30XXXXX

Losartan potassium Amlodipine besilate

Amlife®

℞

50 mg / 5 mg, 100 mg / 5 mg and 100 mg / 10 mg Film-Coated Tablet

Angiotensin II Receptor Antagonist / Calcium Channel Blocker / Antihypertensive

FORMULATION
Each film-coated tablet contains:

Losartan potassium, USP	50 mg
Amlodipine (as besilate)	5 mg
or	
Losartan potassium, USP	100 mg
Amlodipine (as besilate)	5 mg
or	
Losartan potassium, USP	100 mg
Amlodipine (as besilate)	10 mg

PRODUCT DESCRIPTION

Losartan + Amlodipine (Amlife®) 50 mg/5 mg Film-coated Tablet: Light yellow to yellow, approximately 9.4 to 9.8 mm, circular, biconvex, film-coated tablet, plain on both sides

Losartan + Amlodipine (Amlife®) 100 mg/5 mg Film-coated Tablet: Light yellow to yellow, approximately 11.4 to 11.8 mm, circular, biconvex, film-coated tablet, plain on both sides

Losartan + Amlodipine (Amlife®) 100 mg/10 mg Film-coated Tablet: Light yellow to yellow, approximately 11.4 to 11.8 mm, circular, biconvex, film-coated tablet, plain on both sides

CLINICAL PHARMACOLOGY

PHARMACODYNAMICS

Losartan potassium

Angiotensin II [formed from angiotensin I in a reaction catalyzed by angiotensin converting enzyme (ACE, kininase II)], is a potent vasoconstrictor, the primary vasoactive hormone of the renin-angiotensin system and an important component in the pathophysiology of hypertension. It also stimulates aldosterone secretion by the adrenal cortex.

Losartan and its principal active metabolite block the vasoconstrictor and aldosterone-secreting effects of angiotensin II by selectively blocking the binding of angiotensin II to the angiotensin II subtype I (AT1) receptor found in many tissues such as vascular smooth muscles, adrenal gland, kidneys, and the heart. A second angiotensin II receptor has been identified as the AT2 receptor subtype found in many tissues but it is not known to be associated with cardiovascular homeostasis. Both losartan and its principal active metabolite do not exhibit any partial agonist activity at the AT1 receptor and have much greater affinity (about 1000-fold) for the AT1 receptor than that for the AT2 receptor. In vitro binding studies indicate that losartan is a reversible, competitive inhibitor of the AT1 receptor. The active metabolite is 10 to 40 times more potent by weight than losartan and appears to be a reversible, non-competitive inhibitor of the AT1 receptor.

Losartan does not bind to or block other hormone receptors or ion channels important in cardiovascular regulation. Furthermore, losartan does not inhibit ACE (kininase II, the enzyme that converts angiotensin I to angiotensin II and degrades bradykinin). Angiotensin II receptor antagonism results in dose-related increases in plasma renin levels, angiotensin I and angiotensin II levels, and a decrease in plasma aldosterone concentration.

Amlodipine besilate

Amlodipine, a dihydropyridine calcium antagonist (slow channel blocker or calcium ion antagonist), inhibits the transmembrane influx of calcium ions into cardiac muscle and vascular smooth muscle. Its antihypertensive action is due to a direct relaxant effect on vascular smooth muscle resulting in decreased peripheral vascular resistance and blood pressure.

Amlodipine's exact mechanism in relieving angina has not been fully established; however, amlodipine decreases total ischemic burden by (1) dilating peripheral arterioles thereby reducing total peripheral resistance (afterload) against which the heart works. The unloading of the heart decreases myocardial energy consumption and oxygen requirements as the heart rate remains stable; and (2) dilating the main coronary arteries and arterioles, both in normal and ischemic areas. This dilatation increases myocardial oxygen delivery in patients with coronary artery spasm (Prinzmetal's or variant angina).

PHARMACOKINETICS

Losartan potassium

Losartan is well absorbed after oral administration. It undergoes presystemic metabolism, forming an active metabolite (E-3174) and other inactive metabolites. Systemic bioavailability of losartan tablets is about 33%. Mean peak concentrations of losartan and its active metabolite are reached in 1 hour and 3 to 4 hours, respectively. There is no clinically significant effect on the plasma concentration profile of losartan when the drug is administered with a meal.

Both losartan and its metabolite are highly bound (≥ 99%) to plasma proteins, primarily albumin. Losartan's volume of distribution is 34 L.

