PROFESSIONAL INFORMATION FOR ULCOPRAZ TABLETS

SCHEDULING STATUS: S4

1. NAME OF THE MEDICINE

ULCOPRAZ 10 (enteric-coated delayed release tablet)

ULCOPRAZ 20 (enteric-coated delayed release tablet)

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

ULCOPRAZ 10: Each enteric-coated delayed release tablet contains 10 mg of rabeprazole sodium equivalent to rabeprazole.

Contains sugar (7 mg mannitol)

ULCOPRAZ 20: Each enteric-coated delayed release tablet contains 20 mg of rabeprazole sodium equivalent to rabeprazole.

Contains sugar (14 mg mannitol)

For the full list of excipients, see section 6.1

3. PHARMACEUTICAL FORM

Enteric-coated delayed release tablets

ULCOPRAZ 10: Pink coloured, circular, biconvex, enteric coated tablet plain on the other side.

ULCOPRAZ 20: Yellow coloured, circular, biconvex, enteric coated tablet plain on other side.

4. CLINICAL PARTICULARS

4.1 Therapeutic indications

ULCOPRAZ are indicated for the treatment of:

- Active duodenal ulcer

- Active benign gastric ulcer
- Symptomatic erosive or ulcerative gastro-oesophageal reflux disease (GORD).
- Maintenance treatment of healed erosive or ulcerative GORD. Efficacy has not been demonstrated for periods exceeding 12 months.
- Symptomatic treatment of gastro-oesophageal reflux disease (GORD).
- Zollinger- Ellison Syndrome and other hypersecretory conditions.
- *H. Pylori*-positive duodenal ulcers, as part of the eradication programme with appropriate antibiotics.

4.2 Posology and method of administration

Posology

Adults/elderly:

Active duodenal ulcer and active benign gastric ulcer:

20 mg to be taken once daily in the morning.

Most patients with active duodenal ulcer heal within four weeks. However, 2 % of patients may require an additional four weeks of therapy to achieve healing.

Some patients with active duodenal ulcer may respond to one 10 mg tablet to be taken once daily in the morning.

Most patients with active benign gastric ulcer heal within six weeks. However, 9 % of patients may require an additional six weeks of therapy to achieve healing.

Erosive or ulcerative Gastro-Oesophageal Reflux Disease (GORD):

20 mg to be taken once daily for four to eight weeks.

Gastro-Oesophageal Reflux long-term management (GORD Maintenance):

For long term management up to 12 months, a maintenance dose of **ULCOPRAZ 10 or 20 mg** once daily can be used. Some patients may respond to a maintenance dose of 10 mg/day.

Symptomatic treatment of gastro-oesophageal reflux disease (symptomatic GORD):

10 mg once daily in patients without oesophagitis.

If symptom control has not been achieved after four weeks, the patient should be further investigated. Once symptoms have resolved, subsequent symptom control can be achieved using an on demand regimen taking 10 mg once daily when needed.

Zollinger-Ellison Syndrome and other pathological hypersecretory conditions:

The recommended adult starting dose is 60 mg once a day. The dose may be titrated upwards to 120 mg/day based on individual patient needs. Single daily doses up to 100 mg/day may be given. 120 mg dose may require divided doses, 60 mg twice daily. Treatment should continue for as long as clinically indicated.

Eradication of *H. Pylori*:

Rabeprazole is indicated for *H. Pylori*-positive duodenal ulcers, as part of the eradication programme with appropriate antibiotics.

Special populations

ULCOPRAZ is not recommended for use in children as there is no experience of its use in this group.

Renal and hepatic impairment:

No dosage adjustment is necessary for patients with renal or hepatic impairment. Caution is however advised when **ULCOPRAZ** is first initiated in patients with severe hepatic dysfunction (See Sections 4.4 and 4.8").

Method of administration

For oral use.

ULCOPRAZ should be taken in the morning, before eating; and although neither the time of day nor food intake was shown to have any effect on **ULCOPRAZ** activity, this regimen will facilitate treatment compliance.

Patients should be cautioned that **ULCOPRAZ** should not be chewed or crushed, but should be

swallowed whole.

