1. Name of the medicinal product

Acamol Tsinun and Shapaat Day

2. Qualitative and quantitative composition

Acamol Tsinun and Shapaat Day caplets contain Paracetamol 500 mg, Pseudoephedrine hydrochloride 30 mg and Dextromethorphan hydrobromide 15 mg .

Excipients with known effect:

Each caplet contains Sodium 0.588-0.882 mg

Each caplet contains Lactose monohydrate 6.5 mg

Each caplet contains FD&C YELLOW #6/SUNSET YELLOW FCF

For the full list of excipients, see section 6.1

3. Pharmaceutical form

Green, capsule shaped biconvex film coated tablet, plain on one side and scored on the other side

4. Clinical particulars

4.1 Therapeutic indications

Acamol Tsinun and Shapaat Day is indicated for a relief of cold, cough and nasal congestion associated with fever and pain, for day care.

4.2 Posology and method of administration

Posology

Adults and children aged 12 years and over:

1-2 caplets every four to six hours, up to four times a day. Maximum daily dose: 8 caplets (i.e. 4 g paracetamol, 240 mg pseudoephedrine hydrochloride, 120 mg Dextromethorphan hydrobromide).

Children under 12 years:

Acamol Tsinun and Shapaat Day is contraindicated in children under the age of 12 years (see section 4.3).

In the elderly the rate and extent of paracetamol absorption is normal but plasma half life is longer and paracetamol clearance is lower than in young adults.

Consult with your doctor before using this product.

When taking with Acamol Tsinun and Shapaat Night, do not take more than a total of 8 caplets a day. You have to take one dose of Acamol Tsinun and Shapaat Night instead of one dose of Acamol Tsinun and Shapaat Day. Do not add to the maximum recommended dosage.

Hepatic dysfunction

Caution should be exercised when administering Acamol Tsinun and Shapaat Day to patients with severe hepatic impairment.

Renal dysfunction:

Caution should be exercised when administering Acamol Tsinun and Shapaat Day to patients with moderate to severe renal impairment.

Method of administration

For oral use

4.3 Contraindications

Acamol Tsinun and Shapaat Day is contraindicated in individuals with known hypersensitivity to paracetamol, pseudoephedrine or any of the excipients listed in section 6.1.

Concomitant use of other sympathomimetic decongestants, beta-blockers or monoamine oxidase inhibitors (MAOIs), or within 14 days of stopping MAOI treatment (see section 4.5). The concomitant use of MAOIs may cause a rise in blood pressure and/or hypertensive crisis.

Taking selective serotonin reuptake inhibitor (SSRI), or other medications for depression, psychiatric or emotional conditions, or Parkinson's disease, or for 2 weeks after stopping the medication. If you are not sure if your prescription medications contains one of these medicines, ask a doctor or pharmacist before taking this product.

Cardiovascular disease including hypertension

Diabetes mellitus

Phaeochromocytoma

Hyperthyroidism

Closed angle glaucoma

Severe renal impairment

Not to be used in children under the age of 12 years.

4.4 Special warnings and precautions for use

Patients experiencing difficulty in urination and/or enlargement of the prostate, or patients with thyroid disease who are receiving thyroid hormones should not take pseudoephedrine unless directed by a physician.

Caution should be exercised when using the product in the presence of severe hepatic impairment or moderate to severe renal impairment (particularly if accompanied by cardiovascular disease), or in occlusive vascular disease. The hazards of overdose are greater in those with non-cirrhotic alcoholic liver disease.

If any of the following occur, this product should be stopped:

- Hallucinations
- Restlessness
- Sleep disturbances

Severe Skin reactions: Severe skin reactions such as acute generalized exanthematous pustulosis (AGEP) may occur with pseudoephedrine-containing products. This acute pustular eruption may occur within the first 2 days of treatment, with fever, and numerous, small, mostly non-follicular pustules arising on a widespread oedematous erythema and mainly localized on the skin folds, trunk, and upper extremities. Patients should be carefully monitored. If signs and symptoms such as pyrexia, erythema, or many small pustules are observed, administration of this medicine should be discontinued, and appropriate measures taken if needed.

Ischaemic colitis: Some cases of ischaemic colitis have been reported with pseudoephedrine. Pseudoephedrine should be discontinued, and medical advice sought if sudden abdominal pain, rectal bleeding or other symptoms of ischaemic colitis develop.

