SUMMARY OF PRODUCT CHARACTERISTICS

1. NAME OF THE FINISHED PHARMACEUTICAL PRODUCT

CHLORPROMAZINE TABLETS B.P. 100 MG

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

Label claim

Each film coated tablet contains:

Chlorpromazine Hydrochloride B.P. 100 mg

List of Excipients:

Croscarmellose sodium, Hydroxypropyl methyl cellulose, lactose, Magnesium Stearate, Maize Starch, Polyvinyl Pyrrolidone, Polyethylene Glycol 400, Sodium Starch Glycolate, Isopropyl alcohol, Talcum, Methylene chloride, Titanium Dioxide.

3. PHARMACEUTICAL FORM

Film coated Tablet

Chlorpromazine Tablet available as white film coated caplets with break line on one side.

4. CLINICAL PARTICULARS

4.1 THERAPEUTIC INDICATIONS

Schizophrenia and other psychoses (especially paranoia), mania and hypomania. In anxiety, psychomotor agitation, excitement, violent or dangerously impulsive behaviour. Is used as an adjunct in the short-term management of these conditions.

Intractable hiccup.

Nausea and vomiting in terminal illness (where other drugs have failed or are not available).

Induction of hypothermia is facilitated by Chlorpromazine Tablets which prevents shivering and causes vasodilatation.

Childhood schizophrenia and autism.

4.2 Posology and method of administration

Dosages should be low to begin with and gradually increased under close supervision until the optimum dosage for the individual is reached. Individuals vary considerably and the optimum dose may be affected by the formulation used.

Dosage of chlorpromazine in schizophrenia, other psychoses, anxiety and agitation etc.

Adult:

Initially 25 mg t.d.s. or 75 mg at bedtime increasing by daily amounts of 25 mg to an effective maintenance dose. This is usually in the range 75 to 300 mg daily, but some patients may require up to 1 g daily.

Children under 1 year:

Do not use unless need is lifesaving.

Children 1-5 years:

0.5 mg/kg body weight every 4-6 hours to a maximum recommended dose of 40 mg daily.

Children 6-12 years:

$^{1}/_{3}$-½ adult dose to a maximum recommended dose of 75 mg daily.

Elderly or debilitated patients:

Start with $^{1}/_{3}$-½ usual adult dose with a more gradual increase in dosage.

Hiccups

Adult:

25-50 mg t.d.s. or q.d.s.

Children under 1 year:

No information available.

Children 1-5 years:

No information available.

Children 6-12 years:

No information available.

Elderly or debilitated patients:

As for adults.

Nausea and vomiting of terminal illness:

Adults:

10-25 mg every 4-6 hours.

Children under 1 year:

Do not use unless need is lifesaving.

Children 1-5 years:

0.5 mg/kg every 4-6 hours. Maximum daily dosage should not exceed 40 mg.

Children 6-12 years:

0.5 mg/kg every 4-6 hours. Maximum daily dosage should not exceed 75 mg.

Elderly or debilitated patients:

Initially $^{1}/_{3}$-½ adult dose. The physician should then use his clinical judgment to obtain control.

Method of administration: Oral

4.3 Contraindications

• Hypothyroidism

• Cardiac failure

• Phaeochromocytoma

• Myasthenia gravis

• Hypersensitivity to chlorpromazine, phenothiazines or one of the other constituents.

• Risk of angle-closure glaucoma.

• Risk of urinary retention related to urethroprostatic disorders.

• History of agranulocytosis.

• Dopaminergic antiparkinsonism agents (see Section 4.5).

• Nursing mothers (see Section 4.6).

• Gluten allergy or intolerance (see Section 4.4).

• Citalopram, escitalopram.

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

4.4 Special warnings and precautions for use

Blood Dyscrasias: Agranulocytosis has been reported rarely, most commonly in the first three months of treatment, but occasionally later. Other blood dyscrasias including thrombocytopenia and haemolytic anaemia have occurred very rarely. All patients must be advised that, if they experience fever, sore throat or any other infection, they should inform their physician immediately and undergo a complete blood count. Treatment will be discontinued if any marked changes (hyperleucocytosis, granulocytopenia) are observed in the latter.

Neuroleptic malignant syndrome: treatment must be interrupted in the event of unexplained hyperpyrexia since this can be one of the signs of neuroleptic malignant syndrome (pallor, hyperthermia, disorders of autonomic function). Signs of autonomic instability, such as hyperhydrosis and irregular blood pressure, can precede the onset of hyperthermia and as such constitute premonitory signs of the syndrome. While this neuroleptic-related effect can be of idiosyncratic origin, certain risk factors such as dehydration and brain damage would seem to indicate a predisposition.