4.3 Contraindications

ULCOPRAZ is contraindicated:

- in patients with a history of hypersensitivity to rabeprazole sodium, substituted benzimidazoles or to any of the components of **ULCOPRAZ** listed in section 6.1**.**
- during breastfeeding of infants and while pregnant (see Section 4.6).
- Co-administration with atazanavir and nelfinavir

4.4 Special warnings and precautions for use

Renal impairment

Acute tubulointerstitial nephritis (TIN) has been observed in patients taking rabeprazole and may occur at any point during **ULCOPRAZ** therapy (see section 4.8). Acute tubulointerstitial nephritis can progress to renal failure.

Rabeprazole should be discontinued in case of suspected TIN, and appropriate treatment should be promptly initiated.

Symptomatic response to therapy with rabeprazole sodium does not preclude the presence of gastric or oesophageal malignancy, therefore the possibility of malignancy should be excluded prior to commencing treatment with **ULCOPRAZ.**

Patients on long-term treatment (particularly those treated for more than a year) should be kept under regular surveillance.

A risk of cross-hypersensitivity reactions with other proton pump inhibitor (PPI) or substituted benzimidazoles cannot be excluded.

There have been post marketing reports of blood dyscrasias (thrombocytopenia and neutropenia). In the majority of cases where an alternative aetiology cannot be identified, the events were uncomplicated and resolved on discontinuation of rabeprazole.

Hepatic enzyme abnormalities have been seen in clinical trials and have also been reported since market authorisation. In the majority of cases where an alternative aetiology cannot be identified, the events were uncomplicated and resolved on discontinuation of rabeprazole.

No evidence of significant drug related safety problems was seen in a study of patients with mild to moderate hepatic impairment versus normal age and sex matched controls. However, because there are no clinical data on the use of **ULCOPRAZ** in the treatment of patients with severe hepatic dysfunction the prescriber is advised to exercise caution when treatment with **ULCOPRAZ** is first initiated in such patients.

Co-administration of atazanavir with **ULCOPRAZ TABLETS** is contraindicated (see section 4.5).

Treatment with PPIs, including **ULCOPRAZ**, may possibly increase the risk of gastrointestinal infections such as *Salmonella, Campylobacter* and *Clostridium difficile* (see section 5.1).

PPIs, especially if used in high doses and over long durations (>1 year), may modestly increase the risk of hip, wrist and spine fracture, predominantly in older people or in the presence of other recognised risk factors. Observational studies suggest that PPIs may increase the overall risk of fracture by 10–40%. Some of this increase may be due to other risk factors. Patients at risk of osteoporosis should receive care according to current clinical guidelines and they should have an adequate intake of vitamin D and calcium.

Severe hypomagnesaemia has been reported in patients treated with PPIs like **ULCOPRAZ** for at least three months, and in most cases for a year. Serious manifestations of hypomagnesaemia such as fatigue, tetany, delirium, convulsions, dizziness and ventricular arrhythmia can occur but they may begin insidiously and be overlooked. In most affected patients, hypomagnesaemia improved after magnesium replacement and discontinuation of **ULCOPRAZ**.

For patients expected to be on prolonged treatment or who take PPIs with digoxin or drugs that may cause hypomagnesaemia (e.g., diuretics), health care professionals should consider measuring

magnesium levels before starting **ULCOPRAZ** treatment and periodically during treatment.

Concomitant use of rabeprazole with methotrexate

Literature suggests that concomitant use of PPIs as in **ULCOPRAZ** with methotrexate (primarily at high dose; see methotrexate prescribing information) may elevate and prolong serum levels of methotrexate and/or its metabolite, possibly leading to methotrexate toxicities. In high-dose methotrexate administration, a temporary withdrawal of the **ULCOPRAZ** may be considered in some patients (see section 4.5)

Influence on vitamin B12 absorption

Rabeprazole sodium, may reduce the absorption of vitamin B12 (cyanocobalamin) due to hypo- or a- chlorhydria. This should be considered in patients with reduced body stores or risk factors for reduced vitamin B12 absorption on long-term therapy or if respective clinical symptoms are observed.

Subacute cutaneous lupus erythematosus (SCLE)

PPIs are associated with cases of SCLE. If lesions occur, especially in sun-exposed areas of the skin and if accompanied by arthralgia, the patient should seek medical help promptly and the health care professional should consider stopping **ULCOPRAZ**. SCLE after previous treatment with a PPI may increase the risk of SCLE with other PPIs.

Blood dyscrasias

There have been post marketing reports of blood dyscrasias (thrombocytopaenia and neutropaenia). In the majority of cases where an alternative aetiology cannot be identified, the events were uncomplicated and resolved on discontinuation of **ULCOPRAZ**.

