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| | | |
|---|---|---|
| **Brand Name** : **FARIN-1 TABLETS**<br>Generic Name : Warfarin Tablets BP 1 mg | | 2022 |
| **Module 1**<br>**1.5** | Administrative Information and Product Information<br>Product Information | **Confidential** |

## 1.5 PRODUCT INFORMATION

### 1.5.1 Prescribing information (Summary of products characteristics)

## SUMMARY PRODUCT CHARACTERISTICS

## 1. Name of drug product:

**Warfarin Tablets BP 1 mg**

## 1.1 (Trade) name of product

**FARIN-1 TABLETS**

## 1.2 Strength

Each uncoated tablet contains:
Warfarin Sodium BP 1 mg

## 1.3 Pharmaceutical Dosage Form

Uncoated tablets

## 2. Qualitative and Quantitative Composition:

## 2.1 Qualitative Declaration

Each uncoated tablet contains:
Warfarin Sodium BP 1 mg

## 2.2 Quantitative Declaration

| Ingredients | Specification | Label Claim | Overages | Qty. / Tab. | Use |
|---|---|---|---|---|---|
| **ACTIVE** | | | | | |
| Warfarin Sodium Clathrate | BP | 1.080 mg | | | Active |
| **NON ACTIVE** | | | | | |
| Lactose | | 60.000mg | | | Diluent |
| Micro Crystalline cellulose powder | | 20.000mg | | | Diluent |
| Pre Gelatinised Starch | | 8.630mg | | | Diluent |
| Methyl Paraben Sodium | | 0.100mg | | | Preservative |
| Propyl Paraben Sodium | | 0.050mg | | | Preservative |
| Maize Starch | | 10.000mg | | | Diluent |
| **Lubrication** | | | | | |
| Talcum | | 2.000mg | | | Lubricant |
| Magnesium sterate | | 1.000mg | | | Lubricant |
| Sodium Starch Glycolate | | 3.000mg | | | Disintegrating agent |
| Sodium Lauryal Sulphate | | 1.000mg | | | Disintegrating agent |
| Colloidal Silicon Dioxide | | 1.000mg | | | Glident |
| Cross carmellose Sodium | | 3.000mg | | | Lubricant |
| Polyplasdone XL-10 (Cross Povidone) | | 1.000mg | | | Disintegrating agent |

BP = British Pharmacopoeia
USNF = United States National Formulary
USP42 = United States Pharmacopoeia

# 3. Pharmaceutical form:

White, circular, flat, uncoated tablets having breakline on one side and other side is plain of each tablet.

# 4. Clinical particulars:

## 4.1 Therapeutic indications

Warfarin is indicated for the prophylaxis of systemic embolisation in patients with rheumatic heart disease and atrial fibrillation.
Warfarin is indicated for the prophylaxis after insertion of prosthetic heart valves.
Warfarin is indicated for the prophylaxis and treatment of venous thrombosis and pulmonary embolism.
Warfarin is indicated for transient cerebral ischaemic attacks.

## 4.2 Posology and method of administration

Posology
Adults and elderly patients: The typical induction dose ofwarfarin is 10 mg daily for 2 days, but this should be tailored to individual requirements. Baseline prothrombin measurements (PT) should be taken before beginning therapy with warfarin.
The daily maintenance dose ofwarfarin is usually 3 to 9 mg taken at the same time each day. The exact maintenance dose for an individual is dependent on the prothrombin time or other appropriate coagulation tests.
The maintenance dose is omitted if the prothrombin time is excessively prolonged. Once the maintenance dose is stabilised in the therapeutic range, it is rarely necessary to alter it.
In emergencies, anticoagulant therapy should be initiated with heparin and warfarin together. Where there is less urgency, as in patients disposed to or at special risk of thromboembolism, anticoagulant therapy may be initiated with warfarin alone.
Concomitant heparin therapy affects the results of control tests and should be discontinued at least six hours before the first test is carried out.
Control is established with INR monitoring at regular intervals and subsequent warfarin maintenance dosage further adjusted according to the results obtained.
Paediatric population: No data are available.
Method of administration
Warfarin Tablets are for oral use
Method of administration: Oral

