ACNETANE is teratogenic. It should not be taken by pregnant women, women intending to become pregnant, or sexually active women in their fertile years, not using at least two methods of contraception, as severe malformations may occur during pregnancy.

SCHEDULING STATUS

S5

1. NAME OF THE MEDICINE

ACNETANE 10 mg capsules
ACNETANE 20 mg capsules

2. QUALITATIVE AND QUANTATIVE COMPOSTION

ACNETANE contains per capsule 10 mg or 20 mg isotretinoin.
Excipients with known effect:
Contains Preservative: Ethylparaben 0,02 % m/m per capsule
Contains Anti-oxidant: Butylated hydroxyanisole 0,005 % m/m per capsule
Contains soybean oil.

Sugar free.

For full list of excipients, see section 6.1.

3. PHARMACEUTICAL FORM

Soft gelatin capsules
ACNETANE 10 mg Capsules: Pink oval shaped soft gelatin capsule containing a yellow oily suspension.

ACNETANE 20 mg Capsules: Purple oval shaped soft gelatin capsule containing a yellow oily suspension.

4. CLINICAL PARTICULARS

4.1 Therapeutic indications

Severe recalcitrant nodular acne: ACNETANE is indicated for the treatment of severe recalcitrant nodular acne. Nodules are inflamed lesions with a diameter of 5 mm or greater. The nodules may become suppurative or haemorrhagic. “Severe”, by definition, means “many” as opposed to “few or several” nodules.

Because of significant adverse effects associated with its use, ACNETANE should only be considered in patients with severe nodular acne who are unresponsive to conventional therapy, including systemic antibiotics.

Many patients may experience complete and prolonged remission of disease after a single course of therapy. In patients who require a second course of therapy, at least 8 weeks should elapse after the first course is completed before reinitiating therapy. This is because improvement of the condition may continue even after termination of therapy.

4.2 Posology and method of administration

The initial diagnosis and prescription of ACNETANE should be performed by a dermatologist with expertise in the use of systemic retinoids for the treatment of severe acne and a full understanding of the risks of isotretinoin therapy and monitoring requirements.
The therapeutic response to ACNETANE and its adverse events are dose-related, and vary between patients. This necessitates individual dosage adjustment during therapy.

Posology

Standard dosage
Therapy should be started at a dose of 0,5 mg/kg daily. For most patients the dose ranges from 0,5 - 1,0 mg/kg per day. Patients with very severe disease, or with truncal acne may require higher daily doses up to 2,0 mg/kg. A cumulative treatment dose of 120 - 150 mg/kg has been documented to increase remission rates and prevent relapse. The therapy duration in individual

patients therefore varies as a function of the daily dose. Complete remission of the acne is often achieved by a therapy course of 16 - 24 weeks. In patients who show a severe intolerance to the recommended dose, treatment may be continued at a lower dose, with consequent increase in therapy duration.

In the majority of patients, complete clearing of the acne is obtained with a single treatment course. In the case of a definite relapse, a renewed course of ACNETANE therapy should be given with the same daily dose as previously. Since further improvement of the acne can be observed up to 8 weeks after discontinuation of treatment, re-treatment should not be initiated until after this period.

Method of administration

The capsules should be taken with meals once or twice daily.

Concurrent topical therapy:

Concurrent administration of other keratolytic or exfoliative anti-acne agents is not indicated. Nor is concurrent radiation therapy with ultraviolet light indicated.
Patients should avoid exposure to the sun. Adjuvant therapy with mild topical medicines may be given, as required.

4.3 Contraindications

Pregnancy and lactation:
ACNETANE must not be used during breastfeeding, as isotretinoin is highly lipophilic and the passage of the drug in human milk is very likely.
ACNETANE is contraindicated in pregnant women and those women who may become pregnant during treatment. It is also contraindicated in all women of childbearing potential, unless at least two reliable forms of contraception are being used simultaneously without any interruption for one month before initiation of treatment, during treatment and for at least one month after termination of therapy. This also applies to women with a history of infertility (except in the case of hysterectomy) or who claim sexual abstinence.

