1. Name of the medicinal product

INN Name: AMLOSIN 5 (Amlodipine Tablets 5 mg)

Trade Name: ----

Strength: 5 mg

Pharmaceutical form: Uncoated Tablets

2. Qualitative and quantitative composition

Each uncoated tablet contains Amlodipine 5mg equivalent to Amlodipine Besilate.

3. Pharmaceutical form

Dosage form: Uncoated tablet

Description: White to off white round shaped, biconvex tablets, debossed with 'J' on one side and '20' on the other side.

4. INDICATION AND USES

- Essential hypertension
- Chronic stable and vasospastic anginal pectoris
- Vasospastic (Prinzmetal's) angina

4.2 DOSAGE AND ADMINISTRATION

Posology

Adults

For both hypertension and angina the usual initial dose is 5 mg amlodipine once daily which may be increased to a maximum dose of 10 mg depending on the individual patient's response. For angina, Amlodipine may be used as monotherapy or in combination with other antianginal medicinal products in patients with angina that is refractory to nitrates and/or to adequate doses of beta blockers.

In hypertensive patients, Amlodipine has been used in combination with a thiazide diuretic, Alpha blocker, beta blockers, or an angiotensin-converting enzyme inhibitors, No dose adjustment of Amlodipine is required upon concomitant administration of thiazide diuretics, beta blockers, and angiotensin-converting enzyme inhibitors**.**

Special populations:

Paediatric population:

Children with hypertension from 6 years to 17 years of age.

The recommended antihypertensive oral dose in pediatric patients ages 6-17 years is 2.5 mg once daily as a starting dose, up-titrated to 5 mg once daily if blood pressure goal is not achieved after 4 weeks. Doses in excess of 5 mg daily have not been studied in pediatric patients (see section 5.1 Pharmacodynamic Properties and section 5.2 Pharmacokinetic Properties).

The 2.5 mg dose cannot be obtained with Amlodipine tablets 5 mg and 10mg as these tablets are not manufactured to break into two equal halves.

Children under 6 years old

The effect of amlodipine on blood pressure in patients less than 6 years of age is not known.

Use in the elderly

Amlodipine, used at similar doses in elderly or younger patients, is equally well tolerated. Therefore normal dosage regimens are recommended, but increase of the dosage should take place with care (see sections 4.4 and 5.2).

Patients with hepatic impairment

Dosage recommendations have not been established in patients with mild to moderate hepatic impairment; therefore dose selection should be cautious and should start at the lower end of the dosing range (see sections 4.4 and 5.2). The pharmacokinetics of amlodipine have not been studied in severe hepatic impairment. Amlodipine should be initiated at the lowest dose and titrated slowly in patients with severe hepatic impairment.

See section 4.4 "Special warnings and special precautions for use".

Patients with renal impairment

Changes in amlodipine plasma concentrations are not correlated with degree of renal impairment, therefore the normal dosage is recommended. Amlodipine is not dialysable.

Method of administration

Tablet for oral administration.

4.3 CONTRAINDICATIONS

Amlodipine is contraindicated in patients with:

Hypersensitivity to dihydropyridines derivatives, amlodipine or to any of the excipients listed in section 6.1.

Shock (including cardiogenic shock), obstruction of the outflow tract of the left ventricle (e.g., high grade aortic stenosis), unstable angina (excluding Prinzmetal's angina), severe hypotension, haemodynamically unstable heart failure after acute myocardial. infarction.

4.4 Special warnings and precautions for use

The safety and efficacy of amlodipine in hypertensive crisis has not been established.

Use in patients with heart failure.

Patients with heart failure should be treated with caution. In a long-term, placebo-controlled study in patients with severe heart failure (NYHA class III and IV) the reported incidence of pulmonary oedema was higher in the amlodipine treated group than in the placebo group (see section 5.1) .Calcium channel blockers, including amlodipine, should be used with caution in patients with congestive heart failure, as they may increase the risk of future cardiovascular events and mortality.

Use in patients with impaired hepatic function

As with all calcium antagonists, amlodipine's half life is prolonged and AUC values are higher in patients with impaired liver function and dosage recommendations have not been established. The drug should therefore be administered with caution in these patients.

Amlodipine should therefore be initiated at the lower end of the dosing range and caution should be used, both on initial treatment and when increasing the dose. Slow dose titration and careful monitoring may be required in patients with severe hepatic impairment.

