FRONT SIDE

250 mm

disease. *H. pylori* is a major factor in the development of gastritis. *H. pylori* together with gastric acid are major factors in the development of peptic ulcer disease. *H. pylori* is a major factor in the development of atrophic gastritis which is associated with an increased risk of developing gastric cancer. Eradication of *H. pylori* with omeprazole and antimicrobials is associated with, high rates of healing and long-term remission of peptic ulcers.

Other effects related to acid inhibition: During long-term treatment gastric glandular cysts have been reported in a somewhat increased frequency. These changes are a physiological consequence of pronounced inhibition of acid secretion, are benign and appear to be reversible.

Decreased gastric acidity due to any means including proton pump inhibitors, increases gastric counts of bacteria normally present in the gastrointestinal tract. Treatment with acid-reducing drugs may lead to slightly increased risk of gastrointestinal infections such as *Salmonella* and *Campylobacter* and, in hospitalised patients, possibly also *Clostridium difficile.* Proton pump inhibitors should be discontinued between 5 days and 2 weeks prior to CgA measurements. This is to allow CgA levels that might be spuriously elevated following PPI treatment to return to reference range.

5.2 Pharmacokinetic properties

Absorption: Absorption of omeprazole is rapid, with peak plasma levels occurring approximately 1-2 hours after dose. Absorption of omeprazole takes place in the small intestine and is usually completed within 3-6 hours. Concomitant intake of food has no influence on the bioavailability. The systemic availability (bioavailability) from a single oral dose of omeprazole is approximately 40%. After repeated once-daily administration, the bioavailability increases to about 60%.

Distribution: The apparent volume of distribution is approximately 0.3 l/kg body weight. Omeprazole is 97% plasma protein bound.

Biotransformation: Omeprazole is completely metabolised by the cytochrome P450 system (CYP). The major part of its metabolism is dependent on the polymorphically expressed CYP2C19, responsible for the formation of hydroxyomeprazole, the major metabolite in plasma. The remaining part is dependent on another specific isoform, CYP3A4, responsible for the formation of omeprazole sulfone. As a consequence of high affinity of omeprazole to CYP2C19, there is a potential for competitive inhibition and metabolic drug-drug interactions with other substrates for CYP2C19. However, due to low affinity to CYP3A4, omeprazole has no potential to inhibit the metabolism of other CYP3A4 substrates. In addition, omeprazole lacks an inhibitory effect on the main CYP enzymes.

Approximately 3% of the Caucasian population and 15-20% of Asian populations lack a functional CYP2C19 enzyme and are called poor metabolisers. In such individuals the metabolism of omeprazole is probably mainly catalysed by CYP3A4. After repeated once-daily administration of 20 mg omeprazole, the mean AUC was 5 to 10 times higher in poor metabolisers than in subjects having a functional CYP2C19 enzyme (extensive metabolisers). Mean peak plasma concentrations were also higher, by 3 to 5 times. These findings have no implications for the posology of omeprazole.

Elimination: The plasma elimination half-life of omeprazole is usually shorter than one hour both after single and repeated oral once-daily dosing. Omeprazole is completely eliminated from plasma between doses with no tendency for accumulation during once-daily administration. Almost 80% of an oral dose of omeprazole is excreted as metabolites in the urine, the remainder in the faeces, primarily originating from bile secretion.

5.3 Preclinical safety data

Gastric ECL-cell hyperplasia and carcinoids, have been observed in life-long studies in rats treated with omeprazole. These changes are the result of sustained hypergastrinaemia secondary to acid inhibition. Similar findings have been made after treatment with H2-receptor antagonists, proton pump inhibitors and after partial fundectomy. Thus, these changes are not from a direct effect of any individual active substance.

6 Pharmaceutical Particulars

6.1 List of excipients

Mannitol
Sucrose
Disodium Hydrogen Phosphate
Calcium Carbonate
Sodium Lauryl Sulphate
Hypromellose
Methacrylic Acid and ethyl acrylate copolymer dispersion
Diethyl Phthalate
Titanium Dioxide
Purified Talc
N.P. Seeds
Empty Hard gelatin capsules Size "2"

6.2 Incompatibilities

Not Applicable

6.3 Shelf life

36 Months from the date of manufacture.

6.4. Special precautions for storage

Store at a temperature not exceeding 30°C, protect from moisture.
Keep out of the reach and sight of children.

6.5 Nature and contents of container

10 x10 hard gelatin capsules in Alu-Alu Strip.

6.6 Special precautions for disposal and other handling

No special requirements.

7. MANUFACTURED BY :
ZIM LABORATORIES LIMITED
B-21/22, MIDC Area,
Kalmeshwar, Nagpur 441 501,
Maharashtra State, India

8. Marketing Authorization Number(S)

NA

9. Date of First Authorization/Renewal of the Authorization

NA

10. Date of Revision of the Text

02 /06/2019

*PB124/X/XX/XX

PRAZIM 20

Gastro-resistant Omeprazole Capsules BP 20 mg

1. Name of the Finished Pharmaceutical Product
1.1 Trade Name : PRAZIM 20 (Gastro-resistant Omeprazole Capsules BP 20 mg)
1.2 Strength : 20 mg
1.3 Pharmaceutical Form : *"Hard Gelatin Capsule"*

2. Qualitative And Quantitative Composition

Each hard gelatin capsule contains:
Omeprazole BP 20 mg
(As enteric coated pellets)
'For full list of excipients, see section 6.1'.