Documented foetal malformations with ACNETANE use, include abnormalities of the external ear (micropinna, small or absent external auditory canals), microphthalmia, hydrocephalus, microcephalus, cardiovascular abnormalities, thymus gland abnormalities, facial dysmorphia, parathyroid gland abnormalities with parathyroid hormone deficiency and cerebellar malformations. There is also evidence of an increased risk of spontaneous abortion.

All female patients should confirm a negative pregnancy test result within 11 days prior to commencement of therapy.

It has not been established whether hormonal contraceptives differ in their efficacy when used with ACNETANE, thus stressing the importance of using two effective methods of contraception simultaneously. Mini-pills (micro-dosed progesterone preparations) may be an insufficient contraceptive method.

All female patients prescribed ACNETANE must adhere to the following conditions:

- **Capability of understanding the instructions and precautions associated with ACNETANE therapy, and her reliability and willingness to comply with effective contraceptive measures.**
- **The patient must be warned of the possibility of the failure of contraceptive measures. It is strongly recommended that monthly pregnancy testing during ACNETANE therapy is undertaken.**
- **ACNETANE therapy should be commenced on the 2nd or 3rd day of the menstrual cycle.**
- **An effective contraceptive method should be used continuously, for 1 month before starting ACNETANE treatment, during treatment and for 1 month following discontinuation of treatment.**
- **In the case of a relapse in treatment, the same contraceptive measures and pregnancy evaluations should be adhered to.**
- **The effectiveness of the chosen method of contraception should be carefully considered in each individual patient especially in the first cycle of hormonal contraception.**
- **In the event of pregnancy occurring despite the outlined precautions, during treatment with, or one month after discontinuation of ACNETANE, the risk of severe malformation of the foetus (involving in particular, the central nervous system, the heart and the large blood vessels), is extremely high, even after exposure for short periods only.**

The manufacturer provides the following supportive material:

1. **Patient Information Brochure**
2. **Brochure on Birth Control**
3. **Female Patient Information and Consent Form**
4. **Physician's Guide to Prescription**
5. **Physician's Checklist for Prescription to Females**

The pregnancy prevention information should be given to patients both orally and in writing.

The Patient Information Brochure must be provided to all patients. In addition, *all* female patients must receive the Brochure on Birth Control and the Female Patient Information and Consent Form.

- Hypersensitivity to isotretinoin, including retinol (Vitamin A) and their derivatives, as well as any of the other ingredients in the formulation. ACNETANE contains soybean oil. If you are allergic to peanut or soya, do not use ACNETANE.
- Hepatic insufficiency
- Hyperlipidaemias
- Patients with pre-existing hypervitaminosis A; concurrent use of Vitamin A and other retinoids (see section 4.5)
- Concurrent use of tetracyclines (see section 4.5)

4.4 Special warnings and precautions for use

ACNETANE is a prescription medicine intended only for use by patients for whom it is specifically prescribed. It is a criminal offence to give this medication to any person for whom it has not been prescribed.

The prescribing of ACNETANE should be done by physicians who are experienced in systemic retinoid use and the associated teratogenic risks thereof. A copy of the Patient Information Leaflet must be provided to all patients prescribed ACNETANE.

Patients should be made aware that during the initial period of therapy, transient exacerbation of acne has been observed.

In the event of severe allergic reactions, therapy should be interrupted and carefully monitored. There have been serious cases of allergic vasculitis, often with purpura (bruises and red patches) of the extremities and extracutaneous involvement. There have been rare reports of anaphylactic reactions in cases where there has been prior exposure to retinoids. There have also been rare reports of allergic cutaneous reactions.

Patients receiving ACNETANE therapy should not donate blood during, or for one month after cessation of therapy.
Excessive exposure to UV rays or sunlight should be avoided.

