

# Summary of Product Characteristics

## 1 NAME OF THE MEDICINAL PRODUCT

Co-Tipol 500 mg/30 mg hard capsules

## 2 QUALITATIVE AND QUANTITATIVE COMPOSITION

Each hard capsule contains 500 mg paracetamol and 30 mg codeine phosphate hemihydrate.

For a full list of excipients, see section 6.1.

## 3 PHARMACEUTICAL FORM

Hard capsule

Co-Tipol are hard capsules consisting of a white and a yellowish orange section containing white powder

## 4 CLINICAL PARTICULARS

### 4.1 Therapeutic indications

Adults: Moderate to severe pain.

Children 12-18 years: Co-Tipol is only suitable for use in children older than 12 years for treatment of acute moderate pain that cannot be relieved by other analgesics such as paracetamol and ibuprofen (alone).

### 4.2 Posology and method of administration

#### Posology

Age	Single dose	Maximum daily dose (24 hours)
Adults (18 years and over)	1 - 2 hard capsules (equivalent to 500 - 1,000 mg of paracetamol and 30 - 60 mg of codeine phosphate hemihydrate)	Up to 8 hard capsules (equivalent to up to 4,000 mg of paracetamol and up to 240 mg of codeine phosphate hemihydrate)

The maximum daily dose must not be exceeded, and the interval between doses should be at least six hours (if any further capsules are needed).

This product should not be used with other paracetamol or codeine-containing medicines.

Co-Tipol should be used at the lowest effective dose for the shortest possible time. This dose may be taken, up to 4 times a day at intervals of not less than 6 hours. Maximum daily dose of codeine should not exceed 240mg.

The maximum daily dose of paracetamol should not exceed 60mg/kg/day (up to a maximum of 2g per day) in the following situations, unless directed by a physician:

- Weight less than 50kg
- Chronic alcoholism
- Dehydration
- Chronic malnutrition

#### Renal and hepatic impairment

The dose should be reduced or the interval between doses should be increased in the presence of impaired liver and/or kidney function and in subjects suffering from Gilbert's syndrome (Meulengracht's disease). Patients with severe renal impairment (creatinine clearance < 10 ml/min) must not exceed a dose interval of at least 8 hours.

The elderly:

A reduced dose may be required (see section 4.4). Experience has indicated that normal adult dosage of paracetamol is usually appropriate. However in frail, immobile, elderly subjects or in elderly patients with renal or hepatic impairment, a reduction in the amount or frequency of dosing may be appropriate.

Paediatric population

Age	Single dose	Maximum daily dose (24 hours)
Adolescents over 15 years	1 - 2 hard capsules (equivalent to 500 - 1,000 mg of paracetamol and 30 - 60 mg of codeine phosphate hemihydrate)	Up to 8 hard capsules (equivalent to up to 4,000 mg of paracetamol and up to 240 mg of codeine phosphate hemihydrate)
Children aged 12 to 15 years:	1 hard capsule (equivalent to 500 mg of paracetamol and 30 mg of codeine phosphate hemihydrate)	Up to 4 hard capsules (equivalent to up to 2,000 mg of paracetamol and up to 120 mg of codeine phosphate hemihydrate)

Children and adolescents with a low body weight.

The administration of Co-Tipol 500 mg / 30 mg is not recommended for children below 40 kg bodyweight as the dosage strength is not suitable for this patient group.

Co-Tipol 500 mg / 30 mg should not be used in children below the age of 12 years because of the risk of opioid toxicity due to the variable and unpredictable metabolism of codeine to morphine (see sections 4.3 and 4.4).

Method of administration

**The capsules should be swallowed whole with fluid. They should not be taken in a supine position.**

**Co-Tipol may have a delayed onset of action if the capsules are taken after meals**

**Duration of treatment**

The duration of treatment should be limited to 3 days and if no effective pain relief is achieved the patients/carers should be advised to seek the views of a physician.

**4.3 Contraindications**

Co-Tipol is contraindicated in

- patients with known hypersensitivity to the active substances or to any of the excipients listed in section 6.1
- patients with respiratory insufficiency,
- patients with pneumonia,
- patients with an acute attack of asthma.
- oncoming childbirth
- imminent premature birth
- children under 12 years or less than 40kg body weight
- women who are breastfeeding (see section 4.6).
- patients who are known to be ultra-rapid metabolisers for CYP2D6
- In all paediatric patients (0-18 years of age) who undergo tonsillectomy and/or adenoidectomy for obstructive sleep apnoea syndrome due to an increased risk of developing serious and life threatening adverse reactions (see section 4.4).