Ischaemic optic neuropathy: Cases of ischaemic optic neuropathy have been reported with pseudoephedrine. Pseudoephedrine should be discontinued if sudden loss of vision or decreased visual acuity such as scotoma occurs.

There have been rare cases of posterior reversible encephalopathy syndrome (PRES) / reversible cerebral vasoconstriction syndrome (RCVS) reported with sympathomimetic drugs, including pseudoephedrine. Symptoms reported include sudden onset of severe headache, nausea, vomiting, and visual disturbances. Most cases improved or resolved within a few days following appropriate treatment. Pseudoephedrine should be discontinued, and medical advice sought immediately if signs or symptoms of PRES/RCVS develop.

Patients suffering from chronic cough as occurs with smoking, asthma or patients suffering from an acute asthma attack, or where cough is accompanied by excessive secretions should be advised to consult a Healthcare Professional before use.

Causes of chronic cough should be excluded if symptoms are persistent. Any accompanying symptoms should be actively sought and appropriately investigated/ treated. Stop use and ask your healthcare professional if your cough lasts more than 7 days, comes back or is accompanied by a fever, rash or persistent headache. These could be signs of serious conditions.

Drug dependence, tolerance and potential for abuse

For all patients, prolonged use of this product may lead to drug dependence (addiction), even at therapeutic doses. The risks are increased in individuals with current or past history of substance misuse disorder (including alcohol misuse) or mental health disorder (e.g., major depression). Caution is particularly recommended for adolescents and young adults as well as in patients with a history of drug abuse or psychoactive substances.

The drug withdrawal syndrome is characterised by some or all of the following: restlessness, lacrimation, rhinorrhoea, yawning, perspiration, chills, myalgia, mydriasis and palpitations. Other symptoms may also develop including irritability, agitation, anxiety, hyperkinesia, tremor, weakness, insomnia, anorexia, abdominal cramps, nausea, vomiting, diarrhoea, increased blood pressure, increased respiratory rate or heart rate.

Dextromethorphan is metabolised by hepatic cytochrome P450 2D6. The activity of this enzyme is genetically determined. About 10% of the general population are poor metabolisers of CYP2D6. Poor metabolisers and patients with concomitant use of CYP2D6 inhibitors may experience exaggerated and/or prolonged effects of dextromethorphan. Caution should therefore be exercised in patients who are slow metabolizers of CYP2D6 or use CYP2D6 inhibitors (see

also section 4.5).

Taking this product with other paracetamol-containing products, could lead to overdose and should therefore be avoided.

For Paracetamol

Paracetamol has been associated with a risk of rare but serious skin reactions. These skin reactions, known as Stevens-Johnson Syndrome (SJS), toxic epidermal necrolysis (TEN), and acute generalized exanthematous pustulosis (AGEP), can be fatal.

- Reddening of the skin, rash, blisters, and detachment of the upper surface of the skin can occur with the use of drug products that contain paracetamol. These reactions can occur with first-time use of paracetamol or at any time while it is being taken.

Anyone who develops a skin rash or reaction while using paracetamol should stop the drug and seek medical attention right away. Anyone who has experienced a serious skin reaction with paracetamol should not take the drug again and should contact their health care professional to discuss alternative pain relievers/fever reducers.

Health care professionals should be aware of this rare risk and consider paracetamol along with other drugs already known to have such an association, when assessing patients with potentially drug induced skin reactions.

Paracetamol can cause accidental poisoning in toddlers and infants. Paracetamol-containing products should be kept well out of reach of children.

Potentially fatal hepatotoxicity can result from paracetamol overdosage. However, in rare cases, hepatotoxicity has occurred in patients receiving high or excessive doses within therapeutic doses. Certain patients may be more susceptible to paracetamol hepatotoxicity, e.g., chronic alcoholics, patients with liver disease, or those who are malnourished or taking other drugs that induce hepatic enzymes.

Because of the risk of heptotoxicity, patients should be cautioned against the inadvertent administration of excessive doses of paracetamol by using multiple paracetamol-containing products at once, such as cough and cold remedies, analgesics or arthritic formulations, antipyretics or products for relief of menstrual symptoms or muscle spasm. Administration of paracetamol to children may be especially prone to error due to the many concentrations and strengths of products available. To avoid dosing errors, all product labels should be checked carefully to ensure calculation of the amount of paracetamol to be given.

Keep out of the sight and reach of children.

Do not exceed recommended dose.