Plasma concentrations of the active metabolite are higher than those of losartan at all doses; Cmax and AUC for E-3174 are about 2 and 5 to 8 times greater than the corresponding values for losartan itself.

After oral administration, plasma concentrations of losartan and its active metabolite decline polyexponentially with terminal half-lives of about 2 hours (1.5 to 2.5 hours) and 6 to 9 hours, respectively. As anticipated from their short half-lives, neither losartan nor its active metabolite accumulates significantly in plasma during once-daily dosing with losartan 100 mg.

The plasma clearance of losartan and its active metabolite is approximately 600 mL/min and 50 mL/min, respectively. Losartan is extensively metabolized in the liver. Approximately 35% of an oral losartan dose is excreted in urine as unchanged compound and metabolites; only 4% of the dose is eliminated unchanged via the kidneys. Renal clearance of losartan and its active metabolite is about 74 mL/min and 26 mL/min, respectively. Losartan and its metabolites are also eliminated by biliary excretion, with 58% of an oral dose recovered in the feces.

Primary Hyperaldosteronism: Patients with primary hyperaldosteronism will not generally respond to antihypertensive drugs acting through inhibition of the renin-angiotensin-aldosterone system. Therefore, the use of losartan is not recommended.

Coronary Heart Disease and Cerebrovascular Disease: As with any antihypertensive agent, excessive hypotension in patients with ischemic cardiovascular and cerebrovascular disease could result in a myocardial infarction or stroke.

Heart Failure: There is a risk of severe arterial hypotension and (often acute) renal impairment in patients with heart failure with or without renal impairment.

Aortic and Mitral Valve Stenosis, Obstructive Hypertrophic Cardiomyopathy: Special caution is indicated in patients with aortic or mitral stenosis, or obstructive hypertrophic cardiomyopathy.

Hypersensitivity: Angioedema. Patients with a history of angioedema (swelling of the face, lips, throat, and/or tongue) should be closely monitored.

Amlodipine besilate

Increased Angina or Myocardial Infarction: After initiating or increasing the dose of amlodipine, particularly in patients with severe obstructive coronary artery disease, worsening angina and acute myocardial infarction may develop.
Hypotension: Symptomatic hypotension is possible, particularly in patients with severe aortic stenosis. However, acute hypotension is unlikely because of the gradual onset of action of amlodipine.
Heart Failure: In general, calcium channel blockers should be used with caution in patients with heart failure. In a controlled trial on amlodipine in patients with severe heart failure (NYHA III and IV), amlodipine was associated with increased reports of pulmonary edema.
Hepatic Impairment: Amlodipine should be used with caution and in reduced dosage in patients with hepatic impairment. Titrate slowly in patients with severe hepatic impairment.
Effects on ability to drive and use machine
No studies on the effects on the ability to drive and use machines have been performed. However, when driving vehicles or operating machinery it should be taken into account that dizziness or drowsiness may occasionally occur when taking antihypertensive therapy, in particular during initiation of treatment or when the dose is increased.

Amlodipine may have minor or moderate influence on the ability to drive and use machines. If patients taking amlodipine suffer from dizziness, headache, fatigue or nausea, the ability to react may be impaired. Caution is recommended.

INTERACTIONS WITH OTHER MEDICAMENTS

Losartan potassium

Lithium: Increases in serum lithium concentrations and lithium toxicity have been reported during concomitant administration of lithium with angiotensin II receptor antagonists. Monitor carefully serum lithium levels during concomitant use.
Potassium-sparing Diuretics/Supplements/Salt Substitutes: As with other medicines that block angiotensin II or its effect, concomitant use of potassium-sparing diuretics (e.g., spironolactone, triamterene, amiloride), potassium supplements, or salt substitutes containing potassium may increase serum potassium.
Nonsteroidal Anti-inflammatory Drugs (NSAIDs) including Selective Cyclooxygenase-2 (COX-2) Inhibitors: The antihypertensive effect of angiotensin II receptor antagonists may be reduced when coadministered with NSAIDs such as selective COX-2 inhibitors and nonselective NSAIDs.
Concurrent administration of angiotensin II receptor antagonists with NSAIDs may result in an increased risk of worsening of renal function (including possible acute renal failure) and an increase in serum potassium, particularly in patients with poor pre-existing renal function. The combination should be administered with caution, especially in the elderly. Regularly monitor renal function after initiation of concomitant therapy and adequately hydrate patients.
Dual Blockade of the Renin-Angiotensin System (RAS): Dual blockade of the RAS with angiotensin receptor blockers, ACE inhibitors or aliskiren is associated with increased risk of hypotension, syncope, hyperkalemia and changes in renal function (including acute renal failure) compared with monotherapy. Closely monitor blood pressure, renal function and electrolytes in patients on losartan and other agents that affect the RAS.
Do not coadminister aliskiren with losartan in patients with diabetes mellitus or renal impairment (GFR <60 mL/min/1.73 m2).
Tricyclic antidepressants, antipsychotics, baclofene, amifostine: Concomitant use with these drugs that may induce hypotension as an adverse effect, may increase the risk of hypotension.
Other Drugs: In studies, coadministration of losartan with other drugs such as hydrochlorothiazide, digoxin, warfarin, cimetidine, phenobarbital, ketoconazole, and erythromycin showed no significant drug interactions. Rifampicin and fluconazole decreased the concentrations of losartan and its active metabolite.