## 4.3 Contraindications

- Hypersensitivity to the active substance or to any of the excipients listed in section 6.1
- Haemorrhagic stroke (see section 4.4 for further details)
- Clinically significant bleeding
- Within 72 hours of major surgery with risk of severe bleeding (for information on other surgery, see section 4.4)
- Within 48 hours postpartum.
- Pregnancy (first and third trimesters, see section 4.6).
- Drugs where interactions may lead to a significantly increased risk of bleeding (see section 4.5)

## 4.4 Special warnings and precautions for use

Most adverse events reported with warfarin are a result of over anticoagulation therefore it is important that the need for therapy is reviewed on a regular basis and therapy discontinued when no longer required.
Patients should be given a patient-held information booklet ('warfarin card') and informed of symptoms for which they should seek medical attention.

Commencement of therapy
Monitoring
When warfarin is started using a standard dosing regimen the INR should be determined daily or on alternate days in the early days of treatment. Once the INR has stabilized in the target range the INR can be determined at longer intervals.
INR should be monitored more frequently in patients at an increased risk of over coagulation e.g. patients with severe hypertension, liver or renal disease.
Patients for whom adherence may be difficult should be monitored more frequently.

Thrombophilia
Patients with protein C deficiency are at risk of developing skin necrosis when starting warfarin treatment. In patients with protein C deficiency therapy should be introduced without a loading dose of warfarin even if heparin is given. Patients with protein S deficiency may also be at risk and it is advisable to introduce warfarin therapy slowly in these circumstances.

Risk of haemorrhage
The most frequently reported adverse effect of all oral anticoagulants is haemorrhage. Warfarin should be given with caution to patients where there is a risk of serious haemorrhage (e.g. concomitant NSAID use, recent ischaemic stroke, bacterial endocarditis, previous gastrointestinal bleeding).
Risk factors for bleeding include high intensity of anticoagulation (INR >4.0), age ≥65, highly variable INRs, history of gastrointestinal bleeding, uncontrolled hypertension,

cerebrovascular disease, serious heart disease, risk of falling, anaemia, malignancy, trauma, renal insufficiency, concomitant drugs (see section 4.5). All patients treated with warfarin should have INR monitored regularly. Those at high risk of bleeding may benefit from more frequent INR monitoring, careful dose adjustment to desired INR, and a shorter duration of therapy. Patients should be instructed on measures to minimize risk of bleeding and to report immediately to physicians signs and symptoms of bleeding.

Checking the INR and reducing or omitting doses depending on INR level is essential, following consultation with anticoagulation services if necessary. If the INR is found to be too high, reduce dose or stop warfarin treatment; sometimes it will be necessary to reverse anticoagulation. INR should be checked within 2-3 days to ensure that it is falling.

Any concomitant anti-platelet drugs should be used with caution due an increased risk of bleeding.

Haemorrhage

Haemorrhage can indicate an overdose of warfarin has been taken. For advice on treatment of haemorrhage see section 4.9.

Unexpected bleeding at therapeutic levels should always be investigated and INR monitored.

Ischaemic stroke

Anticoagulation following an ischaemic stroke increases the risk of secondary haemorrhage into the infarcted brain. In patients with atrial fibrillation long term treatment with warfarin is beneficial, but the risk of early recurrent embolism is low and therefore a break in treatment after ischaemic stroke is justified. Warfarin treatment should be re-started 2-14 days following ischaemic stroke, depending on the size of the infarct and blood pressure. In patients with large embolic strokes, or uncontrolled hypertension, warfarin treatment should be stopped for 14 days.

Surgery

For surgery where there is no risk of severe bleeding, surgery can be performed with an INR of <2.5.