Fundic gland polyps

Long-term use of **ULCOPRAZ** is associated with an increased risk of fundic gland polyps (see section 4.8, “Undesirable effects – Postmarketing data). Most fundic polyps are asymptomatic. Patients with large or ulcerated polyps may be at risk of gastrointestinal bleeding or small intestinal blockage. Use the lowest dose and the shortest duration of Proton Pump Inhibitors (PPI) therapy

appropriate to the condition being treated.

Acute Tubulointerstitial Nephritis

Acute tubulointerstitial nephritis (TIN) has been observed in patients taking Proton Pump Inhibitors (PPIs) and may occur at any point during PPI therapy. Patients may present with varying signs and symptoms from symptomatic hypersensitivity reactions to non-specific symptoms of decreased renal function (e.g., malaise, nausea, anorexia). In reported case series, some patients were diagnosed on biopsy and in the absence of extra-renal manifestations (e.g., fever, rash or arthralgia). Discontinue **ULCOPRAZ** and evaluate patients with suspected acute TIN.

Interference with laboratory tests

Increased Chromogranin A (CgA) level may interfere with investigations for neuroendocrine tumours. To avoid this interference, **ULCOPRAZ** treatment should be stopped for at least 5 days before CgA measurements (see section 5.1). If CgA and gastrin levels have not returned to reference range after initial measurement, measurements should be repeated 14 days after cessation of PPI treatment.

4.5 Interaction with other medicines and other forms of interaction

Rabeprazole sodium produces a profound and long lasting inhibition of gastric acid secretion. An interaction with compounds whose absorption is pH dependent may occur. Co-administration of rabeprazole sodium with ketoconazole or itraconazole may result in a significant decrease in antifungal plasma levels and an increase in trough digoxin levels in normal subjects. Therefore, individual patients may need to be monitored to determine if a dosage adjustment is necessary when ketoconazole or itraconazole are taken concomitantly with **ULCOPRAZ.**

In clinical trials, antacids were used concomitantly with the administration of **ULCOPRAZ** and, in a specific drug-drug interaction study, no interaction with liquid antacids was observed.

Co-administration of atazanavir 300 mg/ritonavir 100 mg with omeprazole (40 mg once daily) or atazanavir 400 mg with lansoprazole (60 mg once daily) to healthy volunteers resulted in a substantial reduction in atazanavir exposure. The absorption of atazanavir is pH dependent.

Although not studied, similar results are expected with other PPIs. Therefore PPIs, including rabeprazole, should not be co-administered with atazanavir (see section 4.4).

Ciclosporin

In vitro studies with human liver microsomes indicated that rabeprazole sodium is metabolised by isoenzymes of CYP450 (CYP2C19 and CYP3A4). The studies suggest a low interaction potential; however the effect on ciclosporin metabolism is similar to that observed for other proton pump inhibitors.

Methotrexate

Case reports, published population pharmacokinetic studies, and retrospective analyses suggest that concomitant administration of PPIs and methotrexate (primarily at high dose; see methotrexate prescribing information) may elevate and prolong serum levels of methotrexate and/or its metabolite hydroxymethotrexate. However, no formal drug interaction studies of methotrexate with PPIs have been conducted.

4.6 Fertility, pregnancy and lactation

Safety in pregnancy and lactation has not been established.

Pregnancy

ULCOPRAZ is contraindicated during pregnancy (see section 4.3)

Breastfeeding

Excretion of rabeprazole sodium in human breast milk has not been studied. Rabeprazole sodium is excreted in rat mammary secretions. **ULCOPRAZ** is contraindicated during breastfeeding.

4.7 Effects on ability to drive and use machines

Based on the pharmacodynamic properties and the adverse events profile, it is unlikely that **ULCOPRAZ** would cause an impairment of driving performance or compromise the ability to use machinery. If however, alertness is impaired due to somnolence, it is recommended that driving and operating complex machinery be avoided.

4.8 Undesirable effects

Summary of the safety profile

The most frequently reported adverse drug reactions, during controlled clinical trials with rabeprazole were headache, diarrhoea, abdominal pain, asthenia, flatulence, rash and dry mouth. The majority of adverse events experienced during clinical studies were mild or moderate in severity, and transient in nature.

