1.6.1 PRESCRIBING INFORMATION (SUMMARY OF PRODUCTS CHARACTERISTICS)

1. NAME OF THE FINISHED PHARMACEUTICAL PRODUCT

LOKIT HP (Combipack of Clarithromycin Tablets 250 mg, Omeprazole Capsules 20 mg & Tinidazole Tablets 500 mg)

1.1 Strength

Clarithromycin Tablets 250 mg,

Omeprazole Capsules 20 mg &

Tinidazole Tablets 500 mg

1.2 Pharmaceutical Form

Combipack of Tablets & Capsules

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

2.1 Qualitative declaration:

Clarithromycin Tablets 250 mg,

Omeprazole Capsules 20 mg &

Tinidazole Tablets 500 mg

2.2 Quantitative declaration:

Qualitative declaration:

Each film coated tablet contains:

Clarithromycin USP ….. 250mg

Colour: Titanium dioxide

Quantitative declaration:

Ingredients	**Reference**	**Quantity/ Tabs (mg)**	**Function**
Clarithromycin	USP/NF	250.00	Antibiotic
Microcrystalline Cellulose PH -101 (Avicel)	EP	100.40	Diluent
Croscarmellose Sodium (AC-DI-SOL)	EP	12.00	Disintegrant
Colloidal Anhydrous Silica (Aerosil 200)	BP	3.80	Glidant
Powdered Cellulose	Ph.Eur	10.00	Disintegrant
Magnesium Stearate	EP	3.80	Lubricant
TOTAL		**380.00**	
FILM COATING			
Opadry White OY-L-28900	IH	20.00	Coating Agent
Purified Water *	BP	Q.S	Solvent

USP/NF - United States Pharmacopoeia/National Formulary
EP- European Pharmacopoeia
BP-British Pharmacopoeia
IH-In-House Specification
* Process solvent not present in final product.

Qualitative declaration:

Each film coated tablet contains:

Tinidazole BP…….. 500 mg

Colour: Titanium dioxide, Quinoline Yellow and Yellow Iron Oxide

Quantitative declaration:

Ingredients	Reference	Quantity/ Tabs (mg)	Function
GRANULATION			
Tinidazole	BP	500.00	Antiprotozoal
Dibasic Calcium Phosphate	BP	11.50	Diluent
Maize Starch (dry mixing)	BP	13.00	Binder
Lactose	BP	10.00	Diluent
Maize Starch (for paste)	BP	25.00	Binder
Methyl Hydroxybenzoate	BP	0.40	Preservative
Propyl Hydroxybenzoate	BP	0.10	Preservative
Sodium Lauryl Sulphate	BP	0.50	Wetting Agent
Purified Water *	BP	Q.S	Solvent
LUBRICATION			
Magnesium Stearate	BP	2.00	Lubricant
Purified Talc	BP	3.00	Lubricant
Maize Starch	BP	10.00	Binder
Colloidal Silicon Dioxide (Aerosil 200/CAB-O-SILM-5)	BP	2.00	Glidant
Microcrystalline Cellulose	BP	8.00	Diluent
Sodium Lauryl Sulphate	BP	5.50	Wetting Agent
Sodium Starch Glycollate	BP	4.00	Disintegrant
TOTAL		**595.00**	
FILM COATING			
Wincoat WT –AQ-1542 Yellow	IH	12.00	Coating Agent
Purified Water *	BP	Q.S	Solvent
TOTAL		**607.00**	

BP-British Pharmacopoeia
IH-In-House Specification

* Process solvent not present in final product.

Qualitative declaration:

Each Capsule contains:

Omeprazole BP…. 20 mg (As enteric coated pellets)

Approved colours used in capsule shells

Quantitative declaration:

Ingredients	Reference	Overages %	Quantity/ Caps (mg)	Function
Omeprazole (As enteric coated pellets 8.5 %)	BP	3.00 (7.06 mg)	235.29 +7.06=242.35	Antiulcer
Sugar Pellets	IH	--	Q.S (A mg)	Pharmaceuticals Aid.
EHG size "2" Light Blue/Dark Blue capsules	IH	--	1 No.	Unit Dose Holder
TOTAL		B mg		

BP-British Pharmacopoeia
IH-In-House Specification

* Considering Omeprazole pellets of 8.5% strength, quantity required to achieve label claim of 20mg is = $\frac{20 \times 100}{8.5}$ = 235.29 mg

Including 3% overages we get = 235.29 + 7.06 = 242.35 mg

Fill weight per capsule (A) = $\frac{242.35 \times 100}{P}$ mg

Where P is the potency of the incoming Omeprazole pellets.