Due to the possibility of scarring, skin resurfacing procedures (such as laser, dermabrasion) and wax depilation should be avoided during and for at least 6 months after cessation of ACNETANE therapy (see section 4.8).
There have been reports of severe skin reactions (e.g., erythema multiforme, Stevens-Johnson syndrome, and toxic epidermal necrolysis) associated with Isotretinoin use (see section 4.8). These events may be serious and result in death, life threatening events, hospitalisation or disability. Patients should be monitored closely for severe skin reactions and ACNETANE should be discontinued if these occur.
Reduced tolerance to contact lenses during and after therapy may be experienced.
Particularly in patients undertaking vigorous physical activity, there have been isolated cases of elevated CPK values. Arthralgia and myalgia may present in patients on ACNETANE therapy, which may result in reduced tolerance to vigorous exercise (see section 4.8).

Hepatotoxicity:

Liver function tests (LFT's) should be conducted prior to onset of therapy and one month after commencement of treatment. Thereafter LFT's should be conducted at three monthly intervals. In high-risk patients these tests should be performed more frequently. Liver transaminases may increase within the normal range, returning to baseline levels during therapy. This may be a transitory and reversible occurrence. However, should hepatitis be suspected or if the transaminase levels are above expected values without returning to normal limits, ACNETANE therapy should be terminated.

Benign intracranial hypertension:

There have been reported cases of benign intracranial hypertension (pseudotumour cerebri) and in some patients concurrently using tetracyclines (see section 4.5). Visual disturbances, papilloedema, headache, nausea and vomiting are early signs and symptoms of benign intracranial hypertension. Patients should be screened for papilloedema in the event of presenting with any of the above symptoms, in which case ACNETANE therapy should be immediately terminated and the patient referred for further diagnosis to a neurologist.

Psychiatric disorders:

ACNETANE may lead to psychosis, depression and infrequently suicidal behaviour (see section 4.8).
All patients should be monitored for signs of depression, with particular care needed in those patients with a history of depression. If necessary, such patients should be referred for appropriate treatment.

***Lipids*:**

Isotretinoin may increase plasma triglycerides, decrease HDL and increase total cholesterol levels. However, the effects are reversible upon discontinuation of treatment or reduction of dose. The lipid profile should therefore be monitored prior to the start of treatment, one month after commencement and at the end of therapy.
Serum triglyceride levels exceeding 8,0 g/l should be controlled as this may be associated with acute pancreatitis, in which case ACNETANE therapy should be discontinued.

Visual impairment:

Visual disturbances include corneal opacities, dry eyes, keratitis and decreased night vision; these are usually reversible after termination of treatment. Patients with dry eyes should be carefully monitored due to the potential occurrence of keratitis.
The onset of decreased night vision may be sudden, and in rare cases may persist after termination of treatment, therefore patients should exercise caution when driving or operating any vehicle at night.
ACNETANE therapy should be discontinued and an ophthalmologic examination is advised should patients experience visual difficulties.

Inflammatory Bowel Disease:

ACNETANE therapy should be immediately terminated in patients experiencing abdominal pain, severe diarrhoea or rectal bleeding, even in patients without a prior history of intestinal disorders, as isotretinoin has been associated with inflammatory bowel disease (including regional ileitis).

***Skeletal*:**

Hyperostosis: An ossification disorder resembling diffuse skeletal hyperostosis, with myalgia, arthralgia, and stiffness was first reported in patients who had taken large doses of isotretinoin for prolonged periods.
Premature epiphyseal closure: Premature closure of the epiphyses in a child treated with isotretinoin has also been described.

Renal insufficiency:

Renal insufficiency and renal failure do not affect the pharmacokinetics of ACNETANE. Therefore, ACNETANE can be given to patients with renal insufficiency. However, it is recommended that patients are started on a low dose and titrated up to the maximum tolerated dose.