There are no data to support the use of amlodipine alone, during or within one month of a myocardial infarction.

Elderly patients

In the elderly increase of the dosage should take place with care (see sections 4.2 and 5.2).

Patients with renal impairment

Amlodipine may be used in such patients at normal doses. Changes in amlodipine plasma concentrations are not correlated with degree of renal impairment. Amlodipine is not dialysable.

There are no data to support the use of amlodipine alone, during or within one month of a myocardial infarction.

4.5 Interaction with other medicinal products and other forms of interaction

In vitro data from studies with human plasma, indicate that amlodipine has no effect on protein binding of digoxin, phenytoin, warfarin or indomethacin.

Consumption of grapefruit/grapefruit juice should be avoided while taking amlodipine. The intake of grapefruit juice may result in increased plasma amlodipine concentrations, which may enhance the blood pressure lowering effects of amlodipine. This interaction has been observed with other dihydropyridine calcium antagonists and represents a class effect.

Effects of other medicinal products on amlodipine

CYP3A4 inhibitors

Concomitant use of amlodipine with strong or moderate CYP3A4 inhibitors (protease inhibitors, azole antifungals, macrolides like erythromycin or clarithromycin, verapamil or diltiazem) may give rise to significant increase in amlodipine exposure resulting in an increased risk of hypotension. The clinical translation of these PK variations may be more pronounced in the elderly. Clinical monitoring and dose adjustment may thus be required.

CYP3A4 inducers

Upon co-administration of known inducers of the CYP3A4, the plasma concentration of amlodipine may vary. Therefore, blood pressure should be monitored and dose regulation considered both during and after concomitant medication particularly with strong CYP3A4 inducers (e.g. rifampicin, hypericum perforatum).

Administration of amlodipine with grapefruit or grapefruit juice is not recommended as bioavailability may be increased in some patients resulting in increased blood pressure lowering effects.

Dantrolene (infusion)

In animals, lethal ventricular fibrillation and cardiovascular collapse are observed in association with hyperkalemia after administration of verapamil and intravenous dantrolene. Due to risk of hyperkalemia, it is recommended that the co- administration of calcium channel blockers such as amlodipine be avoided in patients susceptible to malignant hyperthermia and in the management of malignant hyperthermia.

Effects of amlodipine on other medicinal products

The blood pressure lowering effects of amlodipine adds to the blood pressure - lowering effects of other medicinal products with antihypertensive properties.

Tacrolimus

There is a risk of increased tacrolimus blood levels when co-administered with amlodipine but the pharmacokinetic mechanism of this interaction is not fully understood. In order to avoid toxicity of tacrolimus, administration of amlodipine in a patient treated with tacrolimus requires monitoring of tacrolimus blood levels and dose adjustment of tacrolimus when appropriate.

Cyclosporine

No drug interaction studies have been conducted with cyclosporine and amlodipine in healthy volunteers or other populations with the exception of renal transplant patients, where variable trough concentration increases (average 0% - 40%) of cyclosporine were observed. Consideration should be given for monitoring cyclosporine levels in renal transplant patients on amlodipine, and cyclosporine dose reductions should be made as necessary.

Simvastatin

Co-administration of multiple doses of 10 mg of amlodipine with 80 mg simvastatin resulted in a 77% increase in exposure to simvastatin compared to simvastatin alone. Limit the dose of simvastatin in patients on amlodipine to 20 mg daily.

Cimetidine: Co-administration of amlodipine with cimetidine did not alter the pharmacokinetics of amlodipine.

Sildenafil: When amlodipine and sildenafil were used in combination, each agent independently exerted its own blood pressure lowering effect.

Special Studies: Effect of amlodipine on other agents

Atorvastatin: Co-administration of multiple 10 mg doses of amlodipine with 80mg of atorvastatin resulted in no significant change in the steady state pharmacokinetic parameters of atrovastatin.

Digoxin: Co-administration of amlodipine with digoxin did not change serum digoxin levels or digoxin renal clearance in normal volunteers.

Warfarin: In healthy male volunteers, the co-administration of amlodipine does not significantly alter the effect of warfarin on prothrombin response time. Co-administration of amlodipine with warfarin did not change the warfarin prothrombin response time.

In clinical interaction studies, amlodipine did not affect the pharmacokinetics of atorvastatin, digoxin or warfarin.