Approximately calculate the net content per capsule as below:

$$\frac{\text{Bulk density of Omeprazole Pellets + Bulk density of Sugar Pellets}}{2} \text{ ------ X } 0.37 \text{ (Volume of size `2' capsule)} = Y$$

Note: If Omeprazole is of different AR Nos of different bulk density then take mean bulk density of the same.

Take the trial for 1Kg blend by taking B as X to fix up average net content,
Quantity of Omeprazole pellets/capsule = 242.35mg/capsule.

(242.35mg	+	A mg	= B mg)
Omeprazole pellets		Sugar pellets	

2.3 Salts and hydrates

Pure form present No Salt or hydrate form.

2.4 Esters and pro-drugs

Not applicable

2.5 Oral Powders for solution or suspension

Not applicable

2.6 Parenterals excluding powders for reconstitution

Not applicable

2.7 Powders for reconstitution prior to parenteral administration

Not applicable

2.8 Concentrates

Not applicable

2.9 Transdermal patches

Not applicable

2.10 Multidose solid or semi-solid products

Not applicable

2.11 Biological medicinal products

Not applicable

3. Pharmaceutical form

Description: LOKIT HP is a combipack kit of Two Clarithromycin Tablets USP 250mg, Two Tinidazole Tablets 500mg , Two Omeprazole Capsules 20mg.

Description of Clarithromycin Tablets USP 250mg:

Clarithromycin Tablets USP 250mg are White, oblong, convex, film coated tablets, Score on both sides

Description of Tinidazole Tablets 500mg:

Tinidazole Tablets 500mg are Yellow coloured circular slightly biconvex, coated tablets.

Description of Omeprazole Capsules 20mg:

Omeprazole Capsules 20 mg are Size "2" hard gelatin Light Blue / Dark Blue Capsules.

4 Clinical Particulars

4.1 Therapeutic indications

Healing of duodenal ulcer associated with Helicobacter pylori and eradication of Helicobacter pylori in patients with active or healed peptic ulcer.

4.2 Posology and Method of Administration

Posology:

FORADULTS:

The recommended dosage regimen of LOKIT HP is omeprazole 20 mg twice daily, tinidazole 500 mg twice daily and clarithromycin 250 mg twice daily for 7 days.

FOR CHILDREN:

LOKIT HP should not be used in children since no data is available.

Geriatrics

Although this regimen has not been specifically studied in the elderly, dosage adjustment is not needed during therapy with the individual components. It is therefore unlikely to require dosage adjustment with LOKIT HP.

Renal Insufficiency

Patients with impaired kidney function require a reduced dose of both tinidazole and clarithromycin.
In renal impairment the excretion of tinidazole will be delayed and depending on the degree of impairment, it may be necessary to reduce the total daily dosage. In patients receiving peritoneal dialysis, the maximum recommended dose of tinidazole is 500mg/day.

Route of administration: Oral

4.3 Method of Administration: Swallow a Capsule/tablet with a glass of water as per dosage.

4.4 Contraindications

Hypersensitivity to omeprazole, substituted benzimidazoles, ß-lactam antibiotics (eg. penicillins, cephalosporins), clarithromycin,tinidazole or any other constituents of the formulations.

History of an allergic reaction to penicillins or any macrolide antibiotic drugs.

4.5 Special warnings and precautions for use

When prescribing omeprazole for eradication of Helicobacter pylori possible drug interactions for all components in the triple therapy should be considered. Clarithromycin is a potent inhibitor of CYP3A4 and hence contraindications and interactions for clarithromycin should be considered when the triple therapy is used in patients concurrently taking other drugs metabolised via CYP3A4 such as cisapride.

Decreased gastric acidity due to any means including proton pump inhibitors, increases gastric counts of bacteria normally present in the gastrointestinal tract. Treatment with proton pump inhibitors may lead to slightly increased risk of gastrointestinal infections such as Salmonella and Campylobacter and, in hospitalised patients, possibly also Clostridium difficile.

As with related compounds, alcoholic beverages should be avoided during tinidazole therapy because of the possibility of a disulfiram-like reaction (flushing, abdominal cramps, vomiting, tachycardia). Alcohol should be avoided until 72 hours after discontinuing LOKIT HP.