Tabulated summary of adverse reactions

System organ class	**Frequent**	**Less frequent**	**Frequency unknown**
Infections and infestations	Infection, including *Salmonella*	-	-
Blood and lymphatic system disorders	-	Neutropenia, Leucopenia, Thrombocytopenia, Leucocytosis	-
Immune system disorders	-	Hypersensitivity*	-
Metabolism and nutrition disorders	-	Anorexia	Hyponatraemia Hypo-magnesaemia
Psychiatric disorders	Insomnia	Nervousness, Depression	Confusion
Nervous system disorders	Headache, Dizziness	Somnolence	-
Eye disorders		Visual disturbance	

Vascular disorders	-	-	Peripheral oedema
Respiratory, thoracic and mediastinal disorders	Cough, Pharyngitis, Rhinitis	Bronchitis, Sinusitis	-
Gastrointestinal disorders	Diarrhoea, Vomiting, Nausea, Abdominal pain, Constipation, Flatulence Fundic Gland Polyps (Benign)	Dyspepsia, Dry mouth, Eructation, Gastritis, Stomatitis, Taste disturbance, Gastric glandular cyst	Microscopic colitis
Skin and subcutane-ous tissue disorders	-	Rash, Erythema, Pruritus, Sweating, Bullous reactions, Erythema multiforme, Toxic epidermal necrolysis (TEN), Stevens-Johnson syndrome (SJS)	Subacute cutaneous lupus, erythematosus
Musculoskeletal, connective tissue and bone disorders	Non-specific pain, Back pain	Myalgia, Leg cramps, Arthralgia, Fracture of the hip, wrist or spine	-

Renal and urinary disorders	-	Urinary tract infection, Interstitial nephritis	-
Reproductive system and breast disorders	-	-	Gynaecomas-tia
General disorders and administra-tion site conditions	Asthenia, Influenza-like illness	Chest pain, Chills, Pyrexia	-
Investigations	-	Increased hepatic enzymes,** Weight gain	-

*****Include facial swelling, hypotension and dyspnoea. Erythema, bullous reaction and hypersensitivity reactions have usually resolved after discontinuation of therapy.

** Reports of hepatic encephalopathy have been received in patients with underlying cirrhosis. In treatment of patients with severe hepatic dysfunction the prescriber is advised to exercise caution when treatment with rabeprazole is first initiated in such patients.

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

4.9 Overdose

Experience to date with deliberate or accidental overdose is limited. The maximum established exposure has not exceeded 60 mg twice daily, or 160 mg once daily. Effects are generally minimal, representative of the known adverse event profile and reversible without further medical intervention. No specific antidote is known. Rabeprazole sodium is extensively protein bound and is,

therefore, not readily dialysable. Treatment should be symptomatic and general supportive measures should be utilised.

5. PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Category and class: A 11.4.3 Medicines acting on the gastro-intestinal tract

Pharmacotherapeutic group: Alimentary tract and metabolism, Drugs for peptic ulcer and gastro-oesophageal reflux disease (GORD), PPIs,

ATC code: A02B C04

Mechanism of action

Rabeprazole sodium belongs to the class of anti-secretory compounds, the substituted benzimidazoles, that do not exhibit anticholinergic or H2 histamine antagonist properties, but suppress gastric acid secretion by the specific inhibition of the H+/K+-ATPase enzyme (the acid or proton pump). The effect is dose-related and leads to inhibition of both basal and stimulated acid secretion irrespective of the stimulus. Animal studies indicate that after administration, rabeprazole sodium rapidly disappears from both the plasma and gastric mucosa. As a weak base, rabeprazole is rapidly absorbed following all doses and is concentrated in the acid environment of the parietal cells. Rabeprazole is converted to the active sulphenamide form through protonation and it subsequently reacts with the available cysteines on the proton pump.

Anti-secretory activity

After oral administration of a 20 mg dose of rabeprazole sodium the onset of the anti-secretory effect occurs within one hour, with the maximum effect occurring within two to four hours. Inhibition of basal and food stimulated acid secretion 23 hours after the first dose of rabeprazole sodium are 69 % and 82 % respectively and the duration of inhibition lasts up to 48 hours. The inhibitory effect of rabeprazole sodium on acid secretion increases slightly with repeated once-daily dosing, achieving steady state inhibition after three days. When the drug is discontinued, secretory activity normalises over 2 to 3 days.

Decreased gastric acidity due to any means, including PPIs such as rabeprazole, increases counts of

bacteria normally present in the gastrointestinal tract. Treatment with PPIs may possibly increase the risk of gastrointestinal infections such as *Salmonella, Campylobacter* and *Clostridium difficile*.