#### 4.4 Special warnings and precautions for use

In order to avoid overdosing, it should be ensured that no other medications containing paracetamol and/or codeine are administered concurrently.

Co-Tipol should only be used after balancing of risks and benefits in patients

- with opioid dependence,
- with impaired consciousness,
- with conditions associated with increased intracerebral pressure,
- under treatment with MAO inhibitors,
- with chronic obstructive airways disease,

CONTAINS PARACETAMOL.

Do not take with other paracetamol or codeine containing medicines.

Paracetamol should be administered with caution under the following circumstances (see section 4.2 where relevant):

- Hepatic impairment
- Chronic alcoholism
- Renal impairment (GFR $\leq$ 50ml/min)
- Gilbert's Syndrome (familial non-haemolytic jaundice)
- Concomitant treatment with medicinal products affecting hepatic function
- Glucose-6-phosphate dehydrogenase deficiency
- Haemolytic anaemia
- Glutathione deficiency
- Dehydration
- Chronic malnutrition
- Weight less than 50kg
- Elderly

#### CYP2D6 metabolism

Codeine is metabolised by the liver enzyme CYP2D6 into morphine, its active metabolite. If a patient has a deficiency or is completely lacking this enzyme an adequate analgesic effect will not be obtained. Estimates indicate that up to 7% of the Caucasian population may have this deficiency. However, if the patient is an extensive or ultra-rapid metaboliser there is an increased risk of developing side effects of opioid toxicity even at commonly prescribed doses. These patients convert codeine into morphine rapidly resulting in higher than expected serum morphine levels.

General symptoms of opioid toxicity include confusion, somnolence, shallow breathing, small pupils, nausea, vomiting, constipation and lack of appetite. In severe cases this may include symptoms of circulatory and respiratory depression, which may be life-threatening and very rarely fatal. Estimates of prevalence of ultra-rapid metabolisers in different populations are summarized below:

Population	Prevalence %
African/Ethiopian	29%
African American	3.4% to 6.5%
Asian	1.2% to 2%
Caucasian	3.6% to 6.5%
Greek	6.0%
Hungarian	1.9%
Northern European	1% to 2%

#### Post-operative use in children

There have been reports in the published literature that codeine given post-operatively in children after tonsillectomy and/or adenoidectomy for obstructive sleep apnoea, led to rare, but life-threatening adverse events including death (see also section 4.3). All children received doses of codeine that were within the appropriate dose range; however there was evidence that these children were either ultrarapid or extensive metabolisers in their ability to metabolise codeine to morphine.

Children with compromised respiratory function

Codeine is not recommended for use in children in whom respiratory function might be compromised including neuromuscular disorders, severe cardiac or respiratory conditions, upper respiratory or lung infections, multiple trauma or extensive surgical procedures. These factors may worsen symptoms of morphine toxicity.

Risk from concomitant use of sedative medicines such as benzodiazepines or related drugs:

Concomitant use of Co-Tipol and sedative medicines such as benzodiazepines or related drugs may result in sedation, respiratory depression, coma and death. Because of these risks, concomitant prescribing with these sedative medicines should be reserved for patients for whom alternative treatment options are not possible. If a decision is made to prescribe Co-Tipol concomitantly with sedative medicines, the lowest effective dose should be used, and the duration of treatment should be as short as possible. The patients should be followed closely for signs and symptoms of respiratory depression and sedation. In this respect, it is strongly recommended to inform patients and their caregivers to be aware of these symptoms (see section 4.5).

Severe acute hypersensitivity reactions such as anaphylactic shock have very rarely been seen. Treatment should be discontinued at the earliest signs of hypersensitivity reactions to the use/administration of Co-Tipol. Measures required to relieve the symptoms should be taken by experienced clinicians.

Severe liver damage may result from exceeding the recommended dose.

If large amounts of paracetamol are taken for extended periods of time or if this medicinal product is not used properly, it may cause headache which should not be treated with increased doses. In such cases, treatment should not be continued without first seeking the advice of a medical practitioner.

