SCHEDULING STATUS

S4

1. NAME OF THE MEDICINE

CO-TRIMOXAZOLE DS PHARMC, 160 mg/800 mg, tablets

CO-TRIMOXAZOLE PHARMC, 80 mg/400 mg, tablets

CO-TRIMOXAZOLE PAED PHARMC, 40 mg/200 mg per 5 mL, suspension

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

CO-TRIMOXAZOLE DS PHARMC

Each tablet contains:

Trimethoprim	160 mg
Sulfamethoxazole	800 mg
Sugar free	
Preserved with Nipastat	0,025 % *w/w*

For full list of excipients, see section 6.1.

CO-TRIMOXAZOLE PHARMC

Each tablet contains:

Trimethoprim	80 mg
Sulfamethoxazole	400 mg
Sugar free	
Preserved with Nipastat	0,025 % *w/w*

For full list of excipients, see section 6.1.

CO-TRIMOXAZOLE PAED PHARMC

Trimethoprim	40 mg/5 mL

Sulfamethoxazole	200 mg/5 mL
Contains sugar as sucrose	2 500 mg/5 mL
Contains sweetener as Sodium Saccharin	20 mg/5 mL
Preserved with Nipastat	15 mg/5 mL (0,5 % *w/v*)
Alcohol 96 %	0,025 mL/5 mL (0,5 % *v/v*)

For full list of excipients, see section 6.1.

3. PHARMACEUTICAL FORM

CO-TRIMOXAZOLE DS PHARMC

Tablets

White, capsule-shaped, biconvex bisected tablets.

The tablet can be divided into equal halves.

CO-TRIMOXAZOLE PHARMC

Tablets

White, flat, bisected, bevelled edged tablets

The tablet can be divided into equal halves.

CO-TRIMOXAZOLE PAED PHARMC

Suspension

A smooth, white suspension with a characteristic aniseed odour.

4. CLINICAL PARTICULARS

4.1 Therapeutic indications

Co-trimoxazole is effective against a wide range of Gram-positive and Gram-negative organisms.

It is indicated for:

1. Upper and lower respiratory tract infections e.g., acute, and chronic bronchitis, bronchiectasis, tonsillitis, sinusitis and pharyngitis, otitis media, pneumonia and pneumocystis carinii pneumonitis (see also section 4.8 Pneumocystis jirovecii Pneumonitis (PJP)).
2. Renal and urinary tract infections e.g., pyelitis, pyelonephritis, urethritis, acute and chronic cystitis and cystopyelitis, including prostatitis.
3. Gastrointestinal tract infections e.g., enteritis, typhoid and paratyphoid fever, typhoid carriage, bacillary dysentery and cholera. (as an adjunct to fluid and electrolyte replacement).
4. Genital tract infections: both male and female including gonococcal infections.
5. Skin infections e.g., pyoderma, boils, furuncles, abscesses.
6. Other bacterial infections: acute brucellosis, mycetoma except those caused by true fungi, nocardiosis, acute and chronic osteomyelitis.

4.2 Posology and method of administration

Posology

CO-TRIMOXAZOLE DS PHARMC

Adults and children over 12 years

The usual dose is one CO-TRIMOXAZOLE DS PHARMC tablet every 12 hours after meals. The maximum dose (for particularly severe cases) is one and a half CO-TRIMOXAZOLE DS PHARMC tablets every 12 hours. The minimum dosage for long term treatment (more than 14 days) is half a CO-TRIMOXAZOLE DS PHARMC tablet every 12 hours.

CO-TRIMOXAZOLE PHARMC

Adults and children over 12 years

The usual dose is two CO-TRIMOXAZOLE PHARMC tablets every 12 hours after meals. The maximum dose (for particularly severe cases) is three CO-TRIMOXAZOLE PHARMC tablets

every 12 hours. The minimum dosage for long term treatment is one CO-TRIMOXAZOLE PHARMC tablet every 12 hours.

