GENRX PIROXICAM CAPSULES

NAME OF THE MEDICINE

Piroxicam.

Chemical name: 4-hydroxy-2-methyl-N-2-pyridinyl-2H-1, 2-benzothiazine-3-carboxamide 1, 1-dioxide. It is a member of a new chemical class of non-steroidal anti-inflammatory agents, N-heterocyclic carboxamides of 1, 2-benzothiazine-1, 1-dioxide.

Structural Formula:

\[
\begin{align*}
\text{C} & \quad \text{O} \\
\text{NMe} & \quad \text{H} \\
\text{CH} & \quad \text{N} \\
\text{CH} & \quad \text{H} \\
\text{N} & \quad \text{O} \\
\end{align*}
\]

Molecular Formula: \( C_{15}H_{13}N_{3}O_{4}S \)

Molecular Weight: 331.4

CAS Registry Number: 36322-90-4

DESCRIPTION

Piroxicam is a white or slightly yellow crystalline powder. It is poorly soluble in water, dilute acid and most organic solvents. It is slightly soluble in alcohols and in aqueous alkaline solution. It is a hygroscopic solid, which melts in the range 196 to 200°C.

Piroxicam is an amphoteric compound. It exhibits a weakly acidic 4-hydroxy proton (pKa 5.1) and a weakly basic pyridyl nitrogen (pKa 1.5) as determined by ultraviolet absorption spectrophotometry in methanol-water (2.5/97.5, v/v) solvent medium.

PHARMACOLOGY

Piroxicam, an oxicam, is a non-steroidal anti-inflammatory drug (NSAID) which is structurally related to tenoxicam, another NSAID.

Pharmacokinetics

Absorption

Following oral administration, piroxicam is well absorbed. The rate and extent of absorption are not affected by administration in the fasting state. The plasma half-life in humans is approximately 36 to 45 hours and stable plasma concentrations are maintained throughout the day on once daily dosage. Following repeated administration, plasma concentrations increase for five to seven days, by which time a steady state is reached which is not exceeded following further constant daily drug administration.

Metabolism and Excretion

Piroxicam is extensively metabolised, with less than 5% of the daily dose excreted unchanged in urine and faeces. One important metabolic pathway is hydroxylation of the pyridyl ring of the piroxicam side chain, followed by conjugation with glucuronic acid and urinary elimination. Approximately 5% of the dose is metabolised to and excreted as saccharin.
Protein Binding
Piroxicam is extensively bound to plasma proteins (99%) and therefore may be expected to displace other protein bound drugs (see PRECAUTIONS, Interactions with Other Medicines).

Use with Cimetidine
Results of two separate studies indicate a slight increase in absorption of piroxicam following cimetidine administration, but no significant changes in elimination parameters. Cimetidine increases the area under the curve (AUC_{0-120}) and C_{max} of piroxicam by approximately 13 to 15%. There were no significant differences in elimination rate constants and half-life. The small but significant increase in absorption is unlikely to be clinically significant.

Pharmacodynamics
Piroxicam is a non-steroidal anti-inflammatory agent with analgesic and antipyretic properties.

The mode of action of piroxicam has not been fully established; however, independent studies, both in vitro and in vivo, have demonstrated that piroxicam interacts at several steps in the immune and inflammation responses through the following:

- Inhibition of prostanoid synthesis, including prostaglandins (known mediators of inflammation), through a reversible inhibition of the cyclooxygenase enzyme.
- Inhibition of neutrophil aggregation in blood vessels.
- Inhibition of lysosomal enzyme release from stimulated leucocytes.
- Inhibition of polymorphonuclear cell and monocyte migration to the area of inflammation.
- Inhibition of superoxide anion generation by the neutrophil.
- Reduction of both systemic and synovial fluid rheumatoid factor production in patients with seropositive rheumatoid arthritis.

It has been demonstrated that piroxicam inhibits chemotaxis of polymorphonuclear leucocytes and the migration of leucocytes in canine synovitis test. Piroxicam also inhibits collagen induced platelet aggregation. It is known that piroxicam does not act by pituitary-adrenal axis stimulation. Studies in vitro have not revealed any negative effect on cartilage metabolism.

Sub-acute and chronic toxicity studies have been carried out in rats, mice, dogs, and monkeys. The pathology most often seen was that characteristically associated with the animal toxicology of non-steroidal anti-inflammatory agents: renal papillary necrosis and gastrointestinal lesions.

