ESCITALOPRAM

JOVIA®

10 mg FILM-COATED TABLET

Antidepressant / Selective Serotonin Reuptake Inhibitor

FORMULATION
Each film-coated tablet contains:
Escitalopram (as oxalate), USP.....10 mg

PRODUCT DESCRIPTION
Escitalopram (Jovia) 10 mg film-coated tablet is a white, biconvex, oblong, film-coated tablet, scored on one side.

PHARMACOLOGY
Escitalopram, the active S-enantiomer of racemic citalopram, is a highly potent and selective inhibitor of the serotonin transporter protein which is responsible for the serotonin (5-HT) reuptake into presynaptic nerve terminals in central nervous system (CNS).

Escitalopram has a primary high-affinity binding site and a secondary lower-affinity allosteric site in the serotonin transporter protein. Binding of escitalopram to the allosteric site enhances binding of the drug to the primary binding site, resulting in more complete serotonin reuptake inhibition. This also explains the enhanced potency of escitalopram compared with citalopram.

In vitro studies showed that escitalopram had no, or minimal effect on noradrenaline (NA), dopamine (DA) and gamma-amino butyric acid (GABA) uptake.

Compared with many tricyclic antidepressants (TCAs) and some of the selective serotonin reuptake inhibitors (SSRIs), escitalopram has no or very low affinity for a number of receptors such as 5-HT_{1A}, 5-HT_2, DA D_1 and DA D_2 receptors, α_1-, α_2-, ß-adrenoceptors, histamine H_1, muscarine cholinergic, benzodiazepine and opioid receptors.

PHARMACOKINETICS
Escitalopram's absorption is almost complete and independent of food intake. As with racemic citalopram, the absolute bioavailability of escitalopram is about 80%.

After multiple dosing, mean time to maximum concentration (mean t_{max}) is about four hours. Escitalopram exhibits linear pharmacokinetics. Steady-state plasma levels are achieved in about one week.

Escitalopram is widely distributed throughout tissues, with an apparent volume of distribution after oral administration of 1,100 L. It exhibits low protein binding (average 56%) over a wide range of concentrations, indicating a low potential for drug displacement interactions.

Escitalopram is metabolized in the liver to less lipophilic compounds that are readily excreted in urine. Biotransformation of the drug occurs via oxidative metabolism with N-demethylation to S-demethylcitalopram (S-DCT) and S-didemethylcitalopram (S-DDCT), deamination and dehydrogenation to a propionic acid derivative, and also N-oxidation and glucuronide conjugation. N-demethylation of escitalopram to S-DCT is mediated by three hepatic CYP isoenzymes in parallel, CYP3A4, CYP2C19 and, to a lesser extent, CYP2D6. After multiple dose administration of citalopram, poor metabolizers of CYP2C19 had higher plasma concentrations of escitalopram and lower concentrations of S-DCT than extensive metabolizers; however, the urinary recovery and renal clearance of escitalopram and its metabolites did not differ significantly between the two phenotypes. The metabolites of escitalopram are unlikely to contribute to the clinical effects, since they are present at much lower concentrations *in vivo* and have been shown *in vitro* to be much weaker inhibitors of serotonin reuptake.

Escitalopram's elimination half-life ($t_{1/2}$) is about 30 hours. Oral plasma clearance is 0.6 L/min. Escitalopram and its metabolites are eliminated by both hepatic and renal routes, with major part of the dose excreted as metabolites in the urine.

Special Population:
Hepatic impairment: In patients with mild to moderate hepatic impairment (Child-Pugh Criteria A and B), the $t_{1/2}$ of escitalopram was about twice as long and the exposure was about 60% higher than in subjects with normal liver function. The dose of escitalopram should therefore be reduced in such patients.