4.6 Fertility, pregnancy and lactation

Pregnancy

The safety of amlodipine in human pregnancy has not been established.

In animal studies, reproductive toxicity was observed at high doses (see section 5.3).

Use in pregnancy is only recommended when there is no safer alternative and when the disease itself carries greater risk for the mother and foetus.

Breast-feeding

Amlodipine is excreted in human milk. The proportion of the maternal dose received by the infant has been estimated with an interquartile range of 3 - 7%, with a maximum of 15%. The effect of amlodipine on infants is unknown. A decision on whether to continue/discontinue

breast- feeding or to continue/discontinue therapy with amlodipine should be made taking into account the benefit of breast- feeding to the child and the benefit of amlodipine therapy to the mother.

Fertility

Reversible biochemical changes in the head of spermatozoa have been reported in some patients treated by calcium channel blockers. Clinical data are insufficient regarding the potential effect of amlodipine on fertility. In one rat study, adverse effects were found on male fertility (see section 5.3).

4.7 Effects on ability to drive and use machines

Amlodipine can have minor or moderate influence on the ability to drive and use machines. If patients taking amlodipine suffer from dizziness, headache, fatigue or nausea the ability to react may be impaired. Caution is recommended especially at the start of treatment.

4.8 Undesirable effects

Summary of the safety profile

The most commonly reported adverse reactions during treatment are somnolence, dizziness, headache, palpitations, flushing, abdominal pain, nausea, ankle swelling, oedema and fatigue.

Tabulated list of adverse reactions

The following adverse reactions have been observed and reported during treatment with amlodipine with the following frequencies: 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).

Within each frequency grouping, adverse reactions are presented in the order of decreasing seriousness:

System organ class	Frequency	Adverse reactions
Blood and lymphatic system disorders	Very rare	Leukocytopenia, thrombocytopenia
Immune system disorders	Very rare	Allergic reactions
Metabolism and nutrition disorders	Very rare	Hyperglycaemia

Psychiatric disorders	Uncommon	Depression, mood changes (including anxiety), insomnia
	Rare	Confusion
Nervous system disorders	Common	Somnolence, dizziness, headache (especially at the beginning of the treatment)
	Uncommon	Tremor, dysgeusia, syncope, hypoaesthesia, paraesthesia
	Very rare	Hypertonia, peripheral neuropathy
Eye disorders	Common	Visual disturbance (including diplopia)
Ear and labyrinth disorders	Uncommon	Tinnitus
Cardiac disorders	Common	Palpitations
	Uncommon	Arrhythmia (including bradycardia, ventricular tachycardia and atrial fibrillation)
	Very rare	Myocardial infarction
Vascular disorders	Common	Flushing
	Uncommon	Hypotension
	Very rare	Vasculitis
Respiratory, thoracic and mediastinal disorders	Common	Dyspnoea
	Uncommon	Cough, rhinitis
Gastrointestinal disorders	Common	Abdominal pain, nausea, dyspepsia, altered bowel habits (including diarrhoea

		and constipation)
	Uncommon	Vomiting, dry mouth
	Very rare	Pancreatitis, gastritis, gingival hyperplasia
Hepatobiliary disorders	Very rare	Hepatitis, jaundice, hepatic enzyme increased*
Skin and subcutaneous tissue disorders	Uncommon	Alopecia, purpura, skin discolouration, hyperhidrosis, pruritus, rash, exanthema, urticaria
	Very rare	Angioedema, erythema multiforme, exfoliative dermatitis, Stevens-Johnson syndrome, Quincke oedema, photosensitivity
	Unknown	Toxic Epidermal Necrolysis
Musculoskeletal and connective tissue disorders	Common	Ankle swelling, muscle cramps
	Uncommon	Arthralgia, myalgia, back
Renal and urinary disorders	Uncommon	Micturition disorder, nocturia, increased urinary frequency
Reproductive system and breast disorders	Uncommon	Impotence, gynaecomastia
General disorders and administration site conditions	Very common	Oedema
	Common	Fatigue, asthenia
	Uncommon	Chest pain, pain, malaise
Investigations	Uncommon	Weight increased, weight

		decreased

*mostly consistent with cholestasis

Exceptional cases of extrapyramidal syndrome have been reported.

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 Yellow Card Scheme at www.mhra.gov.uk/yellowcard or search for MHRA Yellow Card in the Google Play or Apple App Store.