INDICATIONS
Indicated for symptomatic treatment of rheumatoid arthritis, osteoarthritis and ankylosing spondylitis.

CONTRAINDICATIONS
Piroxicam should not be administered to patients with peptic ulcer, active gastrointestinal bleeding or active inflammatory disease of the gastrointestinal tract, or a recent history of these conditions.

Piroxicam should not be used in patients who have previously shown a hypersensitivity to the drug or in whom a hypersensitive reaction(s) (e.g. asthma, nasal polyps, angioedema or urticaria) has been precipitated by aspirin or other NSAIDs, since cross sensitivity exists.

Piroxicam should not be administered to patients with a history of previous severe allergic drug reactions of any type, especially cutaneous reactions such as erythema multiforme, Stevens-Johnson syndrome, toxic epidermal necrolysis, or those who have exhibited a previous skin reaction (regardless of severity) to piroxicam.

Piroxicam is contraindicated in the treatment of peri-operative pain in the setting of coronary artery bypass graft (CABG) surgery.

Piroxicam is contraindicated in patients with severe renal and hepatic failure.
Piroxicam is contraindicated in patients with severe heart failure.

Concomitant use with other NSAIDs, including COX-2 selective NSAIDs and acetylsalicylic acid at analgesic doses.

**PRECAUTIONS**

Undesirable effects may be minimised by using the minimum effective dose for the shortest duration necessary to control symptoms. The clinical benefit and tolerability should be re-evaluated periodically and treatment should be immediately discontinued at the first appearance of cutaneous reactions or relevant gastrointestinal events. Evidence from observational studies suggests that piroxicam may be associated with a high risk of serious gastrointestinal toxicity, relative to other NSAIDs. Piroxicam should only be commenced after careful weighing of the risks and benefits in each individual patient.

**Cardiovascular Effects**

**Cardiovascular Thrombotic Events**

NSAIDs may cause an increased risk of serious cardiovascular thrombotic events, myocardial infarction and stroke, which can be fatal. This risk may increase with dose or duration of use. Patients with cardiovascular disease or risk factors for cardiovascular disease may be at greater risk. To minimise the potential risk for an adverse cardiovascular event in patients treated with piroxicam, especially in those with cardiovascular risk factors, the lowest effective dose should be used for the shortest duration possible. Physicians and patients should remain alert for the development of such events, even in the absence of previous cardiovascular symptoms. Patients should be informed about the signs and/or symptoms of serious cardiovascular toxicity and the steps to take if they occur (see CONTRAINDICATIONS).

There is no consistent evidence that the concurrent use of aspirin mitigates the increased risk of serious cardiovascular events associated with NSAID use.

**Hypertension**

NSAIDs may lead to the onset of new hypertension or worsening of pre-existing hypertension and patients taking antihypertensives with NSAIDs may have an impaired anti-hypertensive response. For example, the anti-hypertensive effect of thiazide diuretics and beta-blocking agents is antagonised by NSAIDs.

Caution is advised when prescribing NSAIDs to patients with hypertension. Blood pressure should be monitored closely during initiation of NSAID treatment and at regular intervals thereafter.

**Heart Failure**

Oedema, mainly ankle oedema, has been reported during piroxicam treatment; as with other nonsteroidal anti-inflammatory agents, piroxicam should be used with caution in patients with compromised cardiac function and other conditions predisposing to or worsened by, fluid retention. Patients with pre-existing congestive heart failure or hypertension should be closely monitored.

**Risk of GI Ulceration, Bleeding and Perforation with NSAID Therapy.**

All NSAIDs can cause gastrointestinal discomfort and serious, potentially fatal gastrointestinal toxicity such as bleeding, ulceration and perforation can occur at any time, with or without warning symptoms, in patients treated chronically with NSAID therapy. The frequency of such events may increase with dose or duration of use.

In patients observed in clinical trials of several months to two years duration, symptomatic, upper GI ulcers, gross bleeding or perforation appear to occur in approximately 1% of patients treated for 3-6 months, and in about 2-4% of patients treated for one year. These trends continue with longer duration of use, increasing the likelihood of developing a serious GI event at some time during the course of therapy. However, even short term therapy is not without risk.