Neuroleptic phenothiazines may potentiate QT interval prolongation which increases the risk of onset of serious ventricular arrhythmias of the torsade de pointes type, which is potentially fatal (sudden death). QT prolongation is exacerbated, in particular, in the presence of bradycardia, hypokalaemia, and congenital or acquired (i.e. drug induced) QT prolongation. If the clinical situation permits, medical and laboratory evaluations should be performed to rule out possible risk factors before

initiating treatment with a neuroleptic agent and as deemed necessary during treatment (see Section 4.8).

Where clinically possible, the absence of any factors favouring the onset of ventricular arrhythmias should be ensured before administration:

• bradycardia less than 55 beats per minute;

• hypokalaemia;

• congenital long QT interval;

• ongoing treatment with any drug which could induce marked bradycardia (<55 beats per minute), hypokalaemia, intracardiac conduction depression or QT prolongation (see Section 4.5).

With the exception of emergencies, it is recommended that the initial work up of patients receiving a neuroleptic should include an ECG.

Except under exceptional circumstances, this drug must not be administered to patients with Parkinson's disease.

The concomitant use of chlorpromazine with lithium, other QT prolongation agents, and dopaminergic antiparkinsonism agents is not recommended (see Section 4.5). Anti-Parkinson agents should not be prescribed routinely, because of the possible risks of aggravating anticholinergic side effects of chlorpromazine, of precipitating toxic-confusional states or of impairing its therapeutic efficacy. They should only be given as required.

Cases of venous thromboembolism (VTE) sometimes fatal, have been reported with antipsychotic drugs. Therefore, Chlorpromazine Tablets should be used with caution in patients with risk factors for thromboembolism (see Section 4.8).

Stroke: In randomised clinical trials versus placebo performed in a population of elderly patients with dementia and treated with certain atypical antipsychotic drugs, a 3-fold increase of the risk of cerebrovascular events has been observed. The mechanism of such risk increase is not known. An increase in the risk with other antipsychotic drugs or other populations of patient cannot be excluded. Chlorpromazine should be used with caution in patients with stroke risk factors.

Elderly Patients with Dementia: Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Analyses of seventeen placebo-controlled trials (modal duration of 10 weeks), largely in patients taking atypical antipsychotic drugs, revealed a risk of death in drug-treated patients of between 1.6 to 1.7 times the risk of death in placebo-treated patients. Over the course of a typical 10-week controlled trial, the rate of death in drug-treated patients was about 4.5% compared to a rate of about 2.65 in the placebo group. Although the cause of death in clinical trials with atypical antipsychotics were varied, most of the deaths appeared to be either cardiovascular (e.g., heart failure, sudden death) or infectious (e.g., pneumonia) in nature. Observational studies suggest that, similar to atypical antipsychotic drugs, treatment with conventional antipsychotic drugs may increase mortality. The extent to which the findings of

increased mortality in observational studies may be attributed to the antipsychotic drug as opposed to some characteristic(s) of the patient is not clear.

Chlorpromazine commonly causes increased susceptibility to sunburn and patients should be warned to avoid excessive exposure. Phototoxic or photoallergic reactions may occur. Various skin rashes and reactions, including exfoliative dermatitis and erythema multiforme have been reported. Contact skin sensitivity may be produced by contact with chlorpromazine. The occurrence of antinuclear antibodies has been reported. SLE has very rarely occurred.

Chlorpromazine impairs body temperature regulation and cases of severe hypothermia or hyperpyrexia have been reported, usually in association with moderate or high dosage. The elderly or hypothyroid patient may be particularly susceptible to hypothermia. The hazard of hyperthermia may be increased by especially hot or humid weather or by drugs, such as anti-Parkinson agents, which impair sweating. It has also been reported after intramuscular injections of chlorpromazine.

Hyperglycaemia or intolerance to glucose has been reported in patients treated with Chlorpromazine Tablets. Patients with an established diagnosis of diabetes mellitus or with risk factors for the development of diabetes who are started on Chlorpromazine Tablets should get appropriate glycaemic monitoring during treatment (see Section 4.8).