CO-TRIMOXAZOLE PAED PHARMC (Bottle to be shaken before use)

Infants and children

6 weeks to 5 months: Half a medicine measure (2,5 mL) twice daily.

6 months to 5 years: One medicine measure (5 mL) twice daily.

6 years to 12 years: Two medicine measures (10 mL) twice daily.

In the treatment of acute infections CO-TRIMOXAZOLE PHARMC should be administered for at least 5 days or for at least 2 days after the symptoms have disappeared. If clinical improvement is not evident after 7 days therapy, the patient should be reassessed.

Special populations

Renal Impairment

If CO-TRIMOXAZOLE PHARMC is indicated for patients with renal impairment, the following dosage scheme, based on creatinine clearance is suggested:

Above 25 mL/min: Standard dosage

15 – 25 mL/min: Standard dosage for a maximum of 3 days followed by half the standard daily dosage.

Below 15 mL/min: Not to be administered unless haemodialysis facilities are available when half the standard daily dosage may be given.

Measurements of plasma concentrations of sulfamethoxazole at intervals of 2 days are recommended in samples obtained 12 hours after administration of CO-TRIMOXAZOLE PHARMC. If the concentration of total sulfamethoxazole exceeds 150 ug/mL then treatment should be interrupted until the value falls below 120 ug/mL.

No Information is available for children with renal failure.

Method of administration

The tablets and suspension must be taken by mouth, after food. The tablets must be swallowed with a drink of water.

4.3 Contraindications

- Hypersensitivity to sulfamethoxazole, trimethoprim, sulfonamides or to any of the excipients listed in section 6.1.
- Patients suffering from porphyria
- Liver parenchymal damage
- Megaloblastic anaemia due to folic acid deficiency
- Severe renal insufficiency
- Pregnancy, in women prior to delivery or by nursing mothers.
- Infants during the first 6 weeks of life.

4.4 Special warnings and precautions for use

Immunocompromised patients

A high incident of side effects occurs in immunocompromised patients such as those suffering from AIDS or patients receiving immunosuppressive therapy. The adverse effects include skin rash, recurrent fever, neutropenia, thrombocytopenia and raised liver enzyme values.

Life threatening skin adverse reactions

CO-TRIMOXAZOLE PHARMC may cause the occurrence of erythema multiforme, toxic dermal necrolysis and allergic vasculitis. Treatment should be discontinued immediately when a rash appears because the danger of severe allergic reactions.

Hemophagocytic lymphohistiocytosis (HLH)

Cases of hemophagocytic lymphohistiocytosis (HLH) have been reported in patients who have been treated with sulfamethoxazole and trimethoprim as in CO-TRIMOXAZOLE PHARMC. HLH is a life-threatening syndrome of pathologic immune activation characterised by clinical signs and symptoms of extreme systemic inflammation. Signs and symptoms of HLH may include fever, hepatosplenomegaly, rash, lymphadenopathy, neurologic symptoms, cytopenias, high serum ferritin, hypertriglyceridemia, and liver enzyme and coagulation abnormalities. If HLH is suspected, CO-TRIMOXAZOLE PHARMC must be discontinued immediately and appropriate management instituted.

Folate

CO-TRIMOXAZOLE PHARMC should be given with caution to patients with actual or possible folate deficiency because of possible interference with human folate metabolism by trimethoprim as in CO-TRIMOXAZOLE PHARMC. Administration of folinic acid could be considered.

Elderly patients

Adverse effects on the blood may be more severe in malnourished or elderly patients: there also appears to be an increased risk of thrombocytopenia in elderly patients concurrently receiving diuretics, mainly thiazides.

Prolonged treatment

All patients receiving prolonged treatment with CO-TRIMOXAZOLE PHARMC should be given regular blood examinations.