Pregnancy and lactation:

ACNETANE IS TERATOGENIC.
Females of childbearing potential, as well as female patients who normally do not employ contraception because of a history of infertility, should be instructed that they must not be pregnant when ACNETANE therapy is initiated, and that they should use effective contraception while taking ACNETANE without any interruptions for 1 month prior to therapy, the duration of therapy and for 1 month after discontinuation of therapy. It is recommended that two reliable forms of contraception be used simultaneously. Micro-dosed progesterone preparation (mini-pills) may be an inadequate method of contraception during ACNETANE therapy. Although other hormonal contraceptives are effective, there have been reports of pregnancy from women who have used oral contraceptives, as well as injectable/implantable contraceptive medicines. These reports are more frequent for women who use only a single method of contraception. It is not known if hormonal contraceptives differ in their effectiveness when used with ACNETANE. Therefore, it is important that women of childbearing potential use two effective forms of contraception simultaneously. They should also sign a Consent Form prior to beginning ACNETANE therapy (see boxed section 4.3).
ACNETANE is contraindicated in women of childbearing potential unless all of the following conditions of the Pregnancy Prevention Programme are met:

- She has severe acne (such as nodular or conglobate acne or acne at risk of permanent scarring) resistant to adequate courses of standard therapy with systemic antibacterials and topical therapy.
- She understands the teratogenic risk.

- She understands the need for rigorous follow-up, on a monthly basis.
- She understands and accepts the need for effective contraception, without interruption, 1 month before starting treatment, throughout the duration of treatment and 1 month after the end of treatment. At least one and preferably two complementary forms of contraception including a barrier method should be used.
- Even if she has amenorrhoea, she must follow all of the advice on effective contraception.
- She should be capable of complying with effective contraceptive measures.
- She is informed and understands the potential consequences of pregnancy and the need to rapidly consult if there is a risk of pregnancy.
- She understands the need and accepts to undergo pregnancy testing before, during and 5 weeks after the end of treatment.
- She has acknowledged that she has understood the hazards and necessary precautions associated with the use of isotretinoin.

These conditions also concern women who are not currently sexually active unless the prescriber considers that there are compelling reasons to indicate that there is no risk of pregnancy.

The prescriber must ensure that:

- The patient complies with the conditions for pregnancy prevention as listed above, including confirmation that she has an adequate level of understanding.
- The patient has acknowledged the aforementioned conditions.
- The patient has used at least one and preferably two methods of effective contraception including a barrier method for at least 1 month prior to starting treatment and is continuing to use effective contraception throughout the treatment period and for at least 1 month after cessation of treatment.
- Negative pregnancy test results have been obtained before, during and 5 weeks after the end of treatment. The dates and results of pregnancy tests should be documented.

Pregnancy testing:

According to local practice, medically supervised pregnancy tests with a minimum sensitivity of 25 mIU/mL are recommended to be performed in the first 3 days of the menstrual cycle, as follows.

Prior to starting therapy:

In order to exclude the possibility of pregnancy prior to starting contraception, it is recommended that an initial medically supervised pregnancy test should be performed and its date and result recorded. In patients without regular menses, the timing of this pregnancy test should reflect the sexual activity of the patient and should be undertaken approximately 3 weeks after the patient

last had unprotected sexual intercourse. The prescriber should educate the patient about contraception.

A medically supervised pregnancy test should also be performed during the consultation when isotretinoin is prescribed or in the 3 days prior to the visit to the prescriber, and should have been delayed until the patient had been using effective contraception for at least 1 month. This test should ensure the patient is not pregnant when she starts treatment with ACNETANE.

Follow-up visits:

Follow-up visits should be arranged at 28-day intervals. The need for repeated medically supervised pregnancy tests every month should be determined according to local practice including consideration of the patient's sexual activity and recent menstrual history (abnormal menses, missed periods or amenorrhoea). Where indicated, follow-up pregnancy tests should be performed on the day of the prescribing visit or in the 3 days prior to the visit to the prescriber.