Serum gastrin effects

In clinical studies patients were treated once daily with 10 or 20 mg rabeprazole sodium, for up to 43 months duration. Serum gastrin levels increased during the first 2 to 8 weeks reflecting the inhibitory effects on acid secretion and remained stable while treatment was continued. Gastrin values returned to pre-treatment levels, usually within 1 to 2 weeks after discontinuation of therapy.

Human gastric biopsy specimens from the antrum and the fundus from over 500 patients receiving rabeprazole or comparator treatment for up to 8 weeks have not detected changes in ECL cell histology, degree of gastritis, incidence of atrophic gastritis, intestinal metaplasia or distribution of *H. pylori* infection. In over 250 patients followed for 36 months of continuous therapy, no significant change in findings present at baseline was observed.

Other effects

Systemic effects of rabeprazole sodium in the CNS, cardiovascular and respiratory systems have not been found to date. Rabeprazole sodium, given in oral doses of 20 mg for 2 weeks, had no effect on thyroid function, carbohydrate metabolism, or circulating levels of parathyroid hormone, cortisol, oestrogen, testosterone, prolactin, cholecystokininin, secretin, glucagon, follicle stimulating hormone (FSH), luteinising hormone (LH), renin, aldosterone or somatotrophic hormone.

Studies in healthy subjects have shown that rabeprazole sodium does not have clinically significant interactions with amoxicillin. Rabeprazole does not adversely influence plasma concentrations of amoxicillin or clarithromycin when co-administered for the purpose of eradicating upper gastrointestinal *H. pylori* infection.

During treatment with antisecretory medicinal products, serum gastrin increases in response to the decreased acid secretion. Also CgA increases due to decreased gastric acidity. The increased CgA level may interfere with investigations for neuroendocrine tumours.

Available published evidence suggests that PPIs should be discontinued between 5 days and 2 weeks prior to CgA measurements. This is to allow CgA levels that might be spuriously elevated following PPI treatment to return to reference range.

5.2 Pharmacokinetic properties

Absorption

ULCOPRAZ is an enteric-coated (gastro-resistant) tablet formulation of rabeprazole sodium. This presentation is necessary because rabeprazole is acid-labile.

Absorption of rabeprazole therefore begins only after the tablet leaves the stomach. Absorption is rapid, with peak plasma levels of rabeprazole occurring approximately 3.5 hours after a 20 mg dose. Peak plasma concentrations (C_{max}) of rabeprazole and AUC are linear over the dose range of 10 mg to 40 mg. Absolute bioavailability of an oral 20 mg dose (compared to intravenous administration) is about 52 % due in large part to pre-systemic metabolism. Additionally, the bioavailability does not appear to increase with repeat administration. In healthy subjects the plasma half-life is approximately one hour (range 0.7 to 1.5 hours), and the total body clearance is estimated to be 283 ± 98 mL/min. There was no clinically relevant interaction with food. Neither food nor the time of day of administration of the treatment affect the absorption of rabeprazole sodium.

Distribution

Rabeprazole is approximately 97 % bound to human plasma proteins.

Metabolism and excretion

Rabeprazole sodium, as is the case with other members of the PPI class of compounds, is metabolised through the cytochrome P450 (CYP450) hepatic drug metabolising system. *In vitro* studies with human liver microsomes indicated that rabeprazole sodium is metabolised by isoenzymes of CYP450 (CYP2C19 and CYP3A4). In these studies, at expected human plasma concentrations rabeprazole neither induces nor inhibits CYP3A4; and although *in vitro* studies may not always be predictive of *in vivo* status these findings indicate that no interaction is expected between rabeprazole and cyclosporin. In humans the thioether (M1) and carboxylic acid (M6) are the main plasma metabolites with the sulphone (M2), desmethyl-thioether (M4) and mercapturic acid conjugate (M5) minor metabolites observed at lower levels. Only the desmethyl metabolite (M3) has a small amount of anti-secretory activity, but it is not present in plasma.

Following a single 20 mg ^{14}C labelled oral dose of rabeprazole sodium, no unchanged drug was

excreted in the urine. Approximately 90 % of the dose was eliminated in urine mainly as the two metabolites: a mercapturic acid conjugate (M5) and a carboxylic acid (M6), plus two unknown metabolites. The remainder of the dose was recovered in faeces.

Gender

Adjusted for body mass and height, there are no significant gender differences in pharmacokinetic parameters following a single 20 mg dose of rabeprazole.