In general, the long-term use of analgesics, above all in combination with pain killers having an anti-inflammatory and antipyretic action, may lead to permanent damage to the kidney, which might result in renal failure (analgesic nephropathy).

Headache, fatigue, muscular pain, nervousness and vegetative symptoms may occur after abrupt discontinuation of any analgesic not used as directed or taken in large doses over long periods of time. No analgesic should be taken before subsidence of such symptoms, which usually disappear within a few days. A physician should be consulted before resuming treatment.

Co-Tipol should not be used in high dosage by patients suffering from hypotension and hypovolaemia.

As a component of a fixed dose mixture, codeine exhibits a primary potential of dependence. The prolonged use of large amounts of such products results in the development of tolerance, psychological and physical dependence. Cross-tolerance to other opioids is induced. Patients with pre-existing opiate dependence – even those in remission – are likely to suffer a quick relapse.

Codeine is regarded as a substitute by heroin addicts. Persons addicted to alcohol and sedatives are also prone to codeine abuse.

Caution is advised if paracetamol is administered concomitantly with flucloxacillin due to increased risk of high anion gap metabolic acidosis (HAGMA), particularly in patients with severe renal impairment, sepsis, malnutrition and other sources of glutathione deficiency (e.g. chronic alcoholism), as well as those using maximum daily doses of paracetamol. Close monitoring, including measurement of urinary 5-oxoproline, is recommended.

Caution:

The prolonged administration of large amounts increases the risk of producing dependence.

Patients receiving large doses and very sensitive persons may develop dose-related disturbances of visuomotor coordination and impaired visual acuity. Furthermore, respiratory depression and euphoria may occur.

Caution must be exercised in the treatment of patients having undergone cholecystectomy. Myocardial infarction-like symptoms may occur and symptoms of patients with pancreatitis may become worse as a result of a contraction of the sphincter of Oddi.

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

Sedative medicines such as benzodiazepines or related drugs:

The concomitant use of opioids with sedative medicines such as benzodiazepines or related drugs increases the risk of sedation, respiratory depression, coma and death because of additive CNS depressant effect. The dose and duration of concomitant use should be limited (see section 4.4).

The concomitant use of drugs causing enzyme induction in the liver, such as certain sedative agents and antiepileptics (phenobarbital, phenytoin, carbamazepine, etc.) as well as rifampicin may result in liver damage caused by otherwise safe doses of paracetamol.

The same applies to compounds that may have a toxic action on the liver and to alcohol abuse.

When administered in combination with chloramphenicol, Co-Tipol may substantially slow down the excretion and increase the toxic risk of this compound.

Anticoagulants: The repeated ingestion of paracetamol for more than one week reinforces the response to anticoagulants, while the occasional use of paracetamol has no significant influence on the effect of these drugs.

The absorption of paracetamol may be impaired and the drug may have a slower onset of action, if products delaying stomach emptying (e. g. propantheline) are given simultaneously.

Conversely, the absorption of paracetamol may be enhanced and the drug may have a more rapid onset of action, if the patient concurrently receives drugs accelerating gastric emptying like metoclopramide or domperidone.

Patients who concomitantly receive paracetamol and zidovudine (AZT or retrovir) may be more susceptible to the development of neutropenia.

Ingestion of probenecid inhibits the linkage of paracetamol to glucuronic acid, reducing paracetamol clearance by a factor of about 2. The dose of paracetamol should therefore be reduced if probenecid is given concurrently.

Salicylamides may increase the elimination half-life of paracetamol.

Cholestyramine reduces the absorption of paracetamol.

Alcohol should be refrained from by patients on Co-Tipol, since their psychomotor performance may be substantially impaired (overadditive effect of the different ingredients).

Codeine-induced respiratory depression may be increased in subjects receiving tricyclic antidepressants (imipramine, amitriptyline) or opipramol.

The concomitant use of MAO inhibitors like tranlycypromine may reinforce the action on the central nervous system and produce other side-effects of unforeseeable severity. That is why Co-Tipol should not be used within two weeks after the last administration of any MAO inhibitor.

Co-Tipol increases the effect of analgesics. Its action may be diminished by the simultaneous use of partial opioid agonists and antagonists such as buprenorphine and pentacozine.