Although minor upper gastrointestinal problems, such as dyspepsia, are common, usually developing early in therapy, physicians should remain alert for ulceration and bleeding in patients treated chronically with NSAIDs even in the absence of previous GI symptoms.
Caution is advised in patients at most risk of developing these types of GI complications with NSAIDS; e.g. the elderly, patients with cardiovascular disease, patients using concomitant aspirin, or patients with a prior history of, or active, gastrointestinal disease, such as ulceration, GI bleeding or inflammatory conditions and patients with a history of smoking and alcoholism. Age over 70 years is associated with high risk of complications. The administration to patients older than 80 years should be avoided.

Patients taking concomitant oral corticosteroids, selective serotonin uptake inhibitors (SSRIs) or anti-platelet agents such as low-dose acetylsalicylic acid are at increased risk of serious GI complications. Patients and physicians should remain alert for signs and symptoms of GI ulceration and/or bleeding during piroxicam treatment. Patients should be asked to report any new or unusual abdominal symptom during treatment. If a gastrointestinal complication is suspected during treatment, piroxicam should be discontinued immediately and additional clinical evaluation and treatment should be considered.

Asthma
Piroxicam should be used with caution in patients with asthma because bronchial smooth muscle spasm may be aggravated by prostaglandin inhibition.

Haemorrhagic Tendencies
Like other NSAIDs, piroxicam decreases platelet aggregation and prolongs bleeding time. This effect should be borne in mind when bleeding times are determined, in patients undergoing surgery and in patients with haemorrhagic disorders. Dosage requirements of coumarin anticoagulants and other drugs that are highly protein bound should be closely and very regularly monitored when these are administered concomitantly with piroxicam. Such drugs include warfarin, hydantoins, sulphonamides and sulfonlyureas. Bleeding has been reported rarely when piroxicam as well as other NSAIDs have been administered to patients on coumarin type anticoagulants (see PRECAUTIONS, Interactions with Other Medicines).

Renal Effects
As with other nonsteroidal anti-inflammatory agents long-term administration of piroxicam to animals has resulted in renal papillary necrosis and other pathology. In rare cases, NSAIDs may cause interstitial nephritis, haematuria, proteinuria and occasionally nephrotic syndrome.

NSAIDs inhibit the synthesis of renal prostaglandin, which plays a supportive role in the maintenance of renal perfusion in patients whose renal blood flow and blood volume are decreased. In these patients administration of an NSAID may precipitate overt renal decompensation, which is typically followed by recovery to the pretreatment state on discontinuation of the NSAID. Patients at greatest risk of this complication include those with impaired hepatic or renal function, with heart failure, taking diuretics or the elderly. Such patients should be carefully monitored while receiving NSAID therapy.

Blood urea nitrogen elevation has been observed in some patients. These elevations are not progressive over the course of treatment with piroxicam, a plateau being reached which returns to or towards baseline levels if treatment is stopped. The rise in blood urea nitrogen as a rule, is not associated with elevations in serum creatinine.

As with other nonsteroidal anti-inflammatory agents, it is recommended that piroxicam be given under close supervision in patients with a history of impaired renal function and periodic renal function tests carried out.

Caution should be used when initiating treatment with piroxicam in patients with severe dehydration. Caution is also recommended in patients with kidney disease (see CONTRAINDICATIONS).

Lower doses should be considered in patients with impaired renal function and they should be carefully monitored.
Concomitant use of ACE inhibitors or Angiotensin Receptor Antagonists and Anti-Inflammatory Drugs and Thiazide Diuretics

The use of an ACE inhibiting drug (ACE-inhibitor or angiotensin receptor antagonist), and an anti-inflammatory drug (NSAID or COX-2 inhibitor) and a thiazide diuretic at the same time increases the risk of renal impairment. This includes use in fixed-combination products containing more than one class of drug. Concomitant use of all three classes of these medications should be accompanied by increased monitoring of serum creatinine, particularly at the institution of the treatment. The concomitant use of drugs from these three classes should be used with caution particularly in elderly patients or those with pre-existing renal impairment.

Impaired Hepatic Function

As with other nonsteroidal anti-inflammatory agents, borderline elevations of liver function tests may occur in up to 15% of patients. These abnormalities may progress, remain essentially unchanged or be transient with continued therapy. A patient with symptoms or signs suggesting impaired hepatic function or in whom an abnormal liver function test has been reported should be evaluated for evidence of development of some severe hepatic dysfunction while on therapy with piroxicam. The ALT (SGPT) is probably the most sensitive indicator of liver dysfunction. Meaningful (3 times the upper limit of normal) elevations of ALT or AST (SGOT) occurred in controlled trials in less than 1% of patients.