Excipients:

Sodium:

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

Lactose:
should be taken into account in patients with diabetes mellitus.

4.5 Interaction with other medicinal products and other forms of interaction

MAOIs (see section 4.3) and/or RIMAs: Pseudoephedrine exerts its vasoconstricting properties by stimulating a-adrenergic receptors and displacing noradrenaline from neuronal storage sites. Since monoamine oxidase inhibitors (MAOIs) impede the metabolism of sympathomimetic amines and increase the store of releasable noradrenaline in adrenergic nerve endings, MAOIs may potentiate the pressor effect of pseudoephedrine. This product should not be used in patients taking monoamine inhibitors or within 14 days of stopping treatment as there is a risk of hypertensive crisis.

Do not use if you are now taking a prescription a selective serotonin reuptake inhibitor (SSRI), or other medications for depression, psychiatric, or emotional conditions, or Parkinson's disease, or for 2 weeks after stopping the medication

Moclobemide: Risk of hypertensive crisis

Sympathomimetic agents: Concomitant use of this product with tricyclic antidepressants or sympathomimetic agents (such as decongestants, appetite suppressants and amphetamine-like psychostimulants) or with monoamine oxidase inhibitors may cause a rise in blood pressure.

Antihypertensives: Because of the pseudoephedrine content, this product may partially reverse the hypotensive action of antihypertensive drugs which interfere with sympathetic activity including bretylium, betanidine, guanethedine, debrisoquine, methyldopa, adrenergic neurone blockers and beta-blockers.

Cardiac glycosides: Increased risk of dysrhythmias.

Ergot alkaloids (ergotamine & methysergide): Increased risk of ergotism

Oxytocin: Risk of hypertension

Anticholinergic drugs: Enhances effects of anticholinergic drugs (such as tricyclic antidepressants)

Anaesthetic agents: Concurrent use with halogenated anaesthetic agents such as chloroform, cyclopropane, halothane, enflurane or isoflurane may provoke or worsen ventricular arrhythmias.

Chronic alcohol intake can increase the hepatotoxicity of paracetamol overdose and may have contributed to the acute pancreatitis reported in one patient who had taken an overdose of paracetamol. Acute alcohol intake may diminish an individual's ability to metabolise large doses of paracetamol, the plasma half-life of which can be prolonged.

The use of drugs which induce hepatic microsomal enzymes, such as anticonvulsants and oral contraceptive steroids, may increase the extent of metabolism of paracetamol, resulting in reduced plasma concentrations of the drug and a faster elimination rate.

The speed of absorption of paracetamol may be increased by metoclopramide or domperidone and absorption reduced by cholestyramine.

The anticoagulant effect of warfarin and other coumarins may be enhanced by prolonged regular use of paracetamol with increased risk of bleeding; occasional doses have no significant effect.

CYP2D6 inhibitors

Dextromethorphan is metabolized by CYP2D6 and has an extensive first-pass metabolism. Concomitant use of potent CYP2D6 enzyme inhibitors can increase the dextromethorphan concentrations in the body to levels multifold higher than normal. This increases the patient's risk for toxic effects of dextromethorphan (agitation, confusion, tremor, insomnia, diarrhoea and respiratory depression) and development of serotonin syndrome. Potent CYP2D6 enzyme inhibitors include fluoxetine, paroxetine, quinidine and terbinafine. In concomitant use with quinidine, plasma concentrations of dextromethorphan have increased up to 20-fold, which has increased the CNS adverse effects of the agent. Amiodarone, flecainide and propafenone, sertraline, bupropion, methadone, cinacalcet, haloperidol, perphenazine and thioridazine also have similar effects on the metabolism of dextromethorphan. If concomitant use of CYP2D6 inhibitors and dextromethorphan is necessary, the patient should be monitored and the dextromethorphan dose may need to be reduced.

4.6 Fertility, pregnancy and lactation

There are no adequate and well-controlled clinical studies in pregnant or breast-feeding women for the combination of paracetamol and pseudoephedrine.

This product should not be used during pregnancy or lactation unless the potential benefit of treatment to the mother outweighs the possible risks to the developing foetus or breastfeeding infant.

Although dextromethorphan has been in widespread use for many years without apparent ill-consequence, there are no specific data on its use during pregnancy. Caution should therefore be exercised by balancing the potential benefit of treatment against any possible hazards. It is not known whether dextromethorphan or its metabolites are excreted in human milk.