Cimetidine and other drugs influencing the liver metabolism may increase the effect of Co-Tipol. Inhibition of morphine degradation resulting in an elevation of plasma levels was seen in patients on morphine treatment. This effect cannot be ruled out for codeine.

Caution should be taken when paracetamol is used concomitantly with flucloxacillin as concurrent intake has been associated with high anion gap metabolic acidosis, especially in patients with risks factors (see section 4.4).

#### Effects on laboratory tests:

Uric acid tests using phosphotungstic acid and the determination of blood glucose with glucose oxidase peroxidase may be influenced by paracetamol.

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

### **Pregnancy**

An association was noted between malformations of the respiratory tract and the use of codeine in the first three months of human pregnancy. Epidemiological studies of narcotic analgesics including codeine have revealed further malformations.

Epidemiological studies on neurodevelopment in children exposed to paracetamol in utero show inconclusive results. If clinically needed, Co-Tipol should only be used during pregnancy especially in the first three months – if clinical circumstances so indicate and after balancing benefits against risks.

The use of Co-Tipol is contraindicated in women well advanced in pregnancy or at risk for premature delivery, since codeine can cross the placental barrier and cause respiratory depression in the newborn.

The prolonged use of codeine may give rise to opioid dependence of the foetus.

The repeated administration of codeine in the last three months of pregnancy has been reported to cause withdrawal symptoms in the newborn

**Breast-feeding**

Co-Tipol should not be used during breastfeeding (see section 4.3).

At normal therapeutic doses codeine and its active metabolite may be present in breast milk at very low doses and is unlikely to adversely affect the breast fed infant. However, if the patient is an ultrarapid metaboliser of CYP2D6, higher levels of the active metabolite, morphine, may be present in breast milk and on very rare occasions may result in symptoms of opioid toxicity in the infant, which may be fatal.

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

Even if used properly, the codeine component of Co-Tipol may modify the patient’s reaction to an extent that his/her ability to drive a car, operate machinery or perform hazardous activities is impaired.

**4.8 Undesirable effects**

In this section frequencies of undesirable effects are defined as follows: 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).

<b>System Organ Class</b>	<b>Very common</b>	<b>Common</b>	<b>Uncommon</b>	<b>Rare</b>	<b>Very rare</b>
Blood and lymphatic system disorders				Allergic thrombocytopenia, leucocytopenia	Agranulocytosis, pancytopenia, hypersensitivity reactions such as angioedema, shortness of breath, sweating, nausea, fall in blood pressure, including shock
Nervous system disorders	Dizziness, headache, fatigue	drowsiness	Sleep disturbances		
Ear and labyrinth disorders			Tinnitus		
Respiratory, thoracic and mediastinal disorders			Shortness of breath		Bronchospasm (analgesic asthma syndrome)
Gastrointestinal disorders	Nausea, vomiting (initially), constipation		Dry mouth		
Hepatobiliary disorders				Increase in liver-specific laboratory findings (increase of liver transaminase level)	
Skin and			Pruritus,		Serious skin

subcutaneous tissue disorders		erythema, allergic exanthema, urticaria	reactions (including Stevens-Johnson syndrome)
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**Note:**

Patients should be instructed to stop treatment and immediately contact a doctor at the earliest signs of hypersensitivity reactions.

**Description of selected adverse reactions**

*Pulmonary oedema:* Patients on large doses may develop pulmonary oedema, especially those with pre-existing disorders of lung function.

*Cardiovascular diseases:* Patients taking large amounts tend to develop fall in blood pressure and syncope.

**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:

HPRA Pharmacovigilance

Website: [www.hpra.ie](http://www.hpra.ie)

**4.9 Overdose**

The symptoms of an overdose with Co-Tipol correspond to the manifestations of poisoning with the single agents.

**Paracetamol**

Paracetamol overdose can result in liver damage which may be fatal.

Symptoms generally appear within the first 24 hours and may comprise: nausea, vomiting, anorexia, pallor, and abdominal pain, or patients may be asymptomatic.

Overdose of paracetamol can cause liver cell necrosis likely to induce complete and irreversible necrosis, resulting in hepatocellular insufficiency, metabolic acidosis and encephalopathy which may lead to coma and death. Simultaneously, increased levels of hepatic transaminases (AST, ALT), lactate dehydrogenase and bilirubin are observed together with increased prothrombin levels that may appear 12 to 48 hours after administration.

