FEV_1: 5.43 % vs. 1.04 %; β-agonist use: -8.70 % vs. 2.64 %). Compared with inhaled beclomethasone (200 µg twice daily with a spacer device), montelukast demonstrated a more rapid initial response, although over the 12-week study, beclomethasone provided a greater average treatment effect (% change from baseline for montelukast vs. beclomethasone, respectively for FEV_1: 7.49 % vs. 13.3 %; β-agonist use: -28.28 % vs. -43.89 %). However, compared with beclomethasone, a high percentage of patients treated with montelukast achieved similar clinical responses (e.g., 50 % of patients treated with beclomethasone achieved an improvement in FEV_1 of approximately 11 % or more over baseline while approximately 42 % of patients treated with montelukast achieved the same response).

In a 12-week, placebo-controlled study in paediatric patients 2 to 5 years of age, montelukast 4 mg once daily improved parameters of asthma control compared with placebo irrespective of concomitant controller therapy (inhaled/nebulised corticosteroids or inhaled/nebulised sodium cromoglycate). Sixty per cent of patients were not on any other controller therapy. Montelukast improved daytime symptoms (including coughing, wheezing, trouble breathing and activity limitation) and night-time symptoms compared with placebo. Montelukast also decreased as-needed β-agonist use and corticosteroid rescue for worsening asthma compared with placebo. Patients receiving montelukast had more days without asthma than those receiving placebo. A treatment effect was achieved after the first dose.

In a 12-month, placebo-controlled study in paediatric patients 2 to 5 years of age with mild asthma and episodic exacerbations, montelukast 4 mg once daily significantly ($p \leq 0.001$) reduced the yearly rate of asthma exacerbation episodes (EE) compared with placebo (1.60 EE vs. 2.34 EE, respectively), [EE defined as ≥3 consecutive days with daytime symptoms requiring β-agonist use, or corticosteroids (oral or inhaled), or hospitalisation for asthma]. The percentage reduction in yearly EE rate was 31.9 %, with a 95 % CI of 16.9, 44.1.

In an 8-week study in paediatric patients 6 to 14 years of age, montelukast 5 mg once daily, compared with placebo, significantly improved respiratory function (FEV_1 8.71 % vs. 4.16 % change from baseline; AM PEFR 27.9 L/min vs. 17.8 L/min change from baseline) and decreased as-needed β-agonist use (-11.7 % vs. +8.2 % change from baseline).

In a 12-month study comparing the efficacy of montelukast to inhaled fluticasone on asthma control in paediatric patients 6 to 14 years of age with mild persistent asthma, montelukast was non-inferior to fluticasone in increasing the percentage of

asthma rescue-free days (RFDs), the primary endpoint. Averaged over the 12-month treatment period, the percentage of asthma RFDs increased from 61.6 to 84.0 in the montelukast group and from 60.9 to 86.7 in the fluticasone group. The between group difference in LS mean increase in the percentage of asthma RFDs was statistically significant (- 2.8 with a 95 % CI of -4.7, -0.9), but within the limit pre-defined to be clinically not inferior. Both montelukast and fluticasone also improved asthma control on secondary variables assessed over the 12 month treatment period:

FEV_1 increased from 1.83 L to 2.09 L in the montelukast group and from 1.85 L to 2.14 L in the fluticasone group. The between-group difference in LS mean increase in FEV_1 was -0.02 L with a 95 % CI of -0.06, 0.02. The mean increase from baseline in % predicted FEV_1 was 0.6 % in the montelukast treatment group, and 2.7 % in the fluticasone treatment group. The difference in LS means for the change from baseline in the % predicted FEV_1 was significant: -2.2 % with a 95 % CI of -3.6, -0.7. The percentage of days with β-agonist use decreased from 38.0 to 15.4 in the montelukast group, and from 38.5 to 12.8 in the fluticasone group. The between group difference in LS means for the percentage of days with β-agonist use was significant: 2.7 with a 95 % CI of 0.9, 4.5.
The percentage of patients with an asthma attack (an asthma attack being defined as a period of worsening asthma that required treatment with oral steroids, an unscheduled visit to the doctor's office, an emergency room visit, or hospitalisation) was 32.2 in the montelukast group and 25.6 in the fluticasone group; the odds ratio (95 % CI) being significant: equal to 1.38 (1.04, 1.84).
The percentage of patients with systemic (mainly oral) corticosteroid use during the study period was 17.8 % in the montelukast group and 10.5 % in the fluticasone group. The between group difference in LS means was significant: 7.3 % with a 95 %CI of 2.9; 11.7.

Significant reduction of exercise-induced bronchoconstriction (EIB) was demonstrated in a 12-week study in adults (maximal fall in FEV_1 22.33 % for montelukast vs. 32.40 % for placebo; time to recovery to within 5 % of baseline FEV_1 44.22 min vs. 60.64 min). This effect was consistent throughout the 12- week study period. Reduction in EIB was also demonstrated in a short term study in paediatric patients 6 to 14 years of age (maximal fall in FEV_1 18.27 % vs. 26.11 %; time to recovery to within 5 % of baseline FEV_1 17.76 min vs. 27.98 min). The effect in both studies was demonstrated at the end of the once-daily dosing interval.

In aspirin-sensitive asthmatic patients receiving concomitant inhaled and/or oral corticosteroids, treatment with montelukast, compared with placebo, resulted in significant improvement in asthma control (FEV_1 8.55 % vs. -1.74 % change from baseline and decrease in total β-agonist use -27.78 % vs. 2.09 % change from baseline).