Amlodipine besilate

Cimetidine, antacid (aluminum/magnesium hydroxide), or sildenafil: No significant effect on the pharmacokinetics of amlodipine
Grapefruit Juice: Coadministration may increase the bioavailability of amlodipine resulting in increased blood pressure lowering effects. Thus, grapefruit should not be taken with amlodipine.
Digoxin: Concomitant use did not change the serum digoxin levels or digoxin renal clearance in normal volunteers
Ethanol (alcohol): No significant effect on the pharmacokinetics of ethanol
Warfarin: Concomitant use did not change the warfarin prothrombin response time
Atorvastatin: No significant change in steady state pharmacokinetic parameters of atorvastatin
Simvastatin: Concomitant use of amlodipine with simvastatin increases the systemic exposure of simvastatin. Do not exceed the dose of simvastatin to 20 mg daily in patients on amlodipine.
Cytochrome P450 3A4 (CYP3A4) Inhibitors: Concomitant use of amlodipine with strong or moderate CYP3A4 inhibitors [protease inhibitors (e.g., ritonavir), azole antifungals (e.g., ketoconazole, itraconazole), macrolides (e.g., erythromycin, clarithromycin), verapamil or diltiazem] may increase the plasma concentrations of amlodipine to a greater extent. The clinical effects of these pharmacokinetic variations may be more pronounced in the elderly. Clinical monitoring and dose adjustment may therefore be required.
CYP3A4 Inducers: There is no data available regarding the effect of CYP3A4 inducers on amlodipine. Concomitant use of CYP3A4 inducers (e.g., rifampicin, St. John's Wort) may result in lower plasma concentrations of amlodipine. Amlodipine should be used with caution when administered with CYP3A4 inducers.
Immunosuppresants (ciclosporin, tacrolimus): Coadministration may increase the systemic exposure of ciclosporin or tacrolimus. Monitor trough blood levels of ciclosporin and tacrolimus and adjust the dose as appropriate to avoid toxicity.

STATEMENT ON USAGE FOR HIGH RISK GROUPS

Pregnancy: **Pregnancy Categories C (first trimester) and D (second and third trimester)** (see **Warnings and Precautions, Fetal Toxicity**)

Lactation: It is not known whether losartan or amlodipine is distributed in human milk. Discontinue breastfeeding or the drug due to potential risk to breastfeeding infants, taking into consideration the importance of the drug to the mother.

Children: The safety and efficacy of losartan + amlodipine FDC in pediatric patients have not been established.

Elderly: There were no age-related differences in efficacy or safety profile of losartan. Observe caution in amlodipine dose selection for an elderly. Elderly patients are more likely to experience delayed clearance of amlodipine and can be at greater risk for toxicity.

UNDESIRABLE EFFECTS

Losartan potassium

Body as a Whole: Asthenia, chest pain, edema, facial edema, fatigue, fever, infection, influenza-like disease, malaise, orthostatic effects, syncope, trauma
Cardiovascular: Angina pectoris, second degree AV block, arrhythmias including atrial fibrillation, cerebrovascular accident (CVA), hypotension/orthostatic hypotension, myocardial infarction, palpitation, sinus bradycardia, tachycardia, ventricular tachycardia, ventricular fibrillation

Amlodipine besilate

After oral administration of therapeutic doses of amlodipine, peak plasma concentrations are reached between 6 and 12 hours. Amlodipine's absolute bioavailability is between 64 and 90%; its bioavailability is unaffected by food. Amlodipine's volume of distribution is about 20 L/kg.