Liver damage is likely in patients who have taken more than the recommended amounts of paracetamol. It is considered that excess quantities of toxic metabolite become irreversibly bound to liver tissue.

Some patients may be at increased risk of liver damage from paracetamol toxicity:

Risk factors include;

- Patients with liver disease
- Elderly patients
- Young children
- Patients receiving long-term treatment with carbamazepine, phenobarbitone, phenytoin, primidone, rifampicin, St John's Wort or other drugs that induce liver enzymes.
- Patients who regularly consume ethanol in excess of recommended amounts
- Patients with glutathione depletion e.g. eating disorders, cystic fibrosis, HIV infection, starvation, cachexia

Acute renal failure with acute tubular necrosis may also develop.

Cardiac arrhythmias and pancreatitis have also been reported.

#### Emergency Procedure:

Immediate transfer to hospital.

Blood sampling to determine initial paracetamol plasma concentration. In the case of a single acute overdose, paracetamol plasma concentration should be measured 4 hours post ingestion. Administration of activated charcoal should be considered if the overdose of paracetamol has been ingested within the previous hour.

The antidote N-acetylcysteine, should be administered as soon as possible in accordance with national treatment guidelines.

Symptomatic treatment should be implemented.

#### **Codeine**

Respiratory depression is a characteristic symptom of codeine overdose. Furthermore, somnolence including stupor and coma, as well as vomiting, headache, urinary and faecal retention and sometimes bradycardia and a fall in blood pressure may occur. Seizure disorders have been reported occasionally, especially in children.

These symptoms may be intensified by the simultaneous ingestion of alcohol or drugs producing a sedative effect on the CNS. The elderly, patients with liver or renal disease, patients with compromised respiratory function, children under 18 years and ultra-rapid metabolisers for CYP2D6 are at a higher risk of toxic symptoms.

Codeine may increase the smooth muscle tone, especially after the ingestion of single doses over 60 mg.

In the event that amounts exceeding 2 mg of codeine per kg bodyweight have been ingested and if the patient develops clinical symptoms, respiration should be monitored and resuscitation should be available until subsidence of symptoms. In the absence of clinical symptoms, these measures should be taken for a period of up to six hours.

The effect of codeine may be blocked in manifest respiratory depression by administration of opiate antagonists such as naloxone. The administration of naloxone is to be repeated because the period of action of codeine lasts longer than that of naloxone. If naloxone cannot be administered, symptomatic measures, in particular, putting the patient in recovery position, ventilation and shock treatment are recommended.

## **5 PHARMACOLOGICAL PROPERTIES**

### **5.1 Pharmacodynamic properties**

Pharmacotherapeutic group: analgesics and antipyretics, anilides

ATC code: N02AJ06

Paracetamol is an analgesic and antipyretic agent having a very weak anti-inflammatory action. Its mode of action is still not entirely clear.

However, it is well established that paracetamol inhibits the central prostaglandin synthesis to a far greater extent than the peripheral one. Furthermore, it counteracts the effect of the endogenous pyrogens on the hypothalamic heat-regulating centre. It may be assumed that there is a correlation between this mechanism and its antipyretic action.

Codeine is a centrally acting weak analgesic. Codeine exerts its effect through  $\mu$  opioid receptors, although codeine has low affinity for these receptors, and its analgesic effect is due to its conversion to morphine. Codeine, particularly in combination with other analgesics such as paracetamol, has been shown to be effective in acute nociceptive pain.

In clinical studies, the association of paracetamol and codeine has been compared with various analgesics and with placebo. In all cases, the fixed dose mixture was shown to be significantly superior to placebo. The results of certain studies suggest that the combination produces a stronger analgesic effect than the single compounds, even after an increase in their doses, providing the risks associated with drug mixtures are found to be acceptable.



## 5.2 Pharmacokinetic properties

### **Paracetamol**

#### Absorption

The drug is metabolized chiefly in the liver by direct conjugation to glucuronic acid or sulphuric acid. Small amounts are metabolized through the cytochrome P 450 system (mainly CYP2E1) producing a toxic metabolite – N-acetyl-p-benzoquinonimine – which is normally bound and eliminated, although its concentration is substantially increased in case of massive intoxication.