Pregnancy

The safety of pseudoephedrine in pregnancy has not been established.

A large amount of data on pregnant women indicate neither malformative, nor feto/neonatal toxicity. Epidemiological studies on neurodevelopment in children exposed to paracetamol in utero show inconclusive results. If clinically needed, paracetamol can be used during pregnancy however it should be used at the lowest effective dose for the shortest possible time and at the lowest possible frequency.

Breastfeeding

Pseudoephedrine is excreted in breast milk in small amounts but the effect of this on breast-fed infants is not known. It has been estimated that approximately 0.4 to 0.7% of a single 60 mg dose of pseudoephedrine ingested by a nursing mother will be excreted in the breast milk over 24 hours. Data from a study of lactating mothers taking 60 mg pseudoephedrine every 6 hours suggests that from 2.2 to 6.7% of the maximum daily dose (240 mg) may be available to the infant from a breastfeeding mother.

Paracetamol is excreted in breast milk but not in a clinically significant amount. Available published data do not contraindicate breast feeding. A pharmacokinetic study of paracetamol in 12 nursing mothers revealed that less than 1% of a 650 mg oral dose of paracetamol appeared in the breast milk. Similar findings have been reported in other studies, therefore maternal ingestion of therapeutic doses of paracetamol does not appear to present a risk to the infant.

It is not known whether dextromethorphan or its metabolites are excreted in human milk.

Fertility

No studies have been conducted in animals to determine whether pseudoephedrine has the potential to impair fertility. There is no information of the effect of this medicine on fertility.

4.7 Effects on ability to drive and use machines

This medicine can impair cognitive function and can affect a patient's ability to drive safely.

When taking this medicine, patients should be told:

- The medicine is likely to affect your ability to drive
- Do not drive until you know how the medicine affects you

4.8 Undesirable effects

Adverse drug reactions identified during clinical trials and post-marketing experience with paracetamol, pseudoephedrine, or the combination are listed below by System Organ Class (SOC).

The frequencies are defined according to the following convention:

Very common ≥1/10

Common ≥1/100 and < 1/10

Uncommon ≥1/1,000 and <1/100

Rare ≥1/10,000 and <1/1,000

Very rare <1/10,000, including isolated reports

Not known (cannot be estimated from the available data)

ADRs are presented by frequency category based on 1) incidence in adequately designed clinical trials or epidemiology studies, if available, or 2) when incidence cannot be estimated, frequency category is listed as 'Not known'.

System Organ Class (SOC)	**Frequency**	**Adverse Drug Reaction (Preferred Term)**
Blood and lymphatic system disorders	Not known	Blood disorders, blood dyscrasias (including agranulocytosis and thrombocytopenia) have been reported following paracetamol use but were not necessarily causally related to the drug
Immune system disorders	Rare	Hypersensitivity (cross-sensitivity may occur with other sympathomimetics)

Psychiatric disorders	Common	Insomnia Nervousness
	Not known	Anxiety Euphoric mood Excitability Hallucinations Irritability Paranoid delusions Restlessness Sleep disorder Drug dependence (see section 4.4)
Nervous system disorders	Very common	Headache
	Common	Dizziness
	Not known	Cerebrovascular accident Paraesthesia Posterior reversible encephalopathy syndrome (PRES)/reversible cerebral vasoconstriction syndrome (RCVS) Psychomotor hyperactivity Somnolence Tremor
	rare	Dizziness, drowsiness, mental confusion
Eye Disorders	Not known	Ischaemic optic neuropathy
Cardiac disorders	Not known	Dysrhythmias Myocardial infarction/myocardial ischaemia Palpitations Tachycardia
Vascular disorders	Not known	Hypertension
Gastrointestinal disorders	Common	Dry mouth Nausea
	Not known	Abdominal pain Diarrhoea Ischaemic colitis Vomiting

	rare	Gastrointestinal upset
Hepatobiliary disorders	Rare	Hepatic necrosis
Skin and subcutaneous tissue disorders	Rare	Rash
	Not known	Angioedema Fixed eruption Pruritus Rash pruritic Severe skin reactions, including Acute generalised exanthematous pustulosis (AGEP) Urticaria
General disorders and administration site conditions	Frequency unknown	drug withdrawal syndrome

Renal and urinary disorders	Uncommon	Nephropathy toxic
	Not known	Dysuria Renal papillary necrosis (after prolonged administration) Urinary retention (in men whom prostatic enlargement could have been an important predisposing factor)

Chronic hepatic necrosis has been reported in a patient who took daily therapeutic dosages of paracetamol for about a year and liver damage has been reported after daily ingestion of excessive amounts for shorter periods. A review of a group of patients with chronic active hepatitis failed to reveal differences in the abnormalities of liver function in those who were long-term users of paracetamol nor was the control of their disease improved after paracetamol withdrawal.