• The following populations must be closely monitored after administration of chlorpromazine.

o epileptics, since chlorpromazine may lower the seizure threshold. Treatment must be discontinued if seizures occur.

o elderly patients presenting with heightened susceptibility to orthostatic hypotension, sedation and extrapyramidal effects; chronic constipation (risk of paralytic ileus), and potentially prostatic hypertrophy.

o patients presenting with certain forms of cardiovascular disease, since this class of drug has quinidine-like effects and can induce tachycardia and hypotension.

o patients with severe liver and/or renal failure because of the risk of accumulation.

• Patients on long-term treatment should receive regular ophthalmological and haematological examinations.

• Patients are strongly advised not to consume alcohol and alcohol-containing drugs throughout treatment (see Section 4.5).

• Chlorpromazine tablets contain lactose and therefore patients with rare hereditary problems of congenital galactosemia, glucose or galactose malabsorption syndrome, lactase deficiency, galactose intolerance or the Lapp lactase deficiency should not take this medicine.

Chlorpromazine can rarely cause obstructive jaundice associated with stasis in biliary canaliculi. It has been thought to be a hypersensitivity reaction and some cases have shown premonitory fever and associated eosinophilia. It has normally been reversible on stopping the drug, but extremely rare cases of progressive liver disease have been reported. In most cases the jaundice has appeared between one

to four weeks after the start of the treatment. Chlorpromazine treatment should be withdrawn and not given again.

Transient abnormalities of liver function tests may occur in the absence of jaundice.

Faecal impaction, severe paralytic ileus or megacolon have been reported. The signs of intestinal obstruction may be obscured by the anti-emetic action of chlorpromazine. The onset of paralytic ileus potentially indicated by abdominal bloating and pain must be treated as an emergency (see Section 4.8).

With long-term usage, chlorpromazine can cause increased melanin pigmentation of the skin, which eventually may develop a bluish-grey colouration. Pigment deposits also occur in the eye and other tissues. Permanent deposits, leading to impairment of vision, may develop in the lens. Epithelial keratopathy has been reported. Toxic pigmentary retinopathy, which may cause progressive loss of vision has occurred very rarely, with excessively high doses.

Acute withdrawal symptoms including nausea, vomiting and insomnia have rarely been described after abrupt cessation of high doses of chlorpromazine. Gradual withdrawal is advisable.

The elderly is especially susceptible to the sedative and hypotensive effects of Chlorpromazine Tablets.

Chlorpromazine Tablets are not licenced for the treatment of dementia-related behavioural disturbances.

4.5 Interaction with other medicinal products and other forms of interaction

Combinations contraindicated

Dopaminergics (quinagolide, cabergoline), not including dopaminergic antiparkinsonism agents, are contraindicated (see Section 4.3): reciprocal antagonism of the dopaminergic agent and neuroleptic.

Combinations not recommended

Dopaminergic antiparkinsonism agents (amantadine, bromocriptine, cabergoline, levodopa, lisuride, pergolide, piribedil, ropinirole) are not recommended: reciprocal antagonism of the antiparkinsonism agent and neuroleptic (see Section 4.4). Neuroleptic-induced extrapyramidal syndrome should be treated with an anticholinergic rather than a dopaminergic antiparkinsonism agent (dopaminergic receptors blocked by neuroleptics).

Levodopa: reciprocal antagonism of levodopa and the neuroleptic. In Parkinson's patients, it is recommended to use the minimal doses of each drug.

QT prolonging drugs: there is an increased risk of arrhythmias when chlorpromazine is used with concomitant QT prolonging drugs (including certain antiarrhythmics and other antipsychotics including sultopride) and drugs causing electrolyte imbalance (see Section 4.4).

Alcohol: alcohol potentiates the sedative effect of neuroleptics. Changes in alertness can make it dangerous to drive or operate machinery. Alcoholic beverages and medication containing alcohol should be avoided (see Section 4.4).

Lithium (high doses of neuroleptics): concomitant use can cause confusional syndrome, hypertonia and hyperreflexivity, occasionally with a rapid increase in serum concentrations of lithium (see Section 4.4).

Combinations requiring precautions

Antidiabetic agents: concomitant administration of high chlorpromazine doses (100 mg/day), and antidiabetic agents can lead to an increase in blood sugar levels (decreased insulin release). Forewarn the patient and advise increased self-monitoring of blood and urine levels. If necessary, adjust the antidiabetic dosage during and after discontinuing neuroleptic treatment.