About 90% of amlodipine is converted to inactive metabolites via hepatic metabolism with 10% of the parent compound and 60% of the metabolites excreted in the urine. Studies have shown that about 93% of the circulating drug is bound to plasma proteins in hypertensive patients. Plasma elimination is biphasic with a terminal elimination half-life of 30 to 50 hours. Steady state plasma amlodipine concentrations are reached after 7 to 8 days of consecutive dosing.

The pharmacokinetics of amlodipine is not significantly influenced by renal impairment. Thus, the usual initial dose may be given to patients with renal failure.
Amlodipine's clearance is decreased and the AUC increased (by 40 to 60%) in elderly patients and patients with hepatic impairment. Plasma amlodipine elimination half-life (t1/2) is prolonged (56 hours) in patients with hepatic impairment. Thus, a lower initial dose may be given in these patients. A comparable increase in AUC was seen in patients with moderate to severe heart failure.

INDICATION
Hypertension

DOSAGE AND ADMINISTRATION
General Dosing Recommendations:
- Dosing must be individualized and adjusted according to blood pressure response
- Losartan 50 mg + Amlodipine 5 mg fixed-dose combination (FDC) may be administered in patients whose blood pressure is inadequately controlled with losartan 50 mg or amlodipine 5 mg alone.
- Dose titration with the individual drugs is recommended before shifting to the FDC. When clinically appropriate, direct shift from monotherapy to the FDC may be considered.

Usual Oral Dose: 1 tablet of Losartan 50 mg + Amlodipine 5 mg FDC once a day
If blood pressure remains uncontrolled after two weeks, increase the dose to:
Losartan 50 mg and Amlodipine 10 mg once a day or
1 tablet of Losartan 100 mg + Amlodipine 5 mg FDC once a day or
1 tablet of Losartan 100 mg + Amlodipine 5 mg FDC once a day

Or, as prescribed by a physician.

CONTRAINDICATIONS

- Hypersensitivity to losartan potassium, amlodipine besilate, or to any component of the product
- Women who are pregnant, trying to get pregnant or suspect that they are pregnant, or breastfeeding mothers
- Severe hepatic impairment
- Concomitant use with aliskiren in patients with diabetes mellitus or renal impairment (GFR <60 mL/min/1.73 m2)
- Severe hypotension
- Shock (including cardiogenic shock)
- Obstruction of the outflow tract of the left ventricle (e.g., high grade aortic stenosis)
- Hemodynamically unstable heart failure after myocardial infarction

WARNINGS AND PRECAUTIONS

Fetal Toxicity: When pregnancy is detected, discontinue losartan + amlodipine FDC as soon as possible. Drugs that act directly on the renin-angiotensin system can cause injury and death to the developing fetus

Losartan potassium

Fetal Toxicity: Use of drugs that act on the renin-angiotensin system during the second and third trimesters of pregnancy reduces renal function and increases fetal and neonatal morbidity and death. Resulting oligohydramnios can be associated with fetal lung hypoplasia and skeletal deformations. Potential neonatal adverse effects include skull hypoplasia, anuria, hypotension, renal failure, and death. When pregnancy is detected, discontinue losartan as soon as possible. These adverse outcomes are usually associated with the use of these drugs in the second and third trimester of pregnancy. Most epidemiologic studies examining fetal abnormalities after exposure to antihypertensive use in the first trimester have not distinguished drugs affecting the renin-angiotensin system from other antihypertensive agents. Appropriate management of maternal hypertension during pregnancy is important to optimize outcomes for both mother and fetus.

In the unusual case that there is no appropriate alternative to therapy with drugs affecting the renin-angiotensin system for a particular patient, the mother should be informed of the potential risk to the fetus. Perform serial ultrasound examinations to assess the intra-amniotic environment. If oligohydramnios is observed, discontinue losartan, unless it is considered life-saving for the mother. Fetal testing may be appropriate, based on the week of pregnancy. However, patients and physicians should be aware that oligohydramnios may not appear until after the fetus has sustained irreversible injury.

Infants with history of in utero exposure to losartan should be closely observed for hypotension, oliguria and hyperkalemia. If oliguria or hypotension occurs, attention should be directed toward support of blood pressure and renal perfusion. Exchange transfusion or dialysis may be required as means of reversing hypotension and/or substituting for disordered renal function.

Hypotension and Electrolyte/Fluid Imbalance: Symptomatic hypotension may be observed in patients who are intravascularly volume-depleted (e.g., those treated with high-dose diuretics). These conditions should be corrected before starting losartan therapy, or a lower starting dose should be used.