Renal impairment

CO-TRIMOXAZOLE PHARMC should be used cautiously and in reduced dosage in patients with impaired renal function (see section 4.2).

Because of the risk of crystalluria, an adequate fluid intake should be maintained, and the administration of alkalis may be necessary if very large doses are used.

Cross-sensitivity

Cross-sensitivity has been observed between sulfamethoxazole as in CO-TRIMOXAZOLE PHARMC and chemically related compounds such as some diuretics, particularly acetazolamide and thiazides, and the sulfonylurea hypoglycaemic medicines.

Excipients with known effect

Nipastat: It is a mixture of parahydroxybenzoate esters. It may cause allergic reactions (possibly delayed).

Alcohol: CO-TRIMOXAZOLE PAED PHARMC contains 0,025 mg alcohol (ethanol) in each 5 mL which is equivalent to 0,5 % v/v alcohol (ethanol). The amount in 5 mL of CO-TRIMOXAZOLE PAED PHARMC is equivalent to 0,5 mL of beer and less than 0,5 mL of wine. The small amount of alcohol in CO-TRIMOXAZOLE PAED PHARMC will not have any noticeable effects.

Sucrose: Patients with rare hereditary problems of fructose intolerance, glucose-galactose malabsorption or sucrase-isomaltase insufficiency should not take CO-TRIMOXAZOLE PAED PHARMC.

The sucrose content of 2 500 mg per 5 mL should be taken into account in patients with diabetes mellitus.

4.5 Interactions with other medicines and other forms of interaction

Oral anticoagulants, methotrexate and phenytoin

Sulfamethoxazole as in CO-TRIMOXAZOLE PHARMC may potentiate the effects of some medicines such as oral anticoagulants, methotrexate, phenytoin; this may be due to displacement of the compound from plasma protein binding sites or to inhibition of metabolism.

Trimethoprim as in CO-TRIMOXAZOLE PHARMC may potentiate the anticoagulant effect of warfarin. It also prolongs the half-life of phenytoin.

Sulfonylurea compounds

High doses of sulfamethoxazole as in CO-TRIMOXAZOLE PHARMC may have a hypoglycaemic effect. The antidiabetic effect of the sulfonylurea compounds may be enhanced by the concomitant administration of sulfamethoxazole.

Para-aminobenzoic acid and compounds

The action of sulfamethoxazole as in CO-TRIMOXAZOLE PHARMC may be antagonised by para-aminobenzoic acid and compounds derived from it, particularly the procaine group of local anaesthetics.

Paraldehyde has been reported to increase the acetylation of sulfamethoxazole with subsequent increased risk of crystalluria.

Diagnostic tests

Sulfamethoxazole as in CO-TRIMOXAZOLE PHARMC may interfere with some diagnostic tests including those for urea, creatinine, and urinary glucose and urobilinogen.

Trimethoprim as in CO-TRIMOXAZOLE PHARMC may interfere with some diagnostic tests including serum methotrexate assay where dihydrofolate reductase is used, and the Jaffe reaction for creatinine

Digoxin, procainamide, and tolbutamide

Trimethoprim has been reported to interact with a number of other medicines by interfering with their clearance; such medicines include digoxin, procainamide, and tolbutamide.

Cyclosporine

Reversible deterioration in renal function has been reported in patients given trimethoprim as in CO-TRIMOXAZOLE PHARMC and cyclosporine following renal transplantation.

Pyrimethamine

Patients receiving pyrimethamine may develop megaloblastic anaemia due to the trimethoprim component in CO-TRIMOXAZOLE PHARMC.

Zidovudine

Concomitant treatment with zidovudine may increase the risk of haematological adverse reactions to CO-TRIMOXAZOLE PHARMC. If concomitant treatment is necessary, consideration should be given to monitoring of haematological parameters.