4.9 Overdose

In humans experience with intentional overdose is limited.

Symptoms:

Available data suggest that gross overdosage could result in excessive peripheral vasodilatation and possibly reflex tachycardia. Marked and probably prolonged systemic hypotension up to and including shock with fatal outcome have been reported.

Treatment

Administration of activated charcoal to healthy volunteers immediately or up to two hours after ingestion of amlodipine 10mg has been shown to significantly decrease amlodipine absorption.

Gastric lavage may be worthwhile in some cases. Clinically significant hypotension due to amlodipine overdosage calls for active cardiovascular support including frequent monitoring of cardiac and respiratory function, elevation of extremities, and attention to circulating fluid volume and urine output. A vasoconstrictor may be helpful in restoring vascular tone and blood pressure, provided that there is no contraindication to its use. Intravenous calcium gluconate may be beneficial in reversing the effects of calcium channel blockade. Since amlodipine is highly protein-bound, dialysis is not likely to be of benefit.

5. Pharmacological properties

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: calcium channel blockers – Dihydropyridine derivatives. ATC code: C08CA01.

Amlodipine is a calcium ion influx inhibitor of the dihydropyridine group (slow channel blocker or calcium ion antagonist) and inhibits the transmembrane influx of calcium ions into cardiac and vascular smooth muscle.

The mechanism of the antihypertensive action of amlodipine is due to a direct relaxant effect on vascular smooth muscle. The precise mechanism by which amlodipine relieves angina has not been fully determined but amlodipine reduces total ischaemic burden by the following two actions:

• Amlodipine dilates peripheral arterioles and thus, reduces the total peripheral resistance (afterload) against which the heart works. Since the heart rate remains stable, this unloading of the heart reduces myocardial energy consumption and oxygen requirements.

• The mechanism of action of amlodipine also probably involves dilatation of the main coronary arteries and coronary arterioles, both in normal and ischaemic regions. This dilatation increases myocardial oxygen delivery in patients with coronary artery spasm (Prinzmetal's or variant angina).

In patients with hypertension, once daily dosing provides clinically significant reductions of blood pressure in both the supine and standing positions throughout the 24 hour interval. Due to the slow onset of action, acute hypotension is not a feature of amlodipine administration.

In patients with angina, once daily administration of amlodipine increases total exercise time, time to angina onset, and time to 1mm ST segment depression, and decreases both angina attack frequency and glyceryl trinitrate tablet consumption.

Amlodipine has not been associated with any adverse metabolic effects or changes in plasma lipids and is suitable for use in patients with asthma, diabetes, and gout.

Use in patients with coronary artery disease (CAD)

The effectiveness of amlodipine in preventing clinical events in patients with coronary artery disease (CAD) has been evaluated in an independent, multicente, randomized, double-blind, placebo-controlled study of 1997 patients; Comparison of Amlodipine vs. Enalapril to Limit Occurrences of Thrombosis (CAMELOT).of these patients, 663 were treated with amlodipine 5-10 mg, 673 patients were treated with enalapril 10-20 mg, and 655 patients were treated with placebo, in addition to standard care of statins, betablockers, diuretics and aspirin, for 2

years. The key efficacy results are presented in Table 1. The results indicate that amlodipine treatment was associated with fewer hospitalizations for angina and revascularization procedures in patients with CAD.

Table 1. Incidence of significant clinical outcomes for CAMELOT

	Cardiovascular event rates, No. (%)			**Amlopidine vs. Placebo**	
Outcomes	Amlopidine	Placebo	Enalapril	Hazard Ratio (95% CI)	P Value
Primary Endpoint					
Adverse cardiovascular events	110 (16.6)	151 (23.1)	136 (20.2)	0.69 (0.54-0.88)	.003
Individual Components					
Coronary revascularization	78 (11.8)	103 (15.7)	95 (14.1)	0.73 (0.54-0.98)	.03
Hospitalization for angina	51 (7.7)	84 (12.8)	86 (12.8)	0.58 (0.41-0.82)	.002
Nonfatal MI	14 (2.1)	19 (2.9)	11 (1.6)	0.73 (0.37-1.46)	.37
Stroke or TIA	6 (0.9)	12 (1.8)	8 (1.2)	0.50 (0.19-1.32)	.15
Cardiovascular death	5 (0.8)	2 (0.3)	5 (0.7)	2.46 (0.48-12.7)	.27
Hospitalization for CHF	3 (0.5)	5 (0.8)	4 (0.6)	0.59 (0.14-2.47)	.46
Resuscitated cardiac arrest	0	4 (0.6)	1 (0.1)	NA	.04
New-onset	5 (0.8)	2 (0.3)	8 (1.2)	2.6 (0.50-	.24

peripheral vascular disease				13.4)	

Abbreviations: CHF, congestive heart failure; CI, confidence interval; MI, myocardial infarction; TIA, transient ischemic attack.