For surgery where there is a risk of severe bleeding, warfarin should be stopped 3 days prior to surgery.

Where it is necessary to continue anticoagulation e.g. risk of life-threatening thromboembolism, the INR should be reduced to <2.5 and heparin therapy should be started.

If surgery is required and warfarin cannot be stopped 3 days beforehand, anticoagulation should be reversed with low-dose vitamin K.

The timing for re-instating warfarin therapy depends on the risk of post operative haemorrhage. In most instances warfarin treatment can be re-started as soon as the patient has an oral intake.

Dental Surgery

Warfarin need not be stopped before routine dental surgery e.g. tooth extraction.

Active peptic ulceration

Due to a high risk of bleeding, patients with active peptic ulcers should be treated with caution. Such patients should be reviewed regularly and informed of how to recognise bleeding and what to do in the event of bleeding occurring.

Interactions

Many drugs and foods interact with warfarin and affect the prothrombin time (see section 4.5). Any change to medication, including self-medication with OTC products, warrants increased monitoring of the INR. Patients should be instructed to inform their doctor before they start to take any additional medications including over the counter medicines, herbal remedies or vitamin preparations.

Calciphylaxis

Calciphylaxis is a rare syndrome of vascular calcification with cutaneous necrosis, associated with high mortality. The condition is mainly observed in patients with end-stage renal disease on dialysis or in patients with known risk factors such as protein C or S deficiency, hyperphosphataemia, hypercalcaemia or hypoalbuminaemia. Rare cases of calciphylaxis have been reported in patients taking warfarin, also in the absence of renal disease. In case calciphylaxis is diagnosed, appropriate treatment should be started and consideration should be given to stopping treatment with warfarin.

Anticoagulant-related nephropathy

In patients with altered glomerular integrity or with a history of kidney disease, acute kidney injury may occur, possibly in relation to episodes of excessive anticoagulation and hematuria. A few cases have been reported in patients with no pre-existing kidney disease. Close monitoring including renal function evaluation is advised in patients with a supratherapeutic INR and hematuria (including microscopic).

Thyroid disorders

The rate of warfarin metabolism depends on thyroid status. Therefore, patients with hyper- or hypo-thyroidism should be closely monitored on starting warfarin therapy.

Additional circumstances where changes in dose may be required

The following also may exaggerate the effect of Warfarin Tablets, and necessitate a reduction of dosage:

- Loss of weight
- Acute illness

- Cessation of smoking

The following may reduce the effect of Warfarin Tablets, and require the dosage to be increased:

- Weight gain
- Diarrhoea
- Vomiting

Other warnings

Acquired or inherited warfarin resistance should be suspected if larger than usual daily doses of warfarin are required to achieve the desired anticoagulant effect.

Genetic information

Genetic variability particularly in relation to CYP2C9 and VKORC1 can significantly affect dose requirements for warfarin. If a family association with these polymorphisms is known extra care is warranted.

This product contains lactose. Patients with rare hereditary problems of galactose intolerance, the Lapp lactase deficiency or glucose-galactose malabsorption should not take this medicine.

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

Warfarin has a narrow therapeutic range and care is required with all concomitant therapy. The individual product information for any new concomitant therapy should be consulted for specific guidance on warfarin dose adjustment and therapeutic monitoring. If no information is provided the possibility of an interaction should be considered. Increased monitoring should be considered when commencing any new therapy if there is any doubt as to the extent of interaction.

**Pharmacodynamic interactions**

Drugs which are contraindicated

Concomitant use of drugs used in the treatment or prophylaxis of thrombosis, or other drugs with adverse effects on haemostasis may increase the pharmacological effect of warfarin, increasing the risk of bleeding.

Fibrinolytic drugs such as streptokinase and alteplase are contra-indicated in patients receiving warfarin.