Lamivudine

Administration of trimethoprim /sulfamethoxazole 160 mg/800 mg as in CO-TRIMOXAZOLE DS PHARMC causes a 40 % increase in lamivudine exposure because of the trimethoprim component. Lamivudine has no effect on the pharmacokinetics of trimethoprim or sulfamethoxazole.

Hyperkalaemia

Caution should be exercised in patients taking any other medicines that can cause hyperkalaemia, for example ACE inhibitors, angiotensin receptor blockers and potassium-

sparing diuretics such as spironolactone. Concomitant use of trimethoprim-sulfamethoxazole (co-trimoxazole) may result in clinically relevant hyperkalaemia.

Repaglinide

Trimethoprim may increase the exposure of repaglinide which may result in hypoglycaemia.

Folinic acid

Folinic acid supplementation has been shown to interfere with the antimicrobial efficacy of trimethoprim sulfamethoxazole as in CO-TRIMOXAZOLE PHARMC. This has been observed in *Pneumocystis jirovecii* pneumonia prophylaxis and treatment.

Contraceptives

Oral contraceptive failures have been reported with antibiotics, such as CO-TRIMOXAZOLE PHARMC. The mechanism of this effect has not been elucidated. Women on CO-TRIMOXAZOLE PHARMC treatment should temporarily use a barrier method in addition to the oral contraceptive or choose another method of contraception.

Azathioprine

There are conflicting clinical reports of interactions between azathioprine and trimethoprim sulfamethoxazole as in CO-TRIMOXAZOLE PHARMC, resulting in serious haematological abnormalities.

4.6 Fertility, pregnancy and lactation

Pregnancy

Trimethoprim and sulfamethoxazole as in CO-TRIMOXAZOLE PHARMC cross the placenta and their safety in pregnant women has not been established. CO-TRIMOXAZOLE PHARMC should not be used during pregnancy (see section 4.3).

Breastfeeding

The components of CO-TRIMOXAZOLE PHARMC (trimethoprim and sulfamethoxazole) are excreted in breast milk. Administration of CO-TRIMOXAZOLE PHARMC should be avoided in late pregnancy and in lactating mothers where the mother or infant has, or is at particular risk of developing, hyperbilirubinemia. CO-TRIMOXAZOLE PHARMC should not be given to the new-born infant during the first weeks of life (see section 4.3)

4.7 Effects on ability to drive and use machines

It is not always possible to predict to what extent CO-TRIMOXAZOLE PHARMC may interfere with the daily activities of a patient. CO-TRIMOXAZOLE PHARMC can cause hallucinations, headache, dizziness and vertigo (see section 4.8). Patients should ensure that they do not engage in the above activities until they are aware of the measure to which CO-TRIMOXAZOLE PHARMC affects them.

4.8 Undesirable effects

a. Summary of the safety profile

Hypersensitivity reactions particularly involving the skin are among the most common adverse effects of CO-TRIMOXAZOLE PHARMC and are usually due to the sulfamethoxazole component. The Stevens-Johnson and Lyell's syndromes have been reported.

Adverse effects on the gastro-intestinal tract may also occur fairly frequently.

b. Tabulated summary of adverse reactions

System Organ Class	Frequency	Adverse reactions
	Frequent	Overgrowth fungal

System Organ Class	Frequency	Adverse reactions
Infections and infestations	Less frequent	Pseudomembranous colitis
Blood and lymphatic system disorders	Less frequent	Agranulocytosis, aplastic anaemia, thrombocytopenia, leukopenia, hypoprothrombinaemia, eosinophilia, methaemoglobinaemia, acute haemolytic anaemia often associated with glucose-6-phosphate dehydrogenase deficiency, neutropenia
Immune system disorders	Less frequent	Anaphylaxis, serum sickness, allergic myocarditis, hypersensitivity vasculitis resembling Henoch-Schoenlein purpura, periarteritis nodosa, systemic lupus erythematosus, severe hypersensitivity reactions associated with PJP*, hemophagocytic lymphohistiocytosis (see section 4.4)
Endocrine disorders	Frequency unknown	Hypothyroidism
Metabolism and nutrition disorders	Frequent	Hyperkalaemia
	Less frequent	Hypoglycaemia, hyponatraemia, decreased appetite, metabolic acidosis
Psychiatric disorders	Less frequent	Depression, hallucination