Monitor serum potassium levels in type 2 diabetic patients with nephropathy treated with an angiotensin II antagonist. Electrolyte imbalances are common in patients with renal impairment, with or without diabetes, and should be addressed.

The concomitant use of potassium-sparing diuretics, potassium supplements and potassium-containing salt substitutes with losartan is not recommended.

Renal Impairment: Due to inhibition of the renin-angiotensin-aldosterone system, changes in renal function including renal failure have been seen in susceptible patients (e.g., patients whose renal function is dependent on the renin-angiotensin-aldosterone system such as those with severe cardiac insufficiency or pre-existing renal dysfunction) treated with losartan; these changes in renal function may be reversible upon discontinuation of therapy in some patients.

Treatment with ACE inhibitors has been associated with oliguria and/or progressive azotemia and (rarely) with acute renal failure and/or death in patients whose renal function may depend on the activity of the renin-angiotensin-aldosterone system (e.g., patients with severe congestive heart failure). Similar outcomes have been observed with losartan.

In studies, ACE inhibitors may increase blood urea nitrogen (BUN) and serum creatinine in patients with unilateral or bilateral renal artery stenosis. Similar effects have been observed with losartan; these effects may be reversible upon discontinuation of therapy in some patients.

The concomitant use of losartan and ACE inhibitors has shown to impair renal function. Therefore, concomitant use is not recommended.

There is no experience with losartan in patients with recent kidney transplantation.

Hepatic Impairment: In patients with a history of hepatic impairment, a lower dose of losartan should be given since significantly increased plasma concentrations of the drug in cirrhotic patients has been observed in pharmacokinetic studies. There is no therapeutic experience with losartan in patients with severe hepatic impairment; thus, losartan should not be administered in patients with severe hepatic impairment.

Endocrine: Diabetic neuropathy, diabetic vascular disease
Gastrointestinal: Abdominal pain, anorexia, constipation, dental pain, diarrhea, dry mouth, dyspepsia, flatulence, gastritis, pancreatitis, nausea, vomiting
Genitourinary: Erectile dysfunction/impotence, nocturia, renal impairment, renal failure, urinary frequency, urinary tract infection
Hematologic: Hemolysis, anemia, thrombocytopenia (rare)
Hepatobiliary: Liver function abnormalities, hepatitis (rare)
Hypersensitivity: Anaphylactic reactions, angioedema (including swelling of the larynx and glottis, causing airway obstruction and or swelling of the face, lips, pharynx, and/or tongue), vasculitis including Henoch-Schönlein purpura (rare)
Metabolic and Nutritional and Laboratory Values: Gout, hyperkalemia, hypoglycemia, hyponatremia, weight gain; Elevations of the following: alanine aminotransferase (ALT), BUN, serum creatinine, liver enzymes and/or bilurubin; Reductions of the following: hemoglobin and hematocrit
Musculoskeletal: Arthralgia, arthritis, fibromyalgia, joint swelling, myalgia, muscle cramps, muscle weakness, pain (back, arm, shoulder, hip, leg, knee, musculoskeletal), stiffness, rhabdomyolysis (rare)
Nervous System/Psychiatric: Dizziness, anxiety, anxiety disorder, ataxia, confusion, depression, dream abnormality, dysgeusia, headache, hypesthesia, insomnia, decreased libido, memory impairment, migraine, nervousness, panic disorder, paresthesia, peripheral neuropathy, sleep disorder, somnolence, tremor, vertigo
Respiratory: Bronchitis, cough/dry cough, dyspnea, epistaxis, nasal congestion, respiratory congestion, pharyngeal discomfort, pharyngitis, rhinitis, sinusitis, sinus disorder, upper respiratory tract infections
Skin: Alopecia, cellulitis, dermatitis, dry skin, ecchymosis, erythema, erythroderma, flushing, photosensitivity, pruritus, rash, sweating, superficial peeling of palms, urticaria,
Special senses: Blurred vision, burning/stinging in the eye, cataract, conjunctivitis, tinnitus, decreased visual acquity

Amlodipine besilate

The most commonly reported adverse reactions during treatment with amlodipine are somnolence, dizziness, headache, palpitations, flushing, abdominal pain, nausea, ankle swelling, edema and fatigue.