Drugs which should be avoided if possible

The following examples should be avoided, or administered with caution with increased clinical and laboratory monitoring:

- Clopidogrel
- NSAIDs (including aspirin and cox-2 specific NSAIDS)
- Sulfinpyrazone
- Thrombin inhibitors such as bivalirudin, dabigatran

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- Dipyridamole
- Unfractionated heparins and heparin derivatives, low molecular weight heparins
- Fondaparinux, rivaroxaban
- Glycoprotein IIb/IIIa receptor antagonists such as eptifibatide, tirofiban and abciximab
- Prostacyclin
- SSRI and SNRI antidepressants
- Other drugs which inhibit haemostasis, clotting or platelet action

Low-dose aspirin with warfarin may have a role in some patients but the risk of gastrointestinal bleeding is increased. Warfarin may initially be given with a heparin in the initial treatment of thrombosis, until the INR is in the correct range.

Metabolic interactions

Warfarin is a mixture of enantiomers which are metabolized by different CYP P450 cytochromes. R-warfarin is metabolized primarily by CYP1A2 and CYP3A4. S-warfarin is metabolized primarily by CYP2C9. The efficacy of warfarin is affected primarily when the metabolism of S-warfarin is altered.

Drugs that compete as substrates for these cytochromes or inhibit their activity may increase warfarin plasma concentrations and INR, potentially increasing the risk of bleeding. When these drugs are co-administered, warfarin dosage may need to be reduced and the level of monitoring increased.

Conversely, drugs which induce these metabolic pathways may decrease warfarin plasma concentrations and INR, potentially leading to reduced efficacy. When these drugs are co-administered, warfarin dosage may need to be increased and the level of monitoring increased.

There are a small subset of drugs for which interactions are known however the clinical effect on the INR is variable, in these cases increased monitoring on starting and stopping therapy is advised.

Care should also be taken when stopping or reducing the dose of a metabolic inhibitor or inducer, once patients are stable on this combination (offset effect).

Listed below are drugs which are known to interact with warfarin in a clinically significant way.

Examples of drugs which potentiate the effect of warfarin

allopurinol, capecitabine, erlotinib, disulfiram, azole antifungals (ketoconazole, fluconazole etc) omeprazole paracetamol (prolonged regular use) propafenone amiodarone tamoxifen methylphenidate zafirlukast fibrates statins (not pravastatin, predominantly associated with fluvastatin) erythromycin sulfamethoxazole metronidazole

Examples of drugs which antagonise the effect of warfarin

Barbiturates, primidone, carbamazepine, griseofulvin, oral contraceptives, rifampicin, azathioprine, phenytoin

Examples of drugs with variable effect

Corticosteroids, nevirapine, ritonavir

Other drug interactions

Broad spectrum antibiotics may potentiate the effect of warfarin by reducing the gut flora which produce vitamin K. Similarly, orlistat may reduce absorption of vitamin K. Cholestyamine and sucralfate potentially decrease absorption of warfarin.

Increased INR has been reported in patients taking glucosamine and warfarin. This combination is not recommended.

Interactions with herbal products

Herbal preparations containing St John's Wort (Hypericum perforatum) must not be used whilst taking warfarin due to a proven risk of decreased plasma concentrations and reduced clinical effects of warfarin.

Many other herbal products have a theoretical effect on warfarin; however most of these interactions are not proven. Patients should generally avoid taking any herbal medicines or food supplements whilst taking warfarin, and should be told to advise their doctor if they are taking any, as more frequent monitoring is advisable.

Alcohol

Acute ingestion of a large amount of alcohol may inhibit the metabolism of warfarin and increase INR. Conversely, chronic heavy alcohol intake may induce the metabolism of warfarin. Moderate alcohol intake can be permitted.

Interactions with food and food supplements

Individual case reports suggest a possible interaction between warfarin and cranberry juice, in most cases leading to an increase in INR or bleeding event. Patients should be advised to avoid cranberry products. Increased supervision and INR monitoring should be considered for any patient taking warfarin and regular cranberry juice.