Severe hepatic reactions, including jaundice and cases of fatal hepatitis, have been reported with piroxicam. Although such reactions are rare, if abnormal liver tests persist or worsen, if clinical signs consistent with liver disease develop or if systemic manifestations occur (e.g. eosinophilia, rash etc.), piroxicam should be discontinued.

Masking of Signs of Infection

As with other nonsteroidal anti-inflammatory agents, the anti-inflammatory, antipyretic and analgesic effects of piroxicam may mask the signs of infection (pain, fever, etc.).

Ophthalmological Monitoring

Adverse ophthalmological effects have been observed with nonsteroidal anti-inflammatory agents; accordingly, patients who develop visual disturbances during treatment with piroxicam should have an ophthalmological examination.

Carcinogenesis, Mutagenesis, Impairment of Fertility

Sub-acute and chronic toxicity studies have been carried out in rats, mice, dogs and monkeys. The pathology most often seen was that characteristically associated with the animal toxicology of NSAIDs, i.e. renal papillary necrosis and gastrointestinal lesions.

Skin Reactions

NSAIDs may very rarely cause serious cutaneous adverse events such as exfoliative dermatitis, toxic epidermal necrolysis (TEN) and Stevens-Johnson syndrome (SJS), which can be fatal and occur without warning. These serious adverse events are idiosyncratic and are independent of dose or duration of use. Evidence from observational studies suggests that piroxicam may be associated with a higher risk of severe cutaneous adverse reactions than other non-oxicam NSAIDs. Patients appear to be at highest risk of these reactions early in the course of therapy, the onset of the reaction occurring in the majority of cases within the first month of treatment. Piroxicam should be discontinued at the first appearance of skin rash, mucosal lesion or any other sign of hypersensitivity. Patients should be advised of the signs and symptoms of serious skin reactions and to consult their doctor at the first appearance of a skin rash, mucosal lesion or any other sign of hypersensitivity.
Use in Pregnancy (Category C)
Nonsteroidal anti-inflammatory drugs inhibit prostaglandin synthesis and, when given during the latter part of pregnancy, may cause premature closure of foetal ductus arteriosus, foetal renal impairment, inhibition of platelet aggregation, prolong labour and delay birth. Continuous treatment with NSAIDs during the last trimester of pregnancy should be given only on sound indications. During the last few days before expected birth, agents with an inhibitory effect on prostaglandin synthesis should be avoided.

Although no teratogenic effects were seen in animal testing, piroxicam should not be used in pregnant women or those likely to become pregnant unless the expected benefits outweigh the potential risk.

Australian Categorisation Definition of Category C:
Drugs which, owing to their pharmacological effects, have caused or may be suspected of causing, harmful effects on the human foetus or neonate without causing malformations. These effects maybe reversible. Accompanying text above should be consulted for further details.

Use in Lactation
Studies in 6 women treated for up to 52 days have shown that piroxicam appeared in breast milk in a concentration approximately 1 to 3% of that reached in maternal plasma. Piroxicam is not recommended for nursing mothers unless the expected benefits outweigh any potential risk, as clinical safety has not been demonstrated.

Use in Children
The use of piroxicam in children under 12 years is not recommended as safety and efficacy in this age group are not established.

Interactions with Other Medicines
The concurrent use of non-steroidal anti-inflammatory agents and coumarin anticoagulants (including warfarin) has been associated with severe, sometimes fatal, haemorrhage. The exact mechanism of the interaction between warfarin and NSAIDs is unknown, but may involve enhanced bleeding from NSAID-induced gastrointestinal ulceration, or an additive effect of anticoagulation by warfarin and inhibition of platelet function by NSAIDs.

Piroxicam, like other NSAIDs, decreases platelet aggregation and prolongs bleeding time. These effects should be considered and patients monitored closely when anticoagulants are being used.

Piroxicam is highly protein bound and therefore might be expected to displace other protein bound drugs. The dosage requirements of coumarin anticoagulants and other drugs that are highly protein bound should be closely monitored by the physician when these are administered concomitantly with piroxicam. Such drugs include warfarin, hydantoins, sulfonamides and sulfonylureas.