Use in patients with heart failure:

Haemodynamic studies and exercise based controlled clinical trials in NYHA Class II-IV heart failure patients have shown that amlodipine did not lead to clinical deterioration as measured by exercise tolerance, left ventricular ejection fraction and clinical symptomatology.

A placebo-controlled study (PRAISE) designed to evaluate patients in NYHA Class III-IV heart failure receiving digoxin, diuretics and ACE inhibitors has shown that amlodipine did not lead to an increase in risk of mortality or combined mortality and morbidity with heart failure.

In a follow-up, long term, placebo-controlled study (PRAISE-2) of Amlodipine in patients with NYHA III and IV heart failure without clinical symptoms or objective findings suggestive of underlying ischaemic disease, on stable doses of ACE inhibitors, digitalis, and diuretics, amlodipine had no effect on total cardiovascular mortality. In this same population amlodipine was associated with increased reports of pulmonary oedema despite no significant difference in the incidence of worsening heart failure as compared to placebo.

Treatment to prevent heart attack trial (ALLHAT):

A randomized double-blind morbidity-mortality study called the Antihypertensive and Lipid-Lowering Treatment to Prevent Heart Attack Trial (ALLHAT) was performed to compare newer drug therapies: amlodipine 2.5-10 mg/d (calcium channel blocker) or lisinopril 10-40 mg/d (ACE-inhibitor) as first-line therapies to that of the thiazide-diuretic, chlorthalidone 12.5-25 mg/d in mild to moderate hypertension.

A total of 33,357 hypertensive patients aged 55 or older were randomized and followed for a mean of 4.9 years. The patients had at least one additional CHD risk factor, including: previous myocardial infarction or stroke (> 6 months prior to enrollment) or documentation of other atherosclerotic CVD (overall 51.5%), type 2 diabetes (36.1%), HDL-C < 35 mg/dL (11.6%), left ventricular hypertrophy diagnosed by electrocardiogram or echocardiography (20.9%), current cigarette smoking (21.9%).

The primary endpoint was a composite of fatal CHD or non-fatal myocardial infarction. There was no significant difference in the primary endpoint between amlodipine-based therapy and chlorthalidone-based therapy: RR 0.98 95% CI (0.90-1.07) p=0.65. Among secondary endpoints, the incidence of heart failure (component of a composite combined cardiovascular endpoint) was significantly higher in the amlodipine group as compared to the chlorthalidone group (10.2% % vs 7.7%, RR 1.38, 95% CI [1.25-1.52] p<0.001). However, there was no significant difference in all-cause mortality between amlodipine-based therapy and chlorthalidone-based therapy. RR 0.96 95% CI [0.89-1.02] p=0.20.

Use in children (aged 6 years and older):

In a study involving 268 children aged 6-17 years with predominantly secondary hypertension, comparison of a 2.5mg dose, and 5.0mg dose of amlodipine with placebo, showed that both doses reduced Systolic Blood Pressure significantly more than placebo. The difference between the two doses was not statistically significant.

The long-term effects of amlodipine on growth, puberty and general development have not been studied. The long-term efficacy of amlodipine on therapy in childhood to reduce cardiovascular morbidity and mortality in adulthood have also not been established.

5.2 Pharmacokinetic properties

Absorption, distribution, plasma protein binding

After oral administration of therapeutic doses, amlodipine is well absorbed with peak blood levels between 6-12 hours post dose. Absolute bioavailability has been estimated to be between 64 and 80%. The volume of distribution is approximately 21 l/kg. In vitro studies have shown that approximately 97.5% of circulating amlodipine is bound to plasma proteins.

The bioavailability of amlodipine is not affected by food intake.

Biotransformation/elimination

The terminal plasma elimination half-life is about 35-50 hours and is consistent with once daily dosing. Amlodipine is extensively metabolised by the liver to inactive metabolites with 10% of the parent compound and 60% of metabolites excreted in the urine.