Body as a Whole: Asthenia, chest pain, edema/swelling, fatigue, malaise, pain, peripheral edema, rigors
Cardiovascular: Arrhythmia (including ventricular tachycardia and atrial fibrillation), bradycardia, flushing, hypotension, hot flushes, myocardial infarction, palpitation, peripheral ischemia, syncope, tachycardia, vasculitis
Gastrointestinal: Abdominal pain, altered bowel habits, anorexia, constipation, diarrhea, dry mouth, dyspepsia, dysphagia, flatulence, gastritis, gingival hyperplasia, nausea, pancreatitis, vomiting
Genitourinary: Gynecomastia, impotence, micturition frequency, micturition disorder, nocturia, sexual dysfunction
Hematologic: Thrombocytopenia, leukopenia
Hepatobiliary: Hepatic enzyme elevations (mostly consistent with cholestasis), hepatitis, jaundice
Hypersensitivity: Allergic reactions
Metabolic: Hyperglycemia, thirst, weight increase/decrease
Musculoskeletal: Ankle swelling, arthralgia, arthrosis, back pain, muscle cramps, myalgia
Nervous System: Abnormal dreams, anxiety, confusion, depersonalization, dysgeusia, depression, dizziness, extrapyramidal disorder, headache, hypertonia, hypoesthesia, insomnia, mood changes, nervousness, paresthesia, peripheral neuropathy, somnolence, tremor, vertigo
Respiratory: Cough, dyspnea, epistaxis, rhinitis
Skin: Alopecia, angioedema, exanthema, erythema multiforme, exfoliative dermatitis, hyperhidrosis, purpura, pruritus, photosensitivity, rash, rash erythematous, rash maculopapular, skin discoloration, urticaria, Stevens-Johnson syndrome (very rare), Quincke edema (very rare)
Special senses: Conjunctivitis, diplopia, eye pain, tinnitus, abnormal vision, visual disturbances

There is limited data on overdosage with losartan in humans. Losartan overdose will most likely manifest as hypotension and tachycardia; bradycardia could occur from parasympathetic (vagal) stimulation.

OVERDOSE AND TREATMENT

Losartan potassium

Institute symptomatic treatment and monitor vital signs if symptomatic hypotension occurs. Measures are depending on the time of drug intake and kind and severity of symptoms. Stabilization of the cardiovascular system should be given priority. After oral intake, the administration of a sufficient dose of activated charcoal is indicated. Close monitoring of the vital parameters should be performed. Vital parameters should be corrected if necessary.

Losartan and its metabolite are not removed by hemodialysis.

Amlodipine besilate

Overdosage might be expected to cause excessive peripheral vasodilation with marked hypotension and possibly a reflex tachycardia.

Institute active cardiac and respiratory monitoring during massive overdose. Frequent blood pressure measurements are necessary. Initiate cardiovascular support (i.e., elevation of extremities, judicious administration of fluids) if hypotension occurs. If hypotension remains unresponsive to these conservative measures, administration of vasopressors such as phenylephrine should be considered with attention to circulation volume and urine output. Intravenous calcium gluconate may help reverse the effects of calcium entry blockade. Hemodialysis is not likely to be of benefit since amlodipine is highly protein bound.

STORAGE CONDITION
Keep the product out of sight and reach of children.
Store at temperatures not exceeding 30°C.
Protect from light.

AVAILABILITY
Amlodipine + Losartan (Amlife®) 5mg/50mg Film-Coated Tablet, blister pack of 10's (box of 30's)
Amlodipine + Losartan (Amlife®) 5mg/100mg Film-Coated Tablet, blister pack of 10's (box of 30's)
Amlodipine + Losartan (Amlife®) 10mg/100mg Film-Coated Tablet, blister pack of 10's (box of 30's)

CAUTION
Foods, Drugs, Devices, and Cosmetics Act prohibits dispensing without prescription.

ADVERSE DRUG REACTION REPORTING STATEMENT
For suspected adverse drug reaction, seek medical attention immediately and report to the FDA at www.fda.gov.ph AND Unilab at (+632) 858-1000 or productsafety@unilab.com.ph. By reporting undesirable effects you can help provide more information on the safety of this medicine.

Date of First Authorization: March 2014
Date of Revision of Package Insert: March 2017

Registration Numbers:
Amlife® 50 mg/5 mg Film-coated Tablet: DR-XY42866
Amlife® 100 mg/5 mg Film-coated Tablet: DR-XY43236
Amlife® 100 mg/10 mg Film-coated Tablet: DR-XY43237

Manufactured by Ajanta Pharma Limited
Plot No. B-4/5/6, MIDC, Paithan, Aurangabad, 431148
Maharashtra State, India
Imported and Distributed by **UNILAB, Inc.**
No. 66 United Street, Mandaluyong City, Metro Manila, Philippines

THE156130IN02

Reg. IPOPHIL