Piroxicam should be used in combination with warfarin only if absolutely necessary, and patients taking this combination of drugs should be closely monitored.

Extreme care should also be exercised in giving methotrexate to patients on piroxicam therapy, because lethal interactions have been reported between NSAIDs and methotrexate.

As with other NSAIDs, the use of piroxicam in conjunction with aspirin or the concomitant use of two NSAIDs is not recommended because data are inadequate to demonstrate that the combination produces greater benefit than with the drug alone and the potential for adverse reactions is increased.

Plasma levels of piroxicam are depressed to approximately 80% of their normal values when piroxicam is administered in conjunction with aspirin (3900 mg/day); but concomitant administration of antacids has no effect on piroxicam plasma levels.

As with other nonsteroidal anti-inflammatory agents, care should be taken in the administration of piroxicam in combination with frusemide for treating cardiac failure since NSAIDs antagonise the diuretic effect of frusemide.
Nonsteroidal anti-inflammatory agents, including piroxicam have been reported to decrease the renal clearance and increase steady state plasma concentrations of lithium. Plasma lithium concentrations should be monitored when initiating, adjusting or discontinuing concurrent piroxicam therapy.

Cimetidine: (see PHARMACOLOGY, Pharmacokinetics).

As with other nonsteroidal anti-inflammatory agents, care should be taken in the administration of piroxicam in combination with frusemide for treating cardiac failure because nonsteroidal anti-inflammatory agents antagonize the diuretic effect of frusemide.

NSAIDs can reduce the efficacy of diuretics and other anti-hypertensive drugs

In patients with impaired renal function (e.g. dehydrated patients or elderly patients with compromised renal function), the co-administration of an ACE inhibitor or an angiotensin II antagonist with a cyclooxygenase inhibitor can increase the deterioration of renal function, including the possibility of acute renal failure, which is usually reversible. Therefore the concomitant administration of these drugs should be done with caution, especially in elderly patients. Patients should be adequately hydrated and the need to monitor renal function should be assessed in the beginning of the concomitant treatment and periodically thereafter.

Concomitant administration of NSAIDs with digoxin may increase plasma digoxin levels.

Concomitant administration of NSAIDs and corticosteroids or selective serotonin reuptake inhibitors (SSRIs) increases the risk of gastrointestinal ulceration or bleeding.

Concomitant administration of NSAIDs with cyclosporin or tacrolimus increases the risk of nephrotoxicity.

ADVERSE EFFECTS

Results from clinical trials involving approximately 2300 patients (of whom about 400 were treated for more than one year and 170 for more than two years) indicate that about 30% of patients reported side effects at a dose of 20 mg/day. This increased with doses of 30 to 40 mg/day.

More Common Reactions (more than 3%)

Gastrointestinal

These have been the most frequent side effects, occurring in about 20% of patients. Approximately 5% discontinued therapy with an overall incidence of peptic ulcer of about 1%.

The gastrointestinal side effects included abdominal discomfort (5.7%), flatulence (5.2%), nausea (4.8%), abdominal pain (4.7%), epigastric distress (4.1%), constipation (3.8%) and diarrhoea (3.2%).

Central nervous system

Dizziness (4.1%), headache (4.1%).

Less Common Reactions (less than 3%)

Auditory and Vestibular

Tinnitus, vertigo, deafness.

Laboratory Abnormalities

Elevated levels of hepatic enzymes (LDH, alkaline phosphatase, transaminases); elevation of blood urea nitrogen (BUN) and serum creatinine; depression of levels of haemoglobin and haematocrit; depression of levels of serum proteins, platelet and white blood cell count.

Cardiovascular

Hypertension, tachycardia, palpitations.
Dermatological
Skin rash (2.4%); pruritus (1.1%); onycholysis, alopecia.

Photoallergic reactions have been infrequently associated with therapy. As with other nonsteroidal anti-inflammatory drugs, toxic epidermal necrolysis (Lyell's disease) and Stevens-Johnson syndrome may develop in rare cases. Vesiculobullous reactions have been reported rarely.

Gastrointestinal
Anorexia, vomiting, indigestion, pancreatitis, hepatitis.

Central Nervous System
Sedation, drowsiness (2.1%), others (each less than 1%) include amnesia, anxiety, depression, malaise, hallucinations, insomnia, dream abnormalities, nervousness, paraesthesia, personality change, tremors, akathisia.