3. Pharmaceutical Form

Hard gelatin capsule
"Pink transparent/ Clear transparent, size "2" hard gelatin capsule filled with white to off white enteric coated pellets."

4. Clinical Particulars

4.1 Therapeutic indications

Omeprazole capsules are indicated in:
Adults:
• Treatment of duodenal ulcers
• Prevention of relapse of duodenal ulcers
• Treatment of gastric ulcers
• Prevention of relapse of gastric ulcers
• In combination with appropriate antibiotics, *Helicobacter pylori (H. pylori)* eradication in peptic ulcer disease
• Treatment of NSAID-associated gastric and duodenal ulcers
• Prevention of NSAID-associated gastric and duodenal ulcers in patients at risk
• Treatment of reflux oesophagitis
• Long-term management of patients with healed reflux oesophagitis
• Treatment of symptomatic gastro-oesophageal reflux disease
• Treatment of Zollinger-Ellison syndrome
Paediatric use
Children over 1 year of age and ≥ 10 kg:
• Treatment of reflux oesophagitis
• Symptomatic treatment of heartburn and acid regurgitation in gastro-oesophageal reflux disease
Children and adolescents over 4 years of age:
• In combination with antibiotics in treatment of duodenal ulcer caused by *H. pylori*

4.2 Posology and method of administration

Posology
Adults:
Treatment of duodenal ulcers: The recommended dose in patients with an active duodenal ulcer is Omeprazole 20 mg once daily. In most patients healing occurs within two weeks. For those patients who may not be fully healed after the initial course, healing usually occurs during a further two weeks treatment period. In patients with poorly responsive duodenal ulcer Omeprazole 40 mg once daily is recommended and healing is usually achieved within four weeks.
Prevention of relapse of duodenal ulcers: For the prevention of relapse of duodenal ulcer in *H. pylori* negative patients or when *H. pylori* eradication is not possible the recommended dose is Omeprazole 20 mg once daily. In some patients a daily dose of 10 mg may be sufficient. In case of therapy failure, the dose can be increased to 40 mg.
Treatment of gastric ulcers: The recommended dose is Omeprazole 20 mg once daily. In most patients healing occurs within four weeks. For those patients who may not be fully healed after the initial course, healing usually occurs during a further four weeks treatment period. In patients with poorly responsive gastric ulcer Omeprazole 40 mg once daily is recommended and healing is usually achieved within eight weeks.
Prevention of relapse of gastric ulcers: For the prevention of relapse in patients with poorly responsive gastric ulcer the recommended dose is Omeprazole 20 mg once daily. If needed the dose can be increased to Omeprazole 40 mg once daily.
Treatment of NSAID-associated gastric and duodenal ulcers: For the treatment of NSAID-associated gastric and duodenal ulcers, the recommended dose is Omeprazole 20 mg once daily. In most patients healing occurs within four weeks. For those patients who may not be fully healed after the initial course, healing usually occurs during a further four weeks treatment period.
Prevention of NSAID-associated gastric and duodenal ulcers in patients at risk: For the prevention of NSAID-associated gastric ulcers or duodenal ulcers in patients at risk (age> 60, previous history of gastric and duodenal ulcers, previous history of upper GI bleeding) the recommended dose is Omeprazole 20 mg once daily.
Treatment of reflux oesophagitis: The recommended dose is Omeprazole 20 mg once daily. In most patients healing occurs within four weeks. For those patients who may not be fully healed after the initial course, healing usually occurs during a further four weeks treatment period. In patients with severe oesophagitis Omeprazole 40 mg once daily is recommended and healing is usually achieved within eight weeks.
Long-term management of patients with healed reflux oesophagitis: For the long-term management of patients with healed reflux oesophagitis the recommended dose is Omeprazole 10 mg once daily. If needed, the dose can be increased to Omeprazole 20-40 mg once daily.
Treatment of symptomatic gastro-oesophageal reflux disease: The recommended dose is Omeprazole 20 mg daily. Patients may respond adequately to 10 mg daily, and therefore individual dose adjustment should be considered. If symptom control has not been achieved after four weeks treatment with Omeprazole 20 mg daily, further investigation is recommended.
Treatment of Zollinger-Ellison syndrome: In patients with Zollinger-Ellison syndrome the dose should be individually adjusted and treatment continued as long as clinically indicated. The recommended initial dose is Omeprazole 60 mg daily. All patients with severe disease and inadequate response to other therapies have been effectively controlled and more than 90% of the patients maintained on doses of Omeprazole 20-120 mg daily. When dose exceed Omeprazole 80 mg daily, the dose should be divided and given twice daily.

Paediatric population
Children over 1 year of age and ≥ 10 kg
Treatment of reflux oesophagitis
Symptomatic treatment of heartburn and acid regurgitation in gastro-oesophageal reflux disease
The posology recommendations are as follows:

200 mm