End of treatment:

Five weeks after stopping treatment, women should undergo a final pregnancy test to exclude pregnancy.

Prescribing and dispensing restrictions:

Prescriptions of ACNETANE for women of childbearing potential should be limited to 30 days of treatment and continuation of treatment requires a new prescription. Ideally, pregnancy testing, issuing a prescription and dispensing of ACNETANE should occur on the same day. Dispensing of ACNETANE should occur within a maximum of 7 days of the prescription.

Male patients:

Male patients should be reminded that they must not share their medicine with anyone, particularly not females.

Special patient groups:

More regular checks of lipid and/or blood glucose serum levels may be necessary in high-risk patients undergoing treatment with ACNETANE. This includes patients with diabetes, alcoholism, obesity or lipid metabolism disorders. During isotretinoin therapy, there have been reports of new cases of diabetes mellitus.

Excipients:

ACNETANE contains ethylparaben. Ethylparaben may cause allergic reactions (possibly delayed).

4.5 Interactions with other medicines and other forms of interaction

Concomitant treatment with tetracyclines is contraindicated as cases of benign intracranial hypertension have been reported.
Concomitant use of Vitamin A, including dietary supplements is not recommended due to their additive toxic effects which may result in hypervitaminosis A.

4.6 Fertility, pregnancy and lactation

Pregnancy is an absolute contraindication to treatment with ACNETANE. Should pregnancy occur despite the detailed precautions during treatment with ACNETANE or in the month following treatment, there is a great risk of very severe and serious malformation of the foetus. (See section 4.3).

4.7 Effects on ability to drive and use machine

- ACNETANE could potentially have an influence on the ability to drive and use machines. Less frequent side effects such as drowsiness and visual disturbances have been reported (see section 4.8). Patients should be warned that if they experience these effects, they should not drive, operate machinery or take part in any other activities where the symptoms could put either themselves or others at risk.
- ACNETANE can affect night time vision. Patients should be warned that ACNETANE may impair their ability to drive and use machines at night.

4.8 Undesirable effects

a) Summary of the safety profile

All patients prescribed ACNETANE should be made aware of the possible side effects; the majority of which are dose-related. (see section 4.4)

b) Tabulated summary of adverse reactions

MedDRA System Organ Class	Frequency	Adverse Reaction
	Frequent	Anaemia, increased red blood cell sedimentation

Blood and lymphatic system disorders		rate, thrombocytopenia, Neutropenia
	Less frequent	Lymphadenopathy
Immune system disorders	Less frequent	Allergic skin reaction, anaphylactic reactions, hypersensitivity
Metabolism and nutrition disorders	Less frequent	Diabetes mellitus, hyperuricaemia
Psychiatric disorders	Less frequent	Depression, aggravated depression, aggressive tendencies, anxiety, mood alterations Abnormal behaviour, psychotic disorder, suicidal ideation, suicide attempt, suicide
Nervous system disorders	Frequent	Headache
	Less frequent	Benign intracranial hypertension, convulsions, drowsiness
Eye disorders	Frequent	Blepharitis, conjunctivitis, dry eye, eye irritation
	Less frequent	Blurred vision, cataract, colour blindness (colour vision deficiencies), contact lens intolerance, corneal opacity, decreased night vision, keratitis, papilloedema (as sign of benign intracranial hypertension), photophobia