Very rare cases of serious skin reactions have been reported with paracetamol.

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.
Any suspected adverse events should be reported to the Ministry of Health according to the National Regulation by using an online form
https://sideeffects.health.gov.il/

4.9 Overdose

Signs and symptoms

Paracetamol

Liver damage is possible in adults who have taken 10 g or more of paracetamol. Ingestion of 5 g or more of paracetamol may lead to liver damage if the patient has risk factors (see below).

Risk Factors:

If the patient

A. Is on long term treatment with carbamazepine, phenobarbital, phenytoin, primidone, rifampicin, St John's Wort or other drugs that induce liver enzymes.

Or

B. Regularly consumes ethanol in excess of recommended amounts.

Or

C. Is likely to be glutathione deplete e.g. eating disorders, cystic fibrosis, HIV infection, starvation, cachexia.

Symptoms

Symptoms of paracetamol overdosage in the first 24 hours are pallor, nausea, vomiting, anorexia and abdominal pain. Liver damage may become apparent 12 to 48 hours after ingestion. Abnormalities of glucose metabolism and metabolic acidosis may occur. In severe poisoning, hepatic failure may progress to encephalopathy, haemorrhage, hypoglycaemia, cerebral oedema, coma and death.

Acute renal failure with acute tubular necrosis, strongly suggested by loin pain, haematuria and proteinuria, may develop even in the absence of severe liver damage. Cardiac arrhythmias and pancreatitis have been reported.

Haemolytic anaemia (in patients with glucose-6-phosphate dehydrogenase [G6PD] deficiency): Haemolysis has been reported in patients with G6PD deficiency, with use of paracetamol in overdose.

Management

Immediate treatment is essential in the management of paracetamol overdose. Despite a lack of significant early symptoms, patients should be referred to hospital urgently for immediate medical attention. Symptoms may be limited to nausea or vomiting and may not reflect the severity of overdose or the risk of organ damage. Management should be in accordance with established treatment guidelines, see BNF overdose section.

Treatment with activated charcoal should be considered if the overdose has been taken within 1 hour. Plasma paracetamol concentration should be measured at 4 hours or later after ingestion (earlier concentrations are unreliable). Treatment with N-acetylcysteine may be used up to 24 hours after ingestion of paracetamol, however, the maximum protective effect is obtained up to 8 hours post-ingestion. The effectiveness of the antidote declines sharply after this time. If required the patient should be given intravenous N-acetylcysteine, in line with the established dosage schedule. If vomiting is not a problem, oral methionine may be a suitable alternative for remote areas, outside hospital. Management of patients who present with serious hepatic dysfunction beyond 24h from ingestion should be discussed with the NPIS or a liver unit.

Pseudoephedrine

Symptoms

8/Overdose may result in:

Hyperglycaemia, hypokalaemia, CNS stimulation, insomnia; irritability, restlessness, anxiety, agitation; confusion, delirium, hallucinations, psychoses, seizures, tremor, intracranial haemorrhage including intracerebral haemorrhage, drowsiness in children, mydriasis, palpitations, tachycardia, reflex bradycardia, supraventricular and ventricular arrhythmias, dysrhythmias, myocardial infarction, hypertension, vomiting, ischaemic bowel infarction, acute renal failure, difficulty in micturition.

Management

Necessary measures should be taken to maintain and support respiration and control convulsions. Catheterisation of the bladder may be necessary. If desired, the elimination of pseudoephedrine can be accelerated by acid diuresis or by dialysis.

Dextromethorphan hydrobromide

Symptoms and signs:

Dextromethorphan overdose may be associated with nausea, vomiting, dystonia, agitation, confusion, somnolence, stupor, nystagmus, cardiotoxicity (tachycardia, abnormal ECG including QTc prolongation), ataxia, toxic psychosis with visual hallucinations, hyperexcitability.

In the event of massive overdose the following symptoms may be observed: coma, respiratory depression, convulsions.