System Organ Class	Frequency	Adverse reactions
	Frequency unknown	Psychotic disorder
Nervous system disorders	Frequent	Headache
	Less frequent	Meningitis aseptic*, ataxia, dizziness, fatigue, insomnia, peripheral neuritis, seizure
Eye disorders	Less frequent	Optic neuropathy, transient myopia, uveitis
Ear and labyrinth disorders	Less frequent	Vertigo, tinnitus
Respiratory, thoracic and mediastinal disorders	Less frequent	Cough*, dyspnoea*, lung infiltration*
	Frequency unknown	Cyanosis due to methaemoglobinaemia or sulphaemoglobinaemia
Gastrointestinal disorders	Frequent	Nausea, diarrhoea
	Less frequent	Vomiting, glossitis, stomatitis, pancreatitis
Hepato-biliary disorders	Less frequent	Jaundice cholestatic*, hepatic necrosis*, increased transaminases, increased blood bilirubin
Skin and subcutaneous tissue disorders	Frequent	Rash
	Less frequent	Photosensitivity reactions, exfoliative dermatitis, angioedema, fixed drug eruption, erythema multiforme, Steven-Johnson syndrome (SJS)*, toxic epidermal necrolysis (Lyell's syndrome) (TEN), acute generalised exanthematous pustulosis (AGEP)

System Organ Class	Frequency	Adverse reactions
	Frequency unknown	Acute febrile neutrophilic dermatosis (Sweet's syndrome), drug reaction with eosinophilia and systemic symptoms (DRESS)*
Musculoskeletal, connective tissue and bone disorders	Less frequent	Arthralgia, myalgia
Renal and urinary disorders	Less frequent	Renal failure, lumbar pain, haematuria, oliguria, and anuria may also occur due to crystallisation in the urine, tubulointerstitial nephritis and uveitis syndrome, renal tubular acidosis

* See below section c.

c. Description of selected adverse reactions

Aseptic meningitis

Aseptic meningitis was rapidly reversible on withdrawal of the medicine but recurred in a number of cases on re-exposure to either CO-TRIMOXAZOLE PHARMC or to trimethoprim alone.

Pulmonary hypersensitivity reactions

Cough, dyspnoea and lung infiltration may be early indicators of respiratory hypersensitivity which, while very rare, has been fatal.

Hepatobiliary disorders

Jaundice cholestatic and hepatic necrosis may be fatal.

Severe cutaneous adverse reactions (SCARs)

Stevens-Johnson syndrome (SJS), toxic epidermal necrolysis (TEN) and medicine reaction with eosinophilia and systemic symptoms (DRESS) have been reported to be life-threatening (see section 4.4)

Allergic reactions such as an itchy rash and hives may occur in patients with hypersensitivity to the components of CO-TRIMOXAZOLE PHARMC. Very rare cases of acute generalised exanthematous pustulosis (AGEP) have been observed (see section 4.4).

Effects associated with Pneumocystis jirovecii Pneumonitis (PJP) management

Severe hypersensitivity reactions, rash, pyrexia, neutropenia, thrombocytopenia, hepatic enzyme increased, hyperkalaemia, hyponatraemia, rhabdomyolysis.

At the high dosages used for PJP management severe hypersensitivity reactions have been reported, necessitating cessation of therapy. Severe hypersensitivity reactions have been reported in PJP patients on re-exposure to co-trimoxazole, sometimes after a dosage interval of a few days. Rhabdomyolysis has been reported in HIV positive patients receiving co-trimoxazole for prophylaxis or treatment of PJP.