Topical gastrointestinal agents (magnesium, aluminium and calcium salts, oxides and hydroxides): decreased GI absorption of phenothiazine neuroleptics. Do not administer phenothiazine neuroleptics simultaneously with topical GI agents (administer more than 2 hours apart if possible).

Combinations to be taken into consideration

Antihypertensive agents: potentiation of the antihypertensive effect and risk of orthostatic hypotension (additive effects). Phenothiazines enhance the hypotensive effect of anaesthetics and calcium channel blockers. Severe postural hypotension may occur with concomitant administration of chlorpromazine and ACE inhibitors.

Atropine and other atropine derivatives: imipramine antidepressants, histamine H1-receptor antagonists, anticholinergic, antiparkinsonism agents, atropinic antispasmodics, disopyramide: build up of atropine-associated adverse effects such as urinary retention, constipation and dry mouth.

Other CNS depressants: morphine derivatives (analgesics, antitussives and substitution treatments), barbiturates, benzodiazepines, anxiolytics other than benzodiazepines, antihypertensive agents increased central depression. Respiratory depression may occur. Changes in alertness can make it dangerous to drive or operate machinery.

The action of some drugs may be opposed by Chlorpromazine Tablets; these include amphetamine, clonidine, guanethidine, adrenaline.

Anticholinergic agents may reduce the antipsychotic effect of Chlorpromazine Tablets. Some drugs interfere with absorption of neuroleptic agents; antacids, anti-Parkinson. Documented clinically significant adverse interactions occur with alcohol, guanethidine and hypoglycaemic agents.

4.6 Fertility, pregnancy and lactation

Pregnancy

A large amount of exposure to chlorpromazine during pregnancy did not reveal any teratogenic effect. However, there is evidence of harmful effects in animals, so like other drugs, it should be

avoided in pregnancy unless the physician considers it essential. It may occasionally prolong labour and at such a time should be withheld until the cervix is dilated 3-4cm.

It is advised to keep an adequate maternal psychic balance during pregnancy in order to avoid decompensation. If a treatment is necessary to ensure this balance, the treatment should be started or continued at effective dose all through the pregnancy.

Neonates exposed to antipsychotics (including chlorpromazine) during the third trimester of pregnancy are at risk of adverse reactions including extrapyramidal and/or withdrawal symptoms that may vary in severity and duration following delivery. There have been reports of agitation, hypertonia, hypotonia, tremor, somnolence, respiratory distress, or feeding disorder. Consequently, newborns should be monitored carefully.

Lactation

Chlorpromazine being excreted in milk, breast-feeding is not recommended during treatment.

Fertility

A decrease in fertility was observed in female animals treated with chlorpromazine. In male animals data are insufficient to assess fertility.

In humans, because of the interaction with dopamine receptors, chlorpromazine may cause hyperprolactinaemia which can be associated with impaired fertility in women (see Section 4.8). In men, data on consequences of hyperprolactinaemia are insufficient with regard to fertility.

4.7 Effects on ability to drive and use machines

The attention of patients, particularly drivers and machine operators, should be drawn to the risk of drowsiness with this medication especially at the start of treatment.

4.8 Undesirable effects

System organ class	**Very common (≥1/10)**	**Common (≥1/100 to <1/10)**	**Not known (cannot be estimated from available data)**
Blood and lymphatic system disorders			Agranulocytosis Leukopenia
Immune system disorders			Systemic lupus erythematosus Antinuclear antibody positive[1]
Endocrine disorders		Hyperprolactinaemia Amenorrhoea	Galactorrhoea Gynaecomastia Erectile dysfunction

			Female sexual arousal disorder
Metabolism and nutrition disorders	Weight increased	Glucose tolerance impaired (see Section 4.4)	Hyperglycaemia (see Section 4.4) Hypertriglyceridaemia Hyponatraemia Inappropriate antidiuretic hormone secretion
Psychiatric disorders		Anxiety	Lethargy Mood altered
Nervous system disorders	Sedation[2] Somnolence[2] Dyskinesia Tardive dyskinesia[3] Extrapyramidal disorder (in the form of acute dystonias, parkinsonian rigidity, tremor or akinesia, akathisia and oculogyric crises may occur, and are common on moderate to high dosage) Akathisia	Hypertonia Convulsion	Torticollis Oculogyric crisis Trismus Akinesia Hyperkinesia Neuroleptic malignant syndrome (see Section 4.4.)
Eye disorders			Accommodation disorder Deposit eye[4]