#### Elimination

Paracetamol is excreted by the kidney. Ninety per cent of the ingested amount is eliminated within 24 hours, mainly as glucuronides (60 to 80 per cent) and sulphate conjugates (20 to 30 per cent). Less than 5 per cent remains unchanged and is excreted as such. The elimination half life is about two hours. Longer half lives were seen in patients with impaired liver and kidney function, after overdose and in the newborn. The maximum effect of the drug and its average duration of action (four to six hours) correlate more or less with its plasma concentration.

#### Severe renal insufficiency

The excretion of paracetamol and its metabolites is delayed in patients with severe renal failure (creatinine clearance below 10 ml/min).

### **Codeine**

#### Absorption

Codeine is rapidly absorbed after administration by mouth. Peak plasma levels are reached after about one hour. The drug is metabolized in the liver (big differences from one person to the other). Morphine, norcodeine and conjugates of morphine and codeine are the main metabolites of the drug. The concentrations of the conjugates are far higher than those of the parent substances.

#### Elimination

Elimination half-life ranges between 3 and 5 hours and rises to 9 to 18 hours in subjects affected with renal failure. The excretion of the drug is slower in the elderly. Codeine is excreted mainly by the kidney. About 10 percent is eliminated from the body unchanged. Codeine crosses the placental barrier and enters the foetal circulation. Pharmacologically relevant concentrations were found in human milk after the administration of large doses of codeine.

Paracetamol and codeine are comparable as regards absorption rates, occurrence of peak plasma concentrations and duration of action. The successive steps of their biotransformation and the renal elimination processes do not interfere with each other.

## 5.3 Preclinical safety data

### Paracetamol

Animal studies of the acute, subchronic and chronic toxicity of paracetamol in rats and mice have revealed gastrointestinal lesions, changes to the blood count, degenerative changes to the hepatic and renal parenchyma and necroses. These changes are due to the mode of action and to the metabolism of paracetamol. The metabolites suspected of producing these toxic effects and the resulting organ changes, were encountered in humans as well. Very rare cases of reversible, chronic aggressive hepatitis were observed during the long-term administration (one year) of maximum therapeutic doses. Symptoms of poisoning may occur after the ingestion of subtoxic doses over a period of three weeks. Thus, paracetamol should not be given for prolonged periods or in large amounts. Comprehensive studies failed to provide evidence that paracetamol carries a significant genotoxic risk, as long as the drug is given in therapeutic, i.e. non-toxic doses. In long-term studies performed in rats and mice, no relevant tumorigenic effects were caused by paracetamol administered in doses that do not produce toxic effects on the liver. Paracetamol crosses the placental barrier. No evidence of foetal damage was noted in animal studies and in human therapy.

Conventional studies using the currently accepted standards for the evaluation of toxicity to reproduction and development are not available.

## **Codeine**

In vitro and in vivo studies of codeine failed to reveal any mutagenic potential. No evidence of a tumorigenic potential was provided in long-term studies conducted in rats and mice. Animal experiments appear to suggest that the drug has a teratogenic potential.

### **6 PHARMACEUTICAL PARTICULARS**

#### **6.1 List of excipients**

Talc

Capsule body:

Gelatin

Titanium dioxide (E171)

Iron oxide red (E172)

Iron oxide yellow (E172)

#### **6.2 Incompatibilities**

Not applicable.

#### **6.3 Shelf life**

5 years

#### **6.4 Special precautions for storage**

Store in the original package to protect from light.

This medicinal product does not require any special temperature storage conditions.

#### **6.5 Nature and contents of container**

White PVC/aluminium blisters strips containing 10 hard capsules.

Pack sizes: 10, 20, 100 and hospital pack sizes of 200 and 1,000.

Not all pack sizes may be marketed.

#### **6.6 Special precautions for disposal**

No special requirements.

### **7 MARKETING AUTHORISATION HOLDER**

Clonmel Healthcare Ltd  
Waterford Road  
Clonmel, Co. Tipperary  
E91 D768  
Ireland

### **8 MARKETING AUTHORISATION NUMBER**

PA0126/332/001

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

Date of first authorisation: 29<sup>th</sup> November 2013

Date of last renewal: 28<sup>th</sup> November 2018

**10 DATE OF REVISION OF THE TEXT**

September 2022