Renal Impairment: The pharmacokinetics of escitalopram in patients with renal impairment have not been explicitly investigated. However, in patients with mild to moderate renal impairment (creatinine clearance 10 to 53 mL/minute), the $t_{1/2}$ of a single dose of citalopram was increased by approximately 35%, with oral and renal clearance being about 15% and 40% lower, respectively, than in healthy volunteers. Plasma concentrations of the metabolites have not been studied, but they may be elevated.

Geriatrics: Escitalopram AUC and half-life were increased by approximately 50% in the elderly (>65 years old); C_{max} was unchanged. A lower initial dosage should be considered.

INDICATIONS
For the treatment of the following:
- Major depressive disorder
- Social anxiety disorder (social phobia)
- Generalized anxiety disorder
- Obsessive-compulsive disorder
- Panic disorder with or without agoraphobia

DOSAGE AND ADMINISTRATION

USUAL RECOMMENDED ORAL ESCITALOPRAM ADULT DOSE *To be administered once daily, in the morning or evening, with or without food.*	
INDICATIONS	**DOSAGE**
Major Depressive Disorder (MDD)	**10 mg once daily;** Depending on individual patient response, the dose may be increased to a **maximum of 20 mg daily.** Antidepressant response is usually seen in 2 to 4 weeks although the onset of therapeutic effect may be seen earlier**.** The treatment of a single episode of depression requires treatment over the acute and medium term. Treatment of a depressive episode should be continued for a minimum of six months to consolidate response and prevent relapse.
Social Anxiety Disorder and Generalized Anxiety Disorder	**10 mg once daily;** Depending on individual patient response, the dose may be increased to a **maximum of 20 mg daily.** Social anxiety disorder and generalized anxiety disorder are diseases with a chronic course and long-term treatment is warranted to consolidate response and prevent relapse. Treatment benefits and dose should be reevaluated at regular intervals.
Obsessive-Compulsive Disorder (OCD)	**10 mg once daily;** Depending on individual patient response, the dose may be increased to **20 mg daily.** As OCD is a chronic disease, patients should be treated for a sufficient period (several months or even longer) to ensure that they are symptom free.
Panic Disorder With or Without Agoraphobia	Initially, **5 mg once daily** for the first week before increasing the dose to **10 mg once daily.** Depending on individual patient response, the dose may be increased up to a **maximum of 20 mg daily.** Maximum effectiveness is reached in about three months. Treatment may last for several months.

Special Population:

Geriatric (>65 years old):
Initial Dose: Half the usual recommended dose
Maximum Maintenance Dose: 10 mg daily

Patients with Reduced Hepatic Function:
Initial Dose: 5 mg daily for the first two weeks of treatment
Depending on individual patient response, the dose may be increased to 10 mg daily**.**

Poor Metabolizers of CYP2C19:
Initial Dose: 5 mg daily during the first two weeks of treatment
Depending on individual patient response, the dose may be increased to 10 mg daily**.**
Or, as prescribed by a physician.

CONTRAINDICATIONS
- Known hypersensitivity to citalopram, escitalopram, or to any ingredient in the formulation
- Concomitant use in patients taking pimozide
- Patients taking monoamine oxidase inhibitors (MAOIs)
- Should not be used if the patient enters a manic phase

WARNINGS AND PRECAUTIONS

Suicidality and Antidepressant Drugs
Antidepressants increased the risk compared to placebo of suicidal thinking and behavior (suicidality) in children, adolescents, and young adults in short-term studies of major depressive disorder (MDD) and other psychiatric disorders. Anyone considering the use of escitalopram or any other antidepressant in a child, adolescent, or young adult must balance this risk with the clinical need. Short-term studies did not show an increase in the risk of suicidality with antidepressants compared to placebo in adults beyond 24 years old; there was a reduction in risk with antidepressants compared to placebo in adults 65 years and older. Depression and certain other psychiatric disorders are themselves associated with increases in the risk of suicide. Patients of all ages who are started on antidepressant therapy should be monitored appropriately and observed closely for clinical worsening, suicidality, or unusual changes in behavior. Families and caregivers should be advised of the need for close observation and communication with the prescriber. Escitalopram is not approved for use in pediatric patients.