Management:

-Activated charcoal can be administered to asymptomatic patients who have ingested overdoses of dextromethorphan within the preceding hour.

-For patients who have ingested dextromethorphan and are sedated or comatose, naloxone, in the usual doses for treatment of opioid overdose, can be considered. Benzodiazepines for seizures and benzodiazepines and external cooling measures for hyperthermia from serotonin syndrome can be used.

5. Pharmacological properties

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: Expectorants, ATC code: N02B E51

Pseudoephedrine

Pseudoephedrine has direct and indirect sympathomimetic activity and is an orally effective upper respiratory tract decongestant. Pseudoephedrine is substantially less potent than ephedrine in producing both tachycardia and elevation of systolic blood pressure and considerably less potent in causing stimulation of the central nervous system.

Paracetamol

Paracetamol has analgesic and antipyretic actions but only weak anti-inflammatory properties. This may be explained by presence of cellular peroxides at sites of inflammation which prevent inhibition of cyclo-oxygenase by paracetamol. At other sites associated with low levels of cellular perioxides, e.g. pain, fever, paracetamol can successfully inhibit prostaglandin biosynthesis.

Dextromethorphan hydrobromide is a cough suppressant which has a central action on the cough centre in the medulla. It has no analgesic properties and little sedative activity.
Dextromethorphan

Pharmacotherapeutic group: Cough suppressant

ATC code: R05DA09

5.2 Pharmacokinetic properties

Pseudoephedrine

Pseudoephedrine is partly metabolised in the liver by N-demethylation to norpseudoephedrine, an active metabolite. Pseudoephedrine and its metabolite are excreted in the urine: 55% to 75% of a dose is excreted unchanged. The rate of urinary excretion of pseudoephedrine is accelerated when the urine is acidified. Conversely as the urine pH increases, the rate of urinary excretion is slowed.

Paracetamol

Peak plasma paracetamol concentration usually occurs between 30 and 90 minutes after oral ingestion. Paracetamol is distributed uniformly throughout most body fluids and is only 15 to 25 per cent bound to plasma proteins. The plasma half life of paracetamol after therapeutic doses is in the range of 1 to 3 hours.

Dextromethorphan hydrobromide

Dextromethorphan hydrobromide is well absorbed from the gastrointestinal tract.

Dextromethorphan undergoes rapid and extensive first-pass metabolism in the liver after oral administration. Genetically controlled O-demethylation (CYD2D6) is the main determinant of dextromethorphan pharmacokinetics in human volunteers.

It appears that there are distinct phenotypes for this oxidation process resulting in highly variable pharmacokinetics between subjects. Unmetabolised dextromethorphan, together with the three demethylated morphinan metabolites dextrorphan (also known as 3-hydroxy-N-methylmorphinan), 3- hydroxymorphinan and 3-methoxymorphinan have been identified as conjugated products in the urine.

Dextrorphan, which also has antitussive action, is the main metabolite. In some individuals metabolism proceeds more slowly and unchanged dextromethorphan predominates in the blood and urine.

5.3 Preclinical safety data

Paracetamol and Pseudoephedrine are well known constituents of medicinal products and their safety profile is well documented. The results of pre-clinical studies do not add anything of relevance for therapeutic purposes.

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

6. Pharmaceutical particulars

6.1 List of excipients

Microcrystalline cellulose, sodium starch glycolate, hypromellose (hydroxypropyl methylcellulose), silicon dioxide, stearic acid, magnesium stearate, lactose monohydrate, HPMC 2910/hypromellose 15cp, titanium dioxide, macrogol 4000 [polyethylene glycol], D&C yellow #10 aluminum lake, FD&C yellow #6/sunset yellow FCF aluminum lake, FD&C blue #1/brilliant blue FCF aluminum lake.

6.2 Incompatibilities None known

6.3 Shelf life 36 months

The expiry date of the product is indicated on the packaging materials

6.4 Special precautions for storage

Do not store above 25°C. store in dry place

Store in the original packaging.*Keep out of reach and sight of children*

6.5 Nature and contents of container

Carton containing 21 or 35 caplets.

Blister strip PVdC/aluminium

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 LICENCE HOLDER AND MANUFACTURER

Teva Israel Ltd. 124 Dvora HaNevi'a St., Tel Aviv 6944020

REGISTRATION NUMBERS

136-49-31130

The leaflet was revised in September 2022 according to MOHs guidelines