Ear and labyrinth disorders	Less frequent	Impaired hearing
Vascular disorders	Less frequent	Vasculitis (e.g., Wegener's (eosinophilic) granulomatosis, allergic vasculitis)
Respiratory, thoracic and mediastinal disorders	Frequent	Epistaxis, nasal dryness, nasopharyngitis
	Less frequent	Bronchospasm (particularly in patients with asthma), hoarseness
Gastrointestinal disorders	Less frequent	Colitis, ileitis, dry throat, gastrointestinal haemorrhage, haemorrhagic diarrhoea and inflammatory bowel disease, nausea, pancreatitis
Hepatobiliary disorders	Frequent	Increased transaminase
	Less frequent	Hepatitis
Skin and subcutaneous tissues disorders	Frequent	Cheilitis, dermatitis, dry skin, localised exfoliation, pruritus, erythematous rash, skin fragility (risk of frictional trauma)
	Less frequent	Alopecia, Acne fulminans, aggravated acne (acne flare), erythema (facial), exanthema, hair disorders, hirsutism, nail dystrophy, paronychia,

		photosensitivity reaction, pyogenic granuloma, skin hyperpigmentation, increased sweating
	Frequency not known	Erythema multiforme, Stevens-Johnson syndrome, toxic epidermal necrolysis
Musculo-skeletal and connective tissue disorders	Frequent	Arthralgia, myalgia, back pain (particularly adolescent patients)
	Less frequent	Arthritis, calcinosis (calcification of ligaments and tendons), epiphyses premature fusion, exostosis, (hyperostotis), reduced bone density, tendonitis
	Frequency not known	Rhabdomyolysis
Renal and urinary disorders	Less frequent	Glomerulonephritis
General disorders and administration site conditions	Less frequent	Increased formation of granulation tissue, malaise
Investigations	Frequent	Increased blood triglycerides, decreased high density lipoprotein Increased blood cholesterol, increased blood glucose, haematuria, proteinuria
	Less frequent	Increased blood creatine phosphokinase

Infections	Less frequent	Gram positive (mucocutaneous) bacterial infection

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. Health care providers are asked to report any suspected adverse reactions to SAHPRA via the "6.04 Adverse Drug Reactions Reporting Form", found online under SAHPRA's publications:
https://www.sahpra.org.za/Publications/Index/8.
Additionally, suspected adverse reactions can be reported to the Holder of Certificate of Registration via Adcock.AEReports@adcock.com.

4.9 Overdose

Treatment is usually supportive and symptomatic. Although the acute toxicity of ACNETANE is low, signs of hypervitaminosis A could appear in cases of accidental overdose.

5 PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

A 13.4.2 Dermatological preparations - other.
Pharmacotherapeutic group: Retinoid for treatment of acne. ATC code: D10B A01.

Mechanism of action:

The active ingredient of ACNETANE is isotretinoin (13-cis-retinoic acid), which is produced upon isomerisation of tretinoin (all-trans retinoic acid). The mechanism of action includes decreasing of sebum production, normalising maturation of follicular epithelium. Furthermore, a dermal anti-inflammatory effect of isotretinoin has been established.

5.2 Pharmacokinetic properties

Time-related blood concentrations can be predicted from single-dose data on the basis of linear

pharmacokinetics. This property also provides some evidence that the activity of hepatic drug metabolising enzymes is not induced by isotretinoin.

Absorption:

Isotretinoin is rapidly absorbed from the gastrointestinal tract; the amount absorbed increases when isotretinoin is taken with food or milk. After oral administration of 80 mg, peak blood concentrations ranged from 167 ng/mL to 459 ng/mL (mean 256 ng/mL) in healthy volunteers. In acne patients peak concentrations ranged from 98 ng/mL to 535 ng/mL (mean 262 ng/mL), and occurred at 2 to 4 hours after administration (mean 2,9 hours). The mean ± Standard Deviation (SD) minimum steady-state blood concentration of isotretinoin was 160 ± 19 ng/mL. The terminal elimination half-life was consistent with that observed in healthy subjects.

Distribution:

Plasma protein binding, mainly to albumin, is 99,9 %. Steady state blood concentrations ($C_{min.ss}$) of isotretinoin in patients with severe acne treated with 40 mg two times a day ranged from 120 - 200 ng/mL. The concentration of 4-oxo-isotretinoin in these patients were 2 - 5 times higher than the isotretinoin concentrations.