Drugs of similar chemical structure have also produced various neurological disturbances such as dizziness, vertigo, incoordination and ataxia. If during therapy with LOKIT HP abnormal neurological signs develop, therapy should be discontinued.

4.6 Interactions with other medicinal products and other forms of interactions

Cytochrome P450 Effects

Both omeprazole and clarithromycin are metabolised in the liver via the cytochrome P450 system and may be expected to interact with other drugs metabolised by this system. Omeprazole is metabolised by cytochrome P450 (CYP2C19 and CYP3A4), while clarithromycin is primarily metabolised by cytochrome P450 (CYP3A4).

Omeprazole inhibits CYP2C19, the major Omeprazole metabolising enzyme. Thus, when Omeprazole is combined with drugs metabolised by CYP2C19, the plasma concentrations of these drugs may be increased and a dose reduction could be needed:

Anti-arrhythmics: Clarithromycin increases plasma concentration of disopyramide (increased risk of toxicity), dronedarone (risk of ventricular arrhythmias).

Antibacterials: Clarithromycin increases plasma concentration of rifabutin (increased risk of toxicity-reduce rifabutin dose), plasma concentration of clarithromycin reduced by refamycins.

Anticoagulants: Clarithromycin and omeprazole enhance anticoagulant effect of coumarins.

Antidepressants: Clarithromycin and omeprazole possibly increases plasma concentration of trazodone and escitalopram.Plasma concentration of omeprazole reduced by St. John's wort

Antidiabetics: Clarithromycin enhances effects of repaglinide.

Antiepileptics: Clarithromycin increases plasma concentration of carbamazepine;inhibits metabolism of phenytoin (increased plasma concentration) whereas, omeprazole enhances effects of phenytoin

Antifungals: Clarithromycin increases plasma concentration of itraconazole whereas, plasma concentration of omeprazole increased by voriconazole (reduce dose of omeprazole)

Antipsychotics: Increased risk of ventricular arrhythmias when clarithromycin given with pimozide-avoid concomitant use. Omeprazole reduces plasma concentration of clozapine

Antivirals: Plasma concentration of clarithromycin and atazanavir increased when administerd concomitantly; increased risk of rash when clarithromycin given with efavirenz; clarithromycin increases plasma concentration of etravirine, also plasma concentration of clarithromycin reduced; clarithromycin possibly increases plasma concentration of maraviroc (consider reducing dose of maraviroc); plasma concentration of clarithromycin reduced by nevirapine (but concentration of an active metabolite increased), also plasma concentration of nevirapine increased; plasma concentration of clarithromycin increased by ritonavir (reduce dose of clarithromycin in renal impairment); increased risk of ventricular arrhythmias when clarithromycin given with saquinavir-avoid concomitant use; Plasma concentration of clarithromycin and telaprevir increased when given concomitantly (increased risk of ventricular arrhythmias); plasma concentration of clarithromycin increased by tipranavir (reduce dose of clarithromycin in renal impairment); clarithromycin tablets reduce absorption of zidovudine (given at least 2 hours apart); omeprazole increases plasma concentration of raltegravir and saquinavir-avoid concomitant use; omeprazole reduces plasma concentration of rilpivirine-avoid concomitant use;whereas, plasma concentration of omeprazole reduced by tipranavir.

Anxiolytics & Hypnotics: Clarithromycin and omeprazole inhibit metabolism of midazolam and diazepam (increased plasma concentration with increased sedation)

Aprepitant: Clarithromycin increases plasma concentration of aprepitant

Calcium-channel Blockers: Clarithromycin possibly inhibits metabolism of calcium channel blockers (increased risk of side- effects)

Ciclosporin: Clarithromycin and omeprazole inhibit metabolism of ciclosporin (increased plasma concentration)

*Clopidogrel:*Omeprazole reduces antiplatelet effect of clopidogrel

Colchicine: Clarithromycin increases risk of colchicine toxicity-suspend or reduce dose of colchicine (avoid concomitant use in hepatic or renal impairment).

Corticosteroids: Clarithromycin increases plasma concentration of methyl prednisolone.

Cytotoxics: Clarithromycin possibly increases plasma concentration of axitinib (reduce dose of axitinib); crizotinib and everolimus-avoid concomitant use; possible increased risk of neutropenia when clarithromycin given with vinorelbine; omeprazole reduces plasma concentration of erlotinib

Diuretics: Clarithromycin increases plasma concentration of eplerenone-avoid concomitant use .