Limited evidence suggests that grapefruit juice may cause a modest rise in INR in some patients taking warfarin.

Certain foods such as liver, broccoli, Brussels sprouts and green leafy vegetables contain large amounts of vitamin K. Sudden changes in diet can potentially affect control of anticoagulation. Patients should be informed of the need to seek medical advice before undertaking any major changes in diet.

Many other food supplements have a theoretical effect on warfarin; however most of these interactions are not proven. Patients should generally avoid taking any food

supplements whilst taking warfarin, and should be told to advise their doctor if they are taking any, as more frequent monitoring is advisable.

Laboratory tests

Heparins and danaparoid may prolong the prothrombin time, therefore a sufficient time interval should be allowed after administration before performing the test.

## 4.6 Pregnancy and lactation

Pregnancy

Based on human experience warfarin causes congenital malformations and foetal death when administered during pregnancy.
Warfarin is contraindicated in pregnancy in the first and third trimester.
Women of child-bearing age who are taking Warfarin Tablets should use effective contraception during treatment.

Breastfeeding

Warfarin is excreted in breast milk in small amounts. However at therapeutic dose of warfarin no effects on the breast feeding child are anticipated. Warfarin can be used during breast-feeding.

## 4.7 Effects on ability to drive and use machines

Warfarin has no influence on the ability to drive and use machines.

## 4.8 Undesirable effects

| **MedDRA system organ class** | **Adverse Reaction** |
|---|---|
| Infections and infestations | Fever |
| Immune system disorders | Hypersensitivity |
| Nervous system disorders | Cerebral haemorrhage; Cerebral subdural haematoma |
| Vascular disorders | Haemorrhage |
| Respiratory, thoracic and mediastinal disorders | Haemothorax, epistaxis |
| Gastrointestinal disorders | Gastroinestinal haemorrhage, rectal haemorrhage, haematemesis; pancreatitis; diarrhoea; nausea; vomiting; melaena |
| Hepatobiliary disorders | Jaundice; hepatic dysfunction |

| | |
|---|---|
| Skin and subcutaneous disorders | Rash; alopecia; purpura; 'purple toes' syndrome; erythematous swollen skin patches leading to ecchymosis, infarction and skin necrosis; calciphylaxis |
| Renal and Urinary disorders | Haematuria; anticoagulant-related nephropathy |
| Investigations | Unexplained drop in haematocrit; haemoglobin decreased |

**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 Yellow Card Scheme at: www.mhra.gov.uk/yellowcard

## 4.9 Overdose

The benefit of gastric decontamination is uncertain. If the patient presents within 1 hour of ingestion of more than 0.25 mg/kg or more than the patient's therapeutic dose, consider activated charcoal (50 g for adults; 1g/kg for children)
In cases of life-threatening haemorrhage Stop warfarin treatment, give prothrombin complex concentrate (factors II, VII, IX, and X) 30-50 units/kg or (if no concentrate available) fresh frozen plasma 15 mL/kg. Discuss with local haematologist or National Poisons Information Service or both.

Non-life threatening haemorrhage
Where anticoagulation can be suspended, give slow intravenous injection of phytomenadione (vitamin K1) 10-20 mg for adults (250 micrograms/kg for a child);
Where rapid re-anticoagulation is desirable (e.g. valve replacements) give prothrombin complex concentrate (factors II, VII, IX, and X) 30–50 units/kg or (if no concentrate available) fresh frozen plasma 15 mL/kg.
Monitor INR to determine when to restart normal therapy. Monitor INR for at least 48 hours post overdose.