Clinical Worsening and Suicide Risk
Patients with major depressive disorder (MDD), both adult and pediatric, may experience worsening of their depression and/or the emergence of suicidal ideation and behavior (suicidality) or unusual changes in behavior, whether or not they are taking antidepressant medications, and this risk may persist until significant remission occurs. Suicide is a known risk of depression and certain other psychiatric disorders, and these disorders themselves are the strongest predictors of suicide. There has been long-standing concern, however, that antidepressants may have a role in inducing worsening of depression and the emergence of suicidality in certain patients during the early phases of treatment.

Symptoms such as anxiety, agitation, panic attacks, insomnia, irritability, hostility, aggressiveness, impulsivity, akathisia (psychomotor restlessness), hypomania, and mania, have been reported in adult and pediatric patients being treated with antidepressants for major depressive disorder as well as for other indications, both psychiatric and nonpsychiatric. Although a causal link between the emergence of such symptoms and either the worsening of depression and/or the emergence of suicidal impulses has not been established, there is concern that such symptoms may represent precursors to emerging suicidality**.**

Consideration should be given to changing the therapeutic regimen, including possibly discontinuing the medication, in patients whose depression is persistently worse, or who are experiencing emergent suicidality or symptoms that might be precursors to worsening depression or suicidality, especially if these symptoms are severe, abrupt in onset, or were not part of the patient's presenting symptoms.

If the decision has been made to discontinue treatment, medication should be tapered, as rapidly as is feasible, but with recognition that abrupt discontinuation can be associated with certain symptoms.

Prescriptions of escitalopram should be written for the smallest quantity of tablets consistent with good patient management, in order to reduce the risk of overdose.

Screening Patients for Bipolar Disorder
Bipolar disorder may present initially as a major depressive episode. It is thought that treating such an episode with an antidepressant alone may precipitate a mixed/manic episode in patients at risk for bipolar disorder**.** Careful screening entails accurate recording of the patient's psychiatric history, especially family history of suicide, bipolar disorder and depression. Escitalopram is not approved for the treatment of bipolar depression.

Potential for Interaction with Monoamine Oxidase Inhibitors (MAOIs)
There have been reports of serious, sometimes fatal, reactions including hyperthermia, rigidity, myoclonus, autonomic instability with possible rapid fluctuations of vital signs, and mental status changes that include extreme agitation progressing to delirium and coma in patients receiving serotonin reuptake inhibitor drugs in combination with a MAOI. These reactions have also been reported in patients who have recently discontinued SSRI treatment and have been started on an MAOI. Some cases presented with features resembling neuroleptic malignant syndrome. Limited animal data on the effects of combined use of SSRIs and MAOIs suggest that these drugs may act synergistically to elevate blood pressure and evoke behavioral excitation. Therefore, it is recommended that escitalopram should not be used in combination with a MAOI, or within 14 days of discontinuing treatment with a MAOI. Similarly, at least 14 days should be allowed after stopping escitalopram before starting a MAOI.

Serotonin Syndrome or Neuroleptic Malignant Syndrome (NMS)-like Reactions
There have been reports of potentially life-threatening serotonin syndrome or NMS-like reactions with selective norepinephrine reuptake inhibitors (SNRIs) and SSRIs alone, including escitalopram treatment, but particularly with concomitant use of serotonergic drugs (including triptans) with drugs which impair serotonin metabolism (including MAOIs), or with antipsychotics or other dopamine antagonists. Serotonin syndrome symptoms may include mental status changes (e.g., agitation, hallucination, coma), autonomic instability (e.g., tachycardia, labile blood pressure, hyperthermia), neuromuscular aberration (e.g., hyperreflexia, incoordination) and/or gastrointestinal symptoms (e.g., nausea, vomiting, diarrhea). Serotonin syndrome, in its most severe form can resemble NMS, which includes hyperthermia, muscle rigidity, autonomic instability with possible rapid fluctuation of vital signs, and mental status changes. Patients should be monitored for the emergence of serotonin syndrome or NMS-like signs and symptoms.