Reporting of suspected adverse reactions

Reporting suspected adverse reactions after authorisation of the medicine is important. It allows continued monitoring of the benefit/risk balance of the medicine. Healthcare professionals are asked to report any suspected adverse reactions to SAHPRA via the Med Safety APP (Medsafety X SAHPRA) and eReporting platform (who- umc.org) found on the SAHPRA website.

In addition, side-effects can also be reported to info@pharmacorp.co.za.

4.9 Overdose

Symptoms and Signs

Nausea, vomiting, dizziness and confusion are likely signs/symptoms of overdosage (see also section 4.8). Bone marrow depression has been reported in acute trimethoprim overdosage.

Treatment

No specific antidote is available for overdose with sulfamethoxazole and/or trimethoprim. Treatment is symptomatic and supportive, including general supportive measures such as monitoring of vital signs, as well as observation of the clinical status of the patient. Monitoring of blood counts and appropriate blood chemistries, including electrolytes is advisable. Dependant on the status of renal function administration of fluids is recommended if urine output is low.

Both trimethoprim and active sulfamethoxazole are moderately dialysable by haemodialysis. Peritoneal dialysis is not effective.

5. PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacological classification: A 20.2.1 Antimicrobial (Chemotherapeutic) agents (other than antibiotics)

Pharmacotherapeutic group: Antibacterials for systemic use – Sulfonamides and trimethoprim, incl. derivatives

ATC code: J01EE01

Co-trimoxazole exerts its bacterial action by the sequential blockade of two enzymes intervening in the biosynthesis of folinic acid in the micro-organism. Co-trimoxazole is bactericidal at concentrations at which the active ingredients trimethoprim and

sulfamethoxazole are usually bacteriostatic. It is therefore often active against organisms resistant to one of the active ingredients thereby minimising the risk of bacterial resistance.

5.2 Pharmacokinetic properties

Absorption

After oral administration trimethoprim and sulfamethoxazole are rapidly and nearly completely absorbed. The presence of food does not appear to delay absorption. Peak levels in the blood occur between one and four hours after ingestion and the level attained is dose related. Effective levels persist in the blood for up to 24 hours after a therapeutic dose. Steady state levels in adults are reached after dosing for 2 to 3 days. Neither component has an appreciable effect on the concentrations achieved in the blood by the other.

Distribution

Approximately 50 % of trimethoprim in the plasma is protein bound. Tissue levels of trimethoprim are generally higher than corresponding plasma levels, the lungs and kidneys showing especially high concentrations. Trimethoprim concentrations exceed those in plasma in the case of bile, prostatic fluid and tissue, saliva, sputum and vaginal secretions. Levels in the aqueous humour, breast milk, cerebrospinal fluid, middle ear fluid, synovial fluid and tissue (intestinal) fluid are adequate for antibacterial activity. Trimethoprim passes into amniotic fluid and foetal tissues reaching concentrations approximating those of maternal serum.

Approximately 66 % of sulfamethoxazole in the plasma is protein bound.

The concentration of active sulfamethoxazole in amniotic fluid, aqueous humour, bile, cerebrospinal fluid, middle ear fluid, sputum, synovial fluid and tissue (interstitial) fluids is of the order of 20 – 50 % of the plasma concentration.

Biotransformation

Renal excretion of intact sulfamethoxazole accounts for 15 – 30 % of the dose. This medicine is more extensively metabolised than trimethoprim, via acetylation, oxidation or glucuronidation. Over a 72-hour period, approximately 85 % of the dose can be accounted for in the urine as unchanged medicine plus the major (N4-acetylated) metabolite.

Elimination

The half-life of trimethoprim in man is in the range 8,6 – 17 hours in the presence of normal renal function. It is increased by a factor of 1,5 to 3,0 when the creatinine clearance is less than 10 mL/minute. There appears to be no significant difference in older patients compared with young patients.