For patients on long-term warfarin therapy without major haemorrhage
- INR > 8.0, no bleeding or minor bleeding—stop warfarin, and give phytomenadione (vitamin K1) 0.5-1 mg for adults, 0.015-0.030 mg/kg (15-30 micrograms/kg) for children by slow intravenous injection or 5 mg by mouth (for partial reversal of anticoagulation give smaller oral doses of phytomenadione e.g. 0.5–2.5 mg using the intravenous preparation orally); repeat dose of phytomenadione if INR still too high after 24 hours. Large doses of phytomenadione may completely reverse the effects of warfarin and make reestablishment of anticoagulation difficult.
- INR 6.0–8.0, no bleeding or minor bleeding—stop warfarin, restart when INR < 5.0
- INR < 6.0 but more than 0.5 units above target value—reduce dose or stop warfarin, restart when INR < 5.0

For patients NOT on long term anticoagulants without major haemorrhage
Measure the INR (prothrombin time) at presentation and sequentially every 24-48 hours after ingestion depending on the initial dose and initial INR.
- If the INR remains normal for 24-48 hours and there is no evidence of bleeding, there should be no further monitoring necessary.
- Give vitamin K1 (phytomenadione) if:
a) there is no active bleeding and the patient has ingested more than 0.25 mg/kg;
OR
b) the prothrombin time is already significantly prolonged (INR >4.0).
The adult dose of vitamin K1 is 10-20 mg orally (250 micrograms/kg body weight for a child). Delay oral vitamin K1 at least 4 hours after any activated charcoal has been given. Repeat INR at 24 hours and consider further vitamin K1.

# 5. Pharmacological properties

## 5.1 Pharmacodynamic properties

Pharmacotherapeutic group: Antithrombotic agent (Vitamin K Antagonist),

**ATC code: B01A A03**

Mechanism of action

Warfarin is a synthetic anti-coagulant of the coumarin series and acts by inhibiting the synthesis of vitamin K dependent clotting factors, which include Factors II, VII, IX and X, and the anticoagulant proteins C and S. Half-lives of these clotting factors are as follows: Factor II-60 hours, VII-4-6 hours, IX-24 hours, and X-48-72 hours.

The half-lives of proteins C and S are approximately 8 hours and 30 hours, respectively.

**Pharmacodynamic effects**

The resultant in vivo effect is a sequential depression of Factors VII, IX, X and II activities. Vitamin K is an essential cofactor for the post ribosomal synthesis of the vitamin K dependent clotting factors. The vitamin promotes the biosynthesis of γ-carboxyglutamic acid residues in the proteins which are essential for biological activity. Warfarin is thought to interfere with clotting factor synthesis by inhibition of the regeneration of vitamin K1 epoxide. The degree of depression is dependent upon the dosage administered. Therapeutic doses of warfarin decrease the total amount of the active form of each vitamin K dependent clotting factor made by the liver by approximately 30% to 50%.

**Clinical efficacy and safety**

An anticoagulation effect generally occurs within 24 hours after drug administration.

However, peak anticoagulant effect may be delayed 72 to 96 hours. The duration of action of a single dose of racemic warfarin is 2 to 5 days. The effects of warfarin sodium may become more pronounced as effects of daily maintenance doses overlap.

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Anticoagulants have no direct effect on an established thrombus, nor do they reverse ischemic tissue damage. However, once a thrombus has occurred, the goal of anticoagulant treatment is to prevent further extension of the formed clot and prevent secondary thromboembolic complications which may result in serious and possibly fatal sequelae.

## 5.2 Pharmacokinetic properties

Warfarin is a racemic mixture of the R- and S-enantiomers with the S-enantiomer exhibiting 2-5 times greater anti-coagulant activity than the R-enantiomer in humans, but generally has a more rapid clearance.

Absorption

Warfarin is essentially completely absorbed after oral administration with peak concentration generally reached within the first 4 hours.