Cardiac disorders		Electrocardiogram QT prolonged (see Section 4.4)	Ventricular arrhythmia Ventricular fibrillation Ventricular tachycardia Torsade de pointes Cardiac arrest Sudden death/Sudden cardiac death (with possible causes of cardiac origin as well as cases of unexplained sudden death, in patients receiving neuroleptic phenothiazines) (see Section 4.4)
Vascular disorders	Orthostatic hypotension		Embolism venous Pulmonary embolism (sometimes fatal) Deep vein thrombosis (see Section 4.4) Dose related postural hypotension may occur, particularly in the elderly and after intramuscular injections
Respiratory, thoracic and mediastinal disorders			Nasal stuffiness
Gastrointestinal disorders	Dry mouth Constipation (see Section 4.4)		Colitis ischaemic Ileus paralytic (see Section 4.4) Intestinal perforation (sometimes fatal) Gastrointestinal necrosis (sometimes fatal) Necrotising colitis (sometimes fatal) Intestinal obstruction

Hepatobiliary disorders			Jaundice cholestatic Liver injury Cholestatic liver injury Mixed liver injury
Skin and subcutaneous tissue disorders			Dermatitis allergic Angioedema Urticaria Photosensitivity reaction
Renal and urinary disorders			Urinary retention (linked to anticholinergic effects)
Pregnancy, puerperium and perinatal conditions			Drug withdrawal syndrome neonatal (see Section 4.6)
Reproductive system and breast disorders			Priapism
General disorders and administration site conditions			Temperature regulation disorder

[1] may be seen without evidence of clinical disease

[2] particularly at the start of treatment

[3] particularly during long term treatment; may occur after the neuroleptic is withdrawn and resolve after reintroduction of treatment or if the dose is increased

[4] in the anterior segment of the eye caused by accumulation of the drug but generally without any impact on sight

Tardive dyskinesia may occur during administration or following withdrawal of Chlorpromazine and other neuroleptic drugs. This syndrome is common among patients treated with moderate to high doses of antipsychotic drugs for prolonged periods of time and may prove irreversible, particularly in patients over the age of 50. It is unlikely to occur in the short-term when low or moderate doses of chlorpromazine are used as recommended, but since its occurrence may be related to duration of treatment as well as daily dose, chlorpromazine should be given in the minimal effective dose for the minimum possible time, unless it is established that long-term administration for the treatment of schizophrenia is required. The potential seriousness and unpredictability of tardive dyskinesia and the fact that it has occasionally been reported to occur when neuroleptic antipsychotic drugs have been prescribed for relatively short periods in low dosage means that the prescribing of such agents requires especially careful assessment of risks versus benefit. Tardive dyskinesia can be precipitated

or aggravated by anti-Parkinson drugs. Short-lived dyskinesias may occur after abrupt drug withdrawal. In schizophrenia, the response to antipsychotic drug treatment may be delayed. If drugs are withdrawn, recurrence of symptoms may not become apparent for several weeks or months. Neuroleptic malignant syndrome is rare but may occur with any neuroleptic.

Chlorpromazine, even in low dosage in susceptible (especially non-psychotic) individuals, may cause unpleasant subjective feelings of being mentally dulled or slowed down, nausea, dizziness, headache, or paradoxical effects of excitement, agitation, or insomnia. Confusional states or epileptic fits can occur. The effects of chlorpromazine on the heart are dose related. ECG changes, with prolongation of the QT interval and T-wave changes have been commonly reported in patients treated with moderate to high dosage; they are reversible on reducing the dose. In a small number of cases, they have been reported to precede serious arrhythmias, including ventricular tachycardia and fibrillation, which have occurred after overdosage.

4.9 Overdose

Symptoms of chlorpromazine overdosage include drowsiness or loss of consciousness, hypotension, tachycardia, E.C.G. changes, ventricular arrhythmias and hypothermia. Severe extra-pyramidal dyskinesias may occur.

Treatment should by symptomatic with continuous respiratory and cardiac monitoring (risk of prolonged QT interval) until the patient's condition resolves.

If the patient is seen up to 6 hours after ingestion of a toxic dose, gastric lavage may be attempted. Induction of emesis is unlikely to be of any use. Activated charcoal should be given. There is no specific antidote. Treatment is supportive.

Generalised vasodilatation may result in circulatory collapse; raising the patient's legs may suffice, in severe cases, volume expansion by intravenous fluids may be needed; infusion fluids should be warmed before administration in order not to aggravate hypothermia.