The principal route of excretion of trimethoprim is renal and approximately 50 % of the dose is excreted in the urine within 24 hours as unchanged medicine. Several metabolites have been identified in the urine. Urinary concentrations of trimethoprim vary widely.

The half-life of sulfamethoxazole in man is approximately 9 to 11 hours in the presence of normal renal function. There is no change in the half-life of active sulfamethoxazole with a reduction in renal function but there is prolongation of the half-life of the major, acetylated metabolite when the creatinine clearance is below 25 mL/minute.

The principal route of excretion of sulfamethoxazole is renal; between 15 % and 30 % of the dose recovered in the urine is in the active form. In older patients there is a reduced renal clearance of sulfamethoxazole.

Paediatric population

The pharmacokinetics in the paediatric population with normal renal function of both components of Co-Trimoxazole, MP and SMZ are age dependent. Elimination of TMP-SMZ is

reduced in neonates, during the first two months of life, thereafter both TMP and SMZ show a higher elimination with a higher body clearance and a shorter elimination half-life. The differences are most prominent in young infants (> 1,7 months up to 24 months) and decrease with increasing age, as compared to young children (1 year up to 3,6 years), children (7,5 years and < 10 years) and adults (see section 4.2).

Elderly patients

In elderly patients, a slight reduction in renal clearance of sulfamethoxazole but not trimethoprim has been observed.

Special patient population

Renal impairment

The elimination half-life of trimethoprim is increased by a factor of 1,5 – 3,0 when the creatinine clearance is less than 10 mL/minute. When the creatinine clearance falls below 30 mL/min the dosage of Co-trimoxazole should be reduced (see section 4.2).

Elderly patients

In elderly patients, a slight reduction in renal clearance of sulfamethoxazole but not trimethoprim has been observed.

6 PHARMACEUTICAL PARTICULARS

6.1 List of excipients

CO-TRIMOXAZOLE DS PHARMC and CO-TRIMOXAZOLE PHARMC tablets

Hydrogenated vegetable oil

Magnesium stearate

Microcrystalline cellulose

Nipastat

Starch, maize

Starch, pregelatinised

Starch, sodium glycolate

CO-TRIMOXAZOLE PAED PHARMC suspension

Aluminium magnesium silicate

Aniseed oil

Ethanol

Nipastat

Polysorbate 80

Purified water

Sodium carboxymethylcellulose

Sodium citrate

Sodium saccharin

Sucrose

6.2 Incompatibilities

Not applicable.

6.3 Shelf life

24 months

6.4 Special precautions for storage

Store below 25 °C.

Protect from light and moisture.

6.5 Nature and contents of container

CO-TRIMOXAZOLE DS PHARMC: Packs containing 10 tablets in blister packs, 30 or 100 tablets in securitainers.

CO-TRIMOXAZOLE PHARMC: Packs containing 20 or 100 tablets in securitainers or 500 in amber PVC bottles.

CO-TRIMOXAZOLE PAED PHARMC: Bottles of 50 mL or 100 mL.

Not all pack sizes may be marketed.

6.6 Special precautions for disposal

No special requirements for disposal.

7. HOLDER OF CERTIFICATE OF REGISTRATION

Pharmacorp (Pty) Ltd

29 Victoria Link

Route 21 Corporate Park

Irene, 0178

RSA

8. REGISTRATION NUMBERS

CO-TRIMOXAZOLE DS PHARMC	Y/20.2.1/144
CO-TRIMOXAZOLE PHARMC	Y/20.2.1/145
CO-TRIMOXAZOLE PAED PHARMC	Y/20.2.1/146

9. DATE OF FIRST AUTHORISATION

CO-TRIMOXAZOLE DS PHARMC	16 January 1991
CO-TRIMOXAZOLE PHARMC	16 January 1991
CO-TRIMOXAZOLE PAED PHARMC	16 January 1991

10. DATE OF REVISION OF THE TEXT

23 October 2026