Distribution

There are no differences in the apparent volumes of distribution after intravenous and oral administration of single doses of warfarin solution. Warfarin distributes into a relatively small apparent volume of distribution of about 0.14 liter/kg. A distribution phase lasting 6 to 12 hours is distinguishable after rapid intravenous or oral administration of an aqueous solution. Using a one compartment model, and assuming complete bioavailability, estimates of the volumes of distribution of R- and S-warfarin are similar to each other and to that of the racemate. Concentrations in foetal plasma approach the maternal values, but warfarin has not been found in human milk (see Section 4.6). Approximately 99% of the drug is bound to plasma proteins.

Biotransformation

The elimination of warfarin is almost entirely by metabolism. Warfarin sodium is stereoselectively metabolized by hepatic microsomal enzymes (cytochrome P-450) to inactive hydroxylated metabolites (predominant route) and by reductases to reduced metabolites (warfarin alcohols). The warfarin alcohols have minimal anticoagulant activity. The metabolites are principally excreted into the urine; and to a lesser extent into the bile. The metabolites of warfarin that have been identified include dehydrowarfarin, two diastereoisomer alcohols, 4-, 6-, 7-, 8- and 10-hydroxywarfarin.

The Cytochrome P-450 isozymes involved in the metabolism of warfarin include 2C9, 2C19, 2C8, 1A2, and 34A. 2C9 is likely to be the principal form of human liver P-450 which modulates the in vivo anticoagulant activity of warfarin.

Elimination

The terminal half-life of warfarin after a single dose is approximately one week; however, the effective half-life ranges from 20 to 60 hours, with a mean of about 40 hours. The clearance of R-warfarin is generally half that of S-warfarin, thus as the volumes of distribution are similar, the half-life of R-warfarin is longer than that of S-Warfarin. The half-life of R-warfarin ranges from 37 to 89 hours, while that of S-Warfarin ranges from 21 to 43 hours. Studies with radiolabeled drug have demonstrated that up to 92% of the orally administered

dose is recovered in urine. Very little warfarin is excreted unchanged in urine. Urinary excretion is in the form of metabolites.

### 5.3 Preclinical safety data

Warfarin has been shown to be teratogenic in animal studies and has been suspected of causing abnormalities and foetal death when administered during human pregnancy. Warfarin should not be used during pregnancy. No reports of mutagenicity studies involving warfarin have been found in published literature. Warfarin, however, is a long established drug with an extensive history of clinical use.

## 6. Pharmaceutical particulars:

### 6.1 List of Excipients:

| | | |
|---|---|---|
| Lactose | BP | 60.000mg |
| Micro Crystalline cellulose powder | BP | 20.000mg |
| Pre Gelatinised Starch | BP | 8.630mg |
| Methyl Paraben Sodium | BP | 0.100mg |
| Propyl Paraben Sodium | BP | 0.050mg |
| Maize Starch | BP | 10.000mg |
| **Lubrication** | | |
| Talcum | BP | 2.000mg |
| Magnesium sterate | BP | 1.000mg |
| Sodium Starch Glycolate | BP | 3.000mg |
| Sodium Lauryal Sulphate | BP | 1.000mg |
| Colloidal Silicon Dioxide | BP | 1.000mg |
| Cross carmellose Sodium | BP | 3.000mg |
| Polyplasdone XL-10 (Cross Povidone) | BP | 1.000mg |

## 6.2 Incompatibilities:
None reported

## 6.3 Shelf-Life:
36 months from the date of manufacture.

## 6.4 Special Precautions for Storage:
Do not store above 30°C. Protect from light.

## 6.5 Nature and Contents of Container:
28 tablets are packed in a poly bag and such poly bag is packed in a jar.

## 6.6 Special precautions for disposal:
Any unused medicinal product or waste material should be disposed of in accordance with local requirements.

## 7. Registrant:
**AGOG PHARMA LTD.**
Plot No. 33, Sector II,
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Co-Op. Estate Ltd., Gauraipada,
Vasai (E), Dist. Thane, India.

## 8. Manufacturer:
**AGOG PHARMA LTD.**
Plot No. 33, Sector II,
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India.

## 9. Date of revision of the text: 06/11/2022