Renal dysfunction

In patients with stable, end-stage, renal failure requiring maintenance haemodialysis (creatinine clearance ≤ 5mL/min/1.73m^2), the disposition of rabeprazole was very similar to that in healthy volunteers. The AUC and the C_{max} in these patients was about 35 % lower than the corresponding parameters in healthy volunteers. The mean half-life of rabeprazole was 0.82 hours in healthy volunteers, 0.95 hours in patients during haemodialysis and 3.6 hours post dialysis. The clearance of the drug in patients with renal disease requiring maintenance haemodialysis was approximately twice that in healthy volunteers.

Hepatic dysfunction

Following a single 20 mg dose of rabeprazole to patients with chronic mild to moderate hepatic impairment the AUC doubled and there was a 2-3 fold increase in half-life of rabeprazole compared to the healthy volunteers. However, following a 20 mg dose daily for 7 days the AUC had increased to only 1.5-fold and the C_{max} to only 1.2-fold. The half-life of rabeprazole in patients with hepatic impairment was 12.3 hours compared to 2.1 hours in healthy volunteers. The pharmacodynamic response (gastric pH control) in the two groups was clinically comparable.

Older people

Elimination of rabeprazole was somewhat decreased in older people. Following 7 days of daily dosing with 20 mg of rabeprazole sodium, the AUC approximately doubled, the C_{max} increased by 60 % and t½ increased by approximately 30 % as compared to young healthy volunteers. However, there was no evidence of rabeprazole accumulation.

CYP2C19 polymorphism

Following a 20 mg daily dose of rabeprazole for 7 days, CYP2C19 slow metabolisers, had AUC and t½ which were approximately 1.9 and 1.6 times the corresponding parameters in extensive metabolisers whilst C_{max} had increased by only 40 %.

6. PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Tablet core contains:

Low substituted hydroxypropyl cellulose, magnesium oxide, magnesium stearate mannitol, sodium hydroxide, povidone, purified talc.

Coating material contains:

ULCOPRAZ 10

Ethyl cellulose, magnesium oxide, ferric oxide red, titanium dioxide, methacrylic acid copolymer dispersion (Eudragit L 30 D-55), triethylcitrate, purified talc.

ULCOPRAZ 20

Ethyl cellulose, magnesium oxide, ferric oxide yellow, titanium dioxide, methacrylic acid copolymer dispersion (Eudragit L 30 D-55), triethylcitrate, purified talc.

6.2 Incompatibilities

Not applicable.

6.3 Shelf life

24 months from the manufacturing date

6.4 Special precautions for storage

Store at or below 25 °C.

Protect from moisture.

Keep the blisters in the carton until required for use.

Keep the HDPE container tightly closed.

Do not store in a refrigerator.

KEEP OUT OF REACH OF CHILDREN

6.5 Nature and contents of container

HDPE container

Tablets are packed in a round white HDPE container closed with child resistant closure with pulp and heat seal liner.

Pack sizes include 28’s, 30’s tablets and 90’s tablets.

Blister pack

Tablets are packed in cold form laminate OPA/aluminium foil/PVC as forming material and aluminium foil as lidding material.

Pack size include 14’s, 28’s, 30’s and 90's tablets

Blister pack with desiccant

Tablets are packed in cold form with desiccant layer and HDPE sealant layer as forming material and aluminium foil with HDPE sealant layer as lidding material.

Pack size include 14’s, 28’s, 30’s and 90's tablets

Not all pack sizes are necessarily marketed.

6.6 Special precautions for disposal

No special requirements.

7. HOLDER OF CERTIFICATE OF REGISTRATION

MACLEODS PHARMACEUTICALS SA (PTY) LTD

GROUND FLOOR, BLOCK 1,

BASSONIA ESTATE OFFICE PARK (EAST),

1 CUSSONIA DRIVE,

BASSONIA ROCK EXT 12

ALBERTON

GAUTENG

8. REGISTRATION NUMBERS

ULCOPRAZ 10: 56/11.4.3/0623.621

ULCOPRAZ 20: 56/11.4.3/0624.622

9. DATE OF FIRST AUTHORISATION

ULCOPRAZ 10: 14 November 2023

ULCOPRAZ 20: 14 November 2023

10. DATE OF REVISION OF THE TEXT

To be advised

PM0080-01

Vanita Rajool

Digitally signed by Vanita Rajool
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