5.2 Pharmacokinetic properties

Absorption
Montelukast is rapidly absorbed following oral administration. For the 10 mg film-coated tablet, the mean peak plasma concentration (C_{max}) is achieved 3 hours (T_{max}) after administration in adults in the fasted state. The mean oral bioavailability is 64 %. The oral bioavailability and C_{max} are not influenced by a standard meal. Safety and efficacy were demonstrated in clinical trials where the 10 mg film-coated tablet was administered without regard to the timing of food ingestion.

For the 5 mg chewable tablet, the C_{max} is achieved in 2 hours after administration in adults in the fasted state. The mean oral bioavailability is 73 % and is decreased to 63 % by a standard meal.

After administration of the 4 mg chewable tablet to paediatric patients 2 to 5 years of age in the fasted state, C_{max} is achieved 2 hours after administration. The mean C_{max} is 66 % higher while mean C_{min} is lower than in adults receiving a 10 mg tablet.

Distribution
Montelukast is more than 99 % bound to plasma proteins. The steady-state volume of distribution of montelukast averages 8-11 litres. Studies in rats with radiolabeled montelukast indicate minimal distribution across the blood-brain barrier. In addition, concentrations of radiolabeled material at 24 hours post-dose were minimal in all other tissues.

Biotransformation
Montelukast is extensively metabolised. In studies with therapeutic doses, plasma concentrations of metabolites of montelukast are undetectable at steady state in adults and children.

In vitro studies using human liver microsomes indicate that cytochromes P450 3A4, 2A6 and 2C9 are involved in the metabolism of montelukast. Based on further in vitro results in human liver microsomes, therapeutic plasma concentrations of montelukast do not inhibit cytochromes P450 3A4, 2C9, 1A2, 2A6, 2C19, or 2D6. The contribution of metabolites to the therapeutic effect of montelukast is minimal.

Elimination:
The plasma clearance of montelukast averages 45 ml/min in healthy adults. Following an oral dose of radiolabeled montelukast, 86 % of the radioactivity was recovered in 5-day faecal collections and < 0.2 % was recovered in urine. Coupled with estimates of montelukast oral bioavailability, this indicates that montelukast and its metabolites are excreted almost exclusively via the bile.

Characteristics in patients
No dosage adjustment is necessary for the elderly or mild to moderate hepatic insufficiency. Studies in patients with renal impairment have not been undertaken. Because montelukast and its metabolites are eliminated by the biliary route, no dose adjustment is anticipated to be necessary in patients with renal impairment. There are no data on the pharmacokinetics of montelukast in patients with severe hepatic insufficiency (Child-Pugh score > 9).

With high doses of montelukast (20- and 60-fold the recommended adult dose), a decrease in plasma theophylline concentration was observed. This effect was not seen at the recommended dose of 10 mg once daily.

5.3 Preclinical safety data

In animal toxicity studies, minor serum biochemical alterations in ALT, glucose, phosphorus and triglycerides were observed which were transient in nature. The signs of toxicity in animals were increased excretion of saliva, gastro-intestinal symptoms, loose stools and ion imbalance. These occurred at dosages which provided > 17-fold the systemic exposure seen at the clinical dosage. In monkeys, the adverse effects appeared at doses from 150 mg/kg/day (> 232-fold the systemic exposure seen at the clinical dose).
In animal studies, montelukast did not affect fertility or reproductive performance at systemic exposure exceeding the clinical systemic exposure by greater than 24-fold. A slight decrease in pup body weight was noted in the female fertility study in rats at 200 mg/kg/day (> 69-fold the clinical systemic exposure). In studies in rabbits, a higher incidence of incomplete ossification, compared with concurrent control animals, was seen at systemic exposure > 24-fold the clinical systemic exposure seen at the clinical dose. No abnormalities were seen in rats. Montelukast has been shown to cross the placental barrier and is excreted in breast milk of animals.

No deaths occurred following a single oral administration of montelukast sodium at doses up to 5,000 mg/kg in mice and rats (15,000 mg/m^2 and 30,000 mg/m^2 in mice and rats, respectively) the maximum dose tested. This dose is equivalent to 25,000 times the recommended daily adult human dose (based on an adult patient weight of 50 kg).

Montelukast was determined not to be phototoxic in mice for UVA, UVB or visible light spectra at doses up to 500 mg/kg/day (approximately > 200-fold based on systemic exposure).

Montelukast was neither mutagenic in in vitro and in vivo tests nor tumorigenic in rodent species.

6 PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Microcrystalline cellulose
Mannitol (E421)
Crospovidone (type B)
Red Iron Oxide (E172)
Hydroxypropylcellulose
Disodium Edetate
Cherry Flavour
Aspartame (E951)
Talc
Magnesium Stearate
Crospovidone

6.2 Incompatibilities

Not applicable.

6.3 Shelf life

3 years

6.4 Special precautions for storage

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

6.5 Nature and contents of container

Nylon/Alu/PVC - Aluminium/blisters:
blister (without weekdays indicated): 10, 20, 30, 50, 60, 90, 100 and 250 tablets
blister (with weekdays indicated): 7, 14, 28, 56, 98, 126 and 154 tablets

HDPE bottles (with PP cap and desiccant):
10, 20, 30, 50, 60, 90, 100 and 250 tablets

Not all pack sizes may be marketed.

6.6 Special precautions for disposal and other handling

No special requirements. Any unused product or waste material should be disposed of in accordance with local requirements.

7 MARKETING AUTHORISATION HOLDER

Clonmel Healthcare Ltd
Clonmel
Co. Tipperary
Ireland

8 MARKETING AUTHORISATION NUMBER

PA0126/215/001

9 DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUTHORISATION

Date of first authorisation: 29th October 2010
Date of last renewal: 31st March 2013

10 DATE OF REVISION OF THE TEXT

November 2019