5-HT1-receptor Agonists: Clarithromycin increases plasma concentration of eletriptan (risk of toxicity)-avoid concomitant use.

Ivabradine: Clarithromycin increases plasma concentration of ivabradine-avoid concomitant use

Lipid-regulating Drugs: Clarithromycin increases plasma concentration of atorvastatin and pravastatin; increased risk of myopathy when clarithromycin given with simvastatin (avoid concomitant use).

Ranolazine: Clarithromycin increases plasma concentration of ranolazine

Sildenafil: Clarithromycin increases plasma concentration of sildenafil-reduce initial dose of sildenafil

Sirolimus: Clarithromycin increases plasma concentration of sirolimus-avoid concomitant use

Tacrolimus: Clarithromycin and omeprazole increases plasma concentration of tacrolimus

Tadalafil: Clarithromycin increases plasma concentration of tadalafil
Theophylline: Clarithromycin increases plasma concentration of theophylline
Ticagrelor: Clarithromycin increases plasma concentration of ticagrelor
Ulcer-healing drugs: Plasma concentration of clarithromycin and omeprazole increased when administered concomitantly

Few drug-drug interactions have been reported for tinidazole:
Alcohol: Possibility of disulfiram-like reaction when tinidazole given with alcohol
Antibacterials: Plasma concentration of tinidazole possibly reduced by rifampicin.

4.6 Pregnancy and Lactation

Pregnancy:

LOKIT HP should only be given to pregnant women if its use is considered essential.

Lactation:

LOKIT HP is not recommended for use during breastfeeding. It is not known if omeprazole or its metabolites appear in human breast milk, although clarithromycin may be excreted in breast milk. The safety of LOKIT HP for use during breast feeding of infants has not been established.Tinidazole is also excreted in breast milk. Tinidazole may continue to appear in breast milk for more than 72 hours after administration. Women should not nurse until at least 3 days after having discontinued taking LOKIT HP.

4.7 Effects on ability to drive and use machine

Omeprazole is not likely to affect Patient ability to drive or use any tools or machines. Side effects such as dizziness and visual disturbances may occur. If affected; Patients should not drive or operate machinery.

4.8 Undesirable effects

Omeprazole is well tolerated. Headache, diarrhea, abdominal pain, nausea, dizziness, vomiting and flatulence have been reported but are rare. Skin rash has occurred in few patients.

4.9 Overdose and antidote

Omeprazole
The symptoms described in connection with deliberate omeprazole overdose (limited experience of doses in excess of 240 mg/day) are transient. Single doses of 80mg omeprazole were uneventful. No specific antidote is known. omeprazole is extensively protein bound and is therefore not readily dialyzable. As in any case of overdose, treatment should be symptomatic and general supportive measures should be utilised.

Clarithromycin
Reports indicate that the ingestion of large amounts of clarithromycin can be expected to produce pronounced gastrointestinal symptoms. Severe liver toxicity, including cholestatic jaundice may occur. There is no known antidote. Treatment consists of prompt elimination of the unabsorbed drug and supportive measures. As with other macrolides, clarithromycin serum levels are not expected to be appreciably affected by haemodialysis or peritoneal dialysis.

Tinidazole
In acute animal studies with mice and rats, the LD50 for mice was >3600mg/kg and >2300mg/kg for oral and intraperitoneal administration respectively. For rats, the LD50 was >2000mg/kg for both oral and intraperitoneal administration.
Signs and symptoms of overdosage: There are no reported overdoses in humans with tinidazole.
Treatment for overdosage: There is no specific antidote for treatment of overdosage with tinidazole. Treatment is symptomatic and supportive. Gastric lavage may be useful. Tinidazole is easily dialysable..

TREATMENT OF OVERDOSAGE:
In the event of overdose, symptomatic treatment should be implemented. No specific antidote exists.

5.0 Pharmacological properties

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: Antisecretory drugs and mucosal Protectants (Gastro-intestinal system).

ATC code: A02BD09

Mechanism of Action: LOKIT HP by virtue of its 3-component regimen, effective antibacterial and acid suppressant activity is ensured for the treatment and management of Helicobacter pylori eradication:

Clarithromycin is bacteriostatic preventing bacteria by acting as a protein synthesis inhibitor. It binds to 23S rRNA, a component of the 50S subunit of the bacterial ribosome, thus inhibiting the translation of peptides.