Positive inotropic agents such as dopamine may be tried if fluid replacement is insufficient to correct the circulatory collapse. Avoid use of adrenaline. Ventricular or supraventricular tachyarrhythmia's usually respond to restoration of normal body temperature and correction of circulatory or metabolic disturbances. If persistent or life threatening, appropriate antiarrhythmic therapy may be considered. Avoid lignocaine and, as far as possible, long acting antiarrhythmic drugs.

Central nervous system depression requires airway maintenance or, in extreme circumstances, assisted respiration. Severe dystonic reactions usually respond to procyclidine (5-10 mg) or orphenedrine (20-40 mg) administered intramuscularly or intravenously. Convulsions should be treated with intravenous diazepam. Neuroleptic malignant syndrome should be treated with cooling.

5. Pharmacological properties

5.1 Pharmacodynamic properties

Chlorpromazine has depressant actions on the Central Nervous System, with alpha-adrenergic blocking and anticholinergic activities. It inhibits Dopamine and Prolactin release-inhibitory factor, thus stimulating the release of Prolactin. It increases the turnover of Dopamine in the brain.

It has anti-emetic, anti-puritic, serotonin-blocking and weak anti-histamine properties and slight ganglion blocking activity. It inhibits the heat regulating centre in the brain, and is analgesic and can relax skeletal muscle.

Due to its action on the autonomic system it produces vasodilatation, hypotension and tachycardia. Salivary and gastric secretions are reduced

5.2 Pharmacokinetic properties

Chlorpromazine is readily absorbed in the gastro-intestinal tract. It is subject to first pass metabolism in the gut wall. It is extensively metabolised in the liver and excreted in the urine and faeces. The plasma half-life is only a few hours but it has a prolonged terminal elimination phase of up to about 3 weeks. Chlorpromazine is extensively bound to plasma proteins.

5.3 Preclinical safety data

No additional data of relevance to prescribes

6. PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Croscarmellose sodium, Hydroxypropyl methyl cellulose, lactose, Magnesium Stearate, Maize Starch, Polyvinyl pyrrolidone, Polyethylene Glycol 400, Sodium Starch Glycolate, Isopropyl alcohol, Talcum, Methylene chloride, Titanium Dioxide.

6.2 Incompatibilities

Chlorpromazine can increase the central nervous system depression produced by other CNS-depressant drugs including alcohol, hypnotics, sedatives or strong analgesics.

It antagonises the action of adrenaline and other sympathomimetic agents and reverses the blood pressure lowering effects of adrenergic blocking agents such guanethidine and clonidine. It may impair the metabolism of tricyclic antidepressants, the anti-Parkinson effects of levodopa and the effects of anticonvulsants; it may possibly affect the control of diabetes, or the action of anticoagulants. Antacids can impair absorption. Tea and coffee may prevent absorption by causing insoluble precipitates.

Undesirable anticholinergic effects can be enhanced by anti-Parkinson or other anticholinergic drugs. It may enhance the cardiac-depressant effects of quinidine, the absorption of corticosteroids and digoxin, the effect of diazoxide and of neuromuscular blocking agents. Interactions with propanolol have been reported. The possibility of interaction with lithium should be bone in mind.

Further information: Chlorpromazine is a phenothiazide with an aliphatic side-chain. Its pharmacological profile of activity includes pronounced sedative and hypotensive properties, with fairly marked anticholinergic and anti-emetic activity and a moderate tendency to cause extrapyramidal reactions.

6.3 Shelf life

3 years

6.4 Special precautions for storage

Store in a cool dark place below 30ºC & keep out of reach of children.

6.5 Nature and contents of container

1000's Tablets in plastic container.

6.6 Instructions for use and handling and disposal

No special requirements.

7. Marketing authorization holder

Name : **GREAT TIMEC PHARMA COMPANY LIMITED**

Address : 19B, Niger Bridge head, Housing Estate,
Fegge, Onitsha, Anambra, Nigeria

Name and address of manufacturer*

Applicant's Name: **Nem Laboratories Pvt. Ltd.**

Address : 133 Krishna Ind. Estate, Vasai (E)
Thane 401210, Maharashtra-India
Tel. no. +91(250) 2390002/3

8. Number(s) in the national register of finished pharmaceutical products

NAFDAC REGN. NO.: A4-1994

9. Date of first authorization/renewal of the authorization

27th June 2013

10. DATE OF REVISION OF THE TEXT

26th June 2018