Metabolism:

Isotretinoin is metabolised in the liver. After oral administration of isotretinoin, three major metabolites have been identified in plasma: 4-oxo-isotretinoin,tretinoin, (all-trans retinoic acid), and 4-oxo-tretinoin . The major metabolite is 4-oxo-isotretinoin with plasma concentrations at steady state, that are 2,5 times higher than those of the parent compound.
Isotretinoin metabolites have shown biological activity in several *in-vitro* tests. Thus, the observed clinical profile in patients could be the result of the pharmacological activity of isotretinoin and its metabolites.
Since isotretinoin and tretinoin (all-trans retinoic acid) are reversibly metabolised (= interconverted), the metabolism of tretinoin is linked with that of isotretinoin. Evidence of presystemic metabolism of isotretinoin has been shown. It has been estimated that 20 % - 30 % of an isotretinoin dose is metabolised by isomerisation. Enterohepatic circulation may play a significant role in the pharmacokinetics of isotretinoin in man. *In vitro* metabolism studies have demonstrated that several CYP enzymes are involved in the metabolism of isotretinoin to 4-oxo isotretinoin and tretinoin. No single isoform appears to have a predominant role. Isotretinoin and its metabolites do not significantly affect CYP activity.

Elimination:

The main elimination half-life of this metabolite is 25 hours. After two 40 mg capsules of isotretinoin, maximum concentrations of the metabolite occurred at 6 to 20 hours. The blood concentration of the major metabolite generally exceeded that of isotretinoin after 6 hours. Isotretinoin is excreted in the bile or faeces (83 %) and renally (65 %).
The terminal elimination half-life of 4-oxo isotretinoin is longer, with a mean value of 29 hours. Isotretinoin is a physiological retinoid and endogenous retinoid concentrations are reached within approximately two weeks following the end of therapy.

5.3 Preclinical safety data

No data available

6 PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Capsule filling:

Butylated Hydroxyanisole
Edetate Disodium
White wax
Soybean Oil

Capsule Shell:

Amaranth (CI 16185)
Brilliant Blue (CI 42090)
Ethylparaben
Gelatin
Glycerin
Polyethylene glycol 400
Titanium Dioxide

6.2 Incompatibilities

Not applicable

6.3 Shelf life

24 months.

6.4 Special precautions for storage

Store at or below 25 ºC and protect from light and moisture. Do not remove from outer container until required for use.

6.5 Nature and contents of container

10 mg Capsules: 6 x PVC/Alu blister strips of 10 soft gelatin capsules
20 mg Capsules: 6 x PVC/Alu blister strips of 10 soft gelatin capsules
The 6 x PVC/Alu blister strips are wrapped in an aluminium outer wrapping.

6.6 Special precautions for disposal and other handling

Any unused product or waste material should be disposed of in accordance with local requirements.

7 HOLDER OF CERTIFICATE OF REGISTRATION

Adcock Ingram Limited
1 New Road,
Erand Gardens,
Midrand, 1685
Customer Care: 0860 ADCOCK / 232625

Name of manufacturer:

Shanghai Sine Wanxiang Pharmaceutical Co., Ltd
No. 217 Zhaochong Road
Qingpu District,
Shanghai
P.R China

8 REGISTRATION NUMBER(S)

10 mg Capsules: 34/13.4.2/0356
20 mg Capsules: 34/13.4.2/0357

9 DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUTHORISATION

24 October 2003

10 DATE OF REVISION OF THE TEXT

10 October 2024

Botswana:		
S2	Acnetane 10 mg (60's)	BOT1302313
S2	Acnetane 20 mg (60's)	BOT1302314

Mauritius:		
	10 mg Capsules:	R8977/02/14
	20 mg Capsules:	R9080/02/14

Namibia:		
NS3	Acnetane 10 mg	05/13.4.3/0337
NS3	Acnetane 20 mg	05/13.4.3/0338

adcock ingram

PI 1030855005 02/2025