Tinidazole is an antiprotozoal, antibacterial agent.Tinidazole is a prodrug. The nitro group of tinidazole is reduced in H. pylori by a ferredoxin-mediated electron transport system. The free nitro radical generated as a result of this reduction is believed to be responsible for the antiprotozoal/antibacterial activity. It is suggested that the toxic free radicals covalently bind to DNA, causing DNA damage and leading to cell death.

Omeprazole is a selective and irreversible proton pump inhibitor. It suppresses stomach acid secretion by specific inhibition of the H+/K+-ATPase system found at the secretory surface of gastric parietal cells.

5.2 Pharmacokinetic properties

Clarithromycin Tablets

Absorption:

Clarithromycin is rapidly and well absorbed from the gastro-intestinal tract after oral administration of Clarithromycin tablets.Clarithromycin may be given without regard to meals as food does not affect the extent of bioavailability of Clarithromycin tablets.Food does slightly delay the onset of absorption of clarithromycin and formation of the 14-hydroxymetabolite.The pharmacokinetics of clarithromycin are non linear; however, steady-state is attained within 2 days of dosing.When clarithromycin (500 mg) is given

three times daily, clarithromycin plasma concentrations are increased with respect to the 500 mg twice daily dosage.

Distribution:

Clarithromycin provides tissue concentrations that are several times higher than the circulating drug levels. Increased levels have been found in both tonsillar and lung tissue. Clarithromycin is 80% bound to plasma proteins at therapeutic levels.Clarithromycin also penetrates the gastric mucus. Levels of clarithromycin in gastric mucus and gastric tissue are higher when clarithromycin is co-administered with omeprazole than when clarithromycin is administered alone.

Metabolism:

The microbiologically active metabolite 14-hydroxyclarithromycin is formed by first pass metabolism.

Excretion:

At 250 mg b.i.d. 15-20% of unchanged drug is excreted in the urine.With 500 mg b.i.d. daily dosing urinary excretion is greater (approximately 36%). The 14-hydroxyclarithromycin is the major urinary metabolite and accounts for 10-15% of the dose.Most of the remainder of the dose is eliminated in the faeces, primarily via the bile. 5-10% of the parent drug is recovered from the faeces.

Omeprazole Capsules

Absorption

Omeprazole and omeprazole magnesium are acid labile and are therefore administered orally as enteric-coated granules in capsules or tablets. 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 in healthy subjects is approximately 0.3 l/kg body weight. Omeprazole is 97% plasma protein bound.

Metabolism

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 sulphone. 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.

Excretion

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.

The AUC of omeprazole increases with repeated administration. This increase is dose-dependent and results in a non-linear dose-AUC relationship after repeated administration. This time- and dose-dependency is due to a decrease of first pass metabolism and systemic clearance probably caused by an inhibition of the CYP2C19 enzyme by omeprazole and/or

its metabolites (e.g. the sulphone). No metabolite has been found to have any effect on gastric acid secretion.

Tinidazole Tablets

Absorption

After oral administration, tinidazole is rapidly and completely absorbed. The elimination half-life (T1/2) was 13.2 (±1.4) hours. Mean plasma levels decreased to 14.3 µg/mL at 24 hours, 3.8 µg/mL at 48 hours and 0.8 µg/mL at 72 hours following administration. Steady-state conditions are reached in 2½ - 3 days of multi-day dosing.

Administration of Tinidazole tablets with food resulted in a delay in Tmax of approximately 2 hours and a decline in Cmax of approximately 10% compared to fasted conditions. However, administration of Tinidazole with food did not affect AUC or T1/2.

Distribution

Tinidazole is distributed into virtually all tissues and body fluids and also crosses the blood-brain barrier. The apparent volume of distribution is about 50 liters. Plasma protein binding of tinidazole is 12%. Tinidazole crosses the placental barrier and is secreted in breast milk.

Metabolism

Tinidazole is significantly metabolized in humans prior to excretion. Tinidazole is partly metabolized by oxidation, hydroxylation, and conjugation. Tinidazole is the major drug-related constituent in plasma after human treatment, along with a small amount of the 2-hydroxymethyl metabolite.

Tinidazole is biotransformed mainly by CYP3A4. In an in vitro metabolic drug interaction study, tinidazole concentrations of up to 75µg/mL did not inhibit the enzyme activities of CYP1A2, CYP2B6, CYP2C9, CYP2D6, CYP2E1, and CYP3A4.

Elimination

The plasma half-life of tinidazole is approximately 12-14 hours. Tinidazole is excreted by the liver and the kidneys. Tinidazole is excreted in the urine mainly as unchanged drug (approximately 20-25% of the administered dose). Approximately 12% of the drug is excreted in the feces.