Hepatic impairment

Very limited clinical data are available regarding amlodipine administration in patients with hepatic impairment. Patients with hepatic insufficiency have decreased clearance of amlodipine resulting in a longer half-life and an increase in AUC of approximately 40-60%.

Paediatric population

A population PK study has been conducted in 74 hypertensive children aged from 1 to 17 years (with 34 patients aged 6 to 12 years and 28 patients aged 13 to 17 years) receiving amlodipine between 1.25 and 20 mg given either once or twice daily. In children 6 to 12 years and in adolescents 13-17 years of age the typical oral clearance (CL/F) was 22.5 and 27.4 L/hr respectively in males and 16.4 and 21.3 L/hr respectively in females. Large variability in exposure between individuals was observed. Data reported in children below 6 years is limited.

Elderly population

The time to reach peak plasma concentrations of amlodipine is similar in elderly and younger subjects. Amlodipine clearance tends to be decreased with resulting increases in AUC and elimination half-life in elderly patients. Increase in AUC and elimination half-life in patients with congestive heart failure were as expected for the patient age group studied.

5.3 Preclinical safety data

Reproductive toxicology

Reproductive studies in rats and mice have shown delayed date of delivery, prolonged duration of labour and decreased pup survival at dosages approximately 50 times greater than the maximum recommended dosage for humans based on mg/kg.

Impairment of fertility

There was no effect on the fertility of rats treated with amlodipine (males for 64 days and females 14 days prior to mating) at doses up to 10 mg/kg/day (8 times* the maximum recommended human dose of 10 mg on a mg/m2 basis). In another rat study in which male rats were treated with amlodipine besilate for 30 days at a dose comparable with the human dose based on mg/kg, decreased plasma follicle-stimulating hormone and testosterone were found as well as decreases in sperm density and in the number of mature spermatids and Sertoli cells.

Carcinogenesis, mutagenesis

Rats and mice treated with amlodipine in the diet for two years, at concentrations calculated to provide daily dosage levels of 0.5, 1.25, and 2.5 mg/kg/day showed no evidence of carcinogenicity. The highest dose (for mice, similar to, and for rats twice* the maximum recommended clinical dose of 10 mg on a mg/m2 basis) was close to the maximum tolerated dose for mice but not for rats.

Mutagenicity studies revealed no drug related effects at either the gene or chromosome levels.

***Based on patient weight of 50 kg**

6. Pharmaceutical particulars

6.1 List of excipients

Microcrystalline cellulose (E460)

Sodium starch glycollate

Sodium acid citrate (E331)

Magnesium stearate (E572)

Croscarmellose sodium

Crospovidone

6.2 Incompatibilities

None stated.

6.3 Shelf life

Blister pack: 3 years.

Bottles: 24 months in-use shelf-life after first opening: 3 months.

6.4 Special precautions for storage

No special precautions for storage.

Store in the original packaging.

6.5 Nature and contents of container

Blisters made of aluminium foil with VMCH coating (a carboxyl modified vinyl copolymer) on one side and amber coloured PVdC coated PVC foil. Packs of 28 tablets

HDPE bottle: 250,500 and 1000 tablets (for hospital or dose dispensing use only).

6.6 Special precautions for disposal and other handling

No special requirements.

7. Marketing authorization holder

7.1 Name and Address of Manufacturer

Name:	**M/s. Hetero Labs Limited, Unit-V**
Business Address:	TSIIC Formulation SEZ, Polepally village, Jadcherla Mandal, Mahaboob Nagar (Dist) - 509301 Telangana.
Country:	INDIA
Phone:	+91 08542-238400
Fax:	+91 08542 238404

Name	: M/s. Hetero Labs Limited, Unit-I,
Address	: Unit- I, Vill. Kalyanpur, Chakkan Road, Baddi, Distt. Solan [H.P.], India
Telephone	: + 91 1795-247429/245732

7.2 Name and Address of Principal

Name	: Hetero Labs Limited
Business Address	: 7-2-A2, Hetero Corporate, Industrial Estates, Sanath Nagar, Hyderabad-500 018 Telangana.
Country	: INDIA
Telephone	: 0091-040-23704923/24

8. REGISTRATION NUMBER

Not applicable

9. DATE OF PUBLICATION OF THIS PACKAGE INSERT

Not applicable