Genitourinary
Oedema (2.7%), others (less than 1%) include dysuria, urinary frequency, haematuria, oliguria, menorrhagia.

Eyes, Nose, and Throat
Stomatitis (1%), blurred vision, eye irritation/swelling, epistaxis, glossitis.

Haematological
Decreases in haemoglobin and haematocrit, unassociated with obvious gastrointestinal bleeding, have occurred. Anaemia has been reported.

Thrombocytopenic and non-thrombocytopenic purpura (Henoch-Schoenlein), petechial rash, ecchymosis, leucopenia and eosinophilia have been reported. Rare cases of aplastic anaemia and haemolytic anaemia are also reported.

Miscellaneous (each less than 1%)
Breathlessness, chest pain, hyperglycaemia, hypoglycaemia, thirst, chills, sweating, flushing, increased appetite, weight increase or decrease. Rare anecdotal reports of positive antinuclear antibodies.

Severe or Life-Threatening Reactions
Peptic ulceration and gastrointestinal haemorrhage may occur. The patient should be admitted to hospital to determine the underlying lesion, followed by appropriate treatment.

Post Marketing Reports:
Additional adverse events reported post-marketing include aseptic meningitis, dermatitis exfoliative and erythema multiforme.

DOSAGE AND ADMINISTRATION
Rheumatoid arthritis, osteoarthritis, ankylosing spondylitis.

After assessing the risk versus benefit for each patient, use the minimum effective dose for the shortest duration possible. The duration of treatment should be preferably be limited to 14 days. If continued treatment is considered necessary, this should be accompanied by evaluation at 14 days and subsequent frequent review.

The dose should be adjusted to each individual patient's response and toleration.. In studies to date, the optimal response generally has been achieved at a daily dose of 20 mg, given as a single dose.

The recommended starting dose is 10 mg. Administration of doses higher than 20 mg daily carries an increased risk of adverse effects and is not recommended.
OVERDOSAGE

Symptoms
Insufficient human data are available to fully assess the toxicity following acute overdosage. Mild symptom of lethargy, drowsiness and gastrointestinal bleeding have been reported. Rarely severe overdose may cause hypotension, coma, respiratory depression, gastrointestinal bleeding or acute renal insufficiency. Low grade fever and sinus tachycardia have been reported with following NSAID overdose. Anaphylactoid reactions have been reported with therapeutic ingestion of NSAIDs, and may occur following overdose.

Treatment
In the event of overdosage with piroxicam, supportive and symptomatic therapy is indicated. Studies indicate that administration of activated charcoal may result in reduced absorption and re-absorption of piroxicam thus reducing the total amount of active drug available. Activated charcoal is most effective when administered within 1 hour of ingestion. In patients who are not fully conscious or who have an impaired gag reflex, consideration should be given to administering activated charcoal via a nasogastric tube once the airway is protected. Haemodialysis, forced diuresis, or haemoperfusion are probably ineffective in enhancing elimination, since the drug is highly protein bound. There appears to be no indication for the alkalisation of the urine.

Contact the Poisons Information Centre on 13 11 26 (Australia) for advice on the management of overdosage.

PRESENTATION AND STORAGE CONDITIONS

GenRx Piroxicam 10 mg Capsules: maroon cap / blue body, marked “APO 10”, in blister packs of 50. AUST R Number 75039

GenRx Piroxicam 20 mg Capsules: maroon cap / maroon body, marked “APO 20”, in blister packs of 25. AUST R Number 75043

GenRx Piroxicam 10mg and 20 mg Capsules are intended for oral administration. Each capsule contains piroxicam 10mg or 20mg.

In addition, each capsule contains the following inactive ingredients: lactose, maize starch, microcrystalline cellulose, stearic acid, purified talc, titanium dioxide, gelatin, brilliant blue FCF (CI 42090), allura red AC (CI 16035), iron oxide red (CI 77491) and Opacode S-1-7085 white.

Store below 25°C. Protect from heat.

NAME AND ADDRESS OF THE SPONSOR

Apotex Pty Ltd
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POISONS SCHEDULE OF THE MEDICINE

S4: Prescription Only Medicine.

Date of TGA approval: 22 August 2000
Date of most recent amendment: 30 June 2012