Special populations

Patients with impaired kidney function require a reduced dose of both tinidazole and clarithromycin.
In renal impairment the excretion of tinidazole will be delayed and depending on the degree of impairment, it may be necessary to reduce the total daily dosage. In patients receiving peritoneal dialysis, the maximum recommended dose of tinidazole is 500mg/day.

5.3 Pre-clinical safety data

There are no pre-clinical data of relevance to the prescriber which are additional to those already included in other sections. Non-clinical data reveal no special hazards for humans based on conventional studies of safety, pharmacology, repeat–dose toxicity or genotoxicity.

6.1 Pharmaceutical Particulars

LOKIT HP is a combipack of Two Clarithromycin Tablets USP 250mg,
Two Tinidazole Tablets 500mg , Two Omeprazole Capsules 20mg.

List of Excipients –for Clarithromycin Tablets USP 250mg :

Sr No.	Approved Name	Specification
1	Clarithromycin	USP/NF
2	Microcrystalline Cellulose PH-101	EP
3	Croscarmellose Sodium	EP
4	Colloidal Anhydrous silica	BP
5	Powdered Cellulose	Ph.Eur
6	Magnesium Stearate	EP
7	Opadry White OY-L-28900	IH
8	Purified Water	BP

USP/NF - United States Pharmacopoeia/National Formulary
EP- European Pharmacopoeia
BP-British Pharmacopoeia
IH-In-House Specification

List of Excipients – for Tinidazole Tablets 500mg:

Sr No.	Approved Name	Specification
1	Dibasic Calcium Phosphate	BP
2	Maize Starch	BP
3	Lactose	BP
4	Methyl Hydroxybenzoate	BP
5	Propyl Hydroxybenzoate	BP
6	Sodium Lauryl Sulphate	BP
7	Magnesium Stearate	BP
8	Purified Talc	BP
9	Colloidal Silicon Dioxide	BP
10	Microcrystalline Cellulose	BP
11	Sodium Starch Glycollate	BP
12	Wincoat WT-AQ-1542 Yellow	IH
13	Purified Water	BP

BP-British Pharmacopoeia
IH-In-House Specification

List of Excipients – for Omeprazole Capsules 20mg:

Sr No.	Approved Name	Specification
1.	Omeprazole enteric coated pellets	BP
2.	Sugar Pellets	IH
3.	EHG size "2" Light Blue/Dark Blue capsules	IH

BP-British Pharmacopoeia
IH-In-house specification

6.2 Incompatibilities:

None

6.3 Shelf life

Proposed shelf life: 36 Months (3 years)

6.4 Special precautions for storage:

Store below 30°C in a dry place . Protect from light.

6.5 Nature and contents of container

Primary: Alu/Alu Strip

Secondary: Paperboard carton

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 authorization holder.

KOPRAN LIMITED, INDIA.

8. Marketing authorization registration number(s).

Applied for registration

9. Date of first authorization registration/renewal of the authorization

Not applicable

10. Date of revision (if any) of this text.

Not applicable

11. DOSIMETRY (IF APPLICABLE)

Not applicable

12. INSTRUCTIONS FOR PREPARATION OF RADIOPHARMACEUTICALS (IFAPPLICABLE)

Not applicable

1.6.2

CONTAINER LABELLING

1.6.2 CONTAINER LABELLING

LABELLING OF THE PRIMARY PACKAGING

1) Name, strength and Pharmaceutical form of the FPP

LOKIT HP (Combipack of Clarithromycin Tablets 250 mg, Omeprazole Capsules 20 mg & Tinidazole Tablets 500 mg) Each film coated tablet contains: Clarithromycin USP ….. 250mg Colour: Titanium dioxide Each film coated tablet contains: Tinidazole BP……... 500 mg Colour: Titanium dioxide, Quinoline Yellow and Yellow Iron Oxide Each Capsule contains: Omeprazole BP…. 20 mg (As enteric coated pellets) Approved colours used in capsule shells Pharmaceutical Form: Combipack of Tablets & Capsules

2) Name and physical address of the manufacturing site

KOPRAN LIMITED Village Savroli, Tal. Khalapur, Dist. Raigad – 410 202

3) The Batch number assigned by the manufacturer

Batch No: K5336001, K5336002 & K5336003

4) Packaging date:

Pkg. Date: Dec. 2016