Discontinuation of Treatment
Discontinuation symptoms when stopping treatment are common, particularly if discontinuation is abrupt. The risk of discontinuation symptoms may be dependent on several factors such as the duration and dose of therapy and the rate of dose reduction. Dizziness, sensory disturbances (e.g., paresthesia and electric shock sensations), sleep disturbances (e.g., insomnia and intense dreams), agitation or anxiety, nausea and/or vomiting, tremor, confusion, sweating, headache, diarrhea, palpitations, emotional instability, irritability and visual disturbances are the most commonly reported reactions. Generally, these symptoms are mild to moderate; however, in some patients they may be severe in intensity**.** They usually occur within the first few days of discontinuing treatment, but there have been very rare reports of such symptoms in patients who have inadvertently missed a dose. Generally, these symptoms are self-limiting and usually resolve within two weeks, though in some individuals they may be prolonged (two to three months or longer). It is therefore advised that escitalopram should be gradually tapered when discontinuing treatment over a period of several weeks or months, according to the patient's needs.

Abnormal bleeding
Cases of bleeding abnormalities of the skin and mucous membranes including purpura, ecchymoses, hematoma, epistaxis, vaginal bleeding and gastrointestinal bleeding were associated with the use of SSRIs. Escitalopram should therefore be used with caution in patients concomitantly treated with oral anticoagulants, drugs known to affect platelet function (e.g., atypical antipsychotics and phenothiazines, most TCAs, acetylsalicylic acid and non-steroidal anti-inflammatory drugs, ticlopidine, and dipyridamole) as well as in patients with a past history of abnormal bleeding or those with predisposing conditions. Pharmacological gastroprotection should be considered for high risk patients.

Hyponatremia
Hyponatremia has been reported as a rare adverse reaction with the use of SSRIs probably due to inappropriate antidiuretic hormone secretion (SIADH). Caution should be exercised in patients at risk, such as the elderly, cirrhotic patients or patients concomitantly treated with drugs known to cause hyponatremia.

Activation of Mania/Hypomania
Clinical trials have documented an activation of mania/hypomania in patients treated with escitalopram. Escitalopram should be used cautiously in patients with a history of mania.

Interference with Cognitive and Motor Performance
Patients should be warned that psychoactive drugs may impair judgment, thinking or motor skills. They should be advised to avoid tasks which require complete mental alertness such as operating hazardous machinery and driving vehicles until they are sure that their treatment does not significantly impede their ability to perform such activities.

Diabetes
In patients with diabetes, treatment with an SSRI may alter glycemic control possibly due to improvement of depressive symptoms. Insulin and/or oral hypoglycemic dosage may need to be adjusted.

Use in Patients with Concomitant Illness
Clinical experience with escitalopram in patients with certain concomitant systematic illnesses is limited. Caution should be exercised when giving escitalopram in patients with diseases or conditions that produce altered metabolism or hemodynamic responses.

Escitalopram has not been systematically evaluated in patients with recent history of myocardial infarction or unstable heart disease.

DRUG INTERACTIONS

Racemic Citalopram	· Concomitant use is not recommended.
Other SSRIs, Selective Norepinephrine Reuptake Inhibitors (SNRIs) (e.g., Venlafaxine), Tryptophan	· Concomitant use is not recommended.
Monoamine Oxidase Inhibitors (MAOIs) (e.g., selegiline, moclobemide)	· Concomitant use is not recommended.
Alcohol	· Concomitant use is not recommended.
Serotonergic Drugs (e.g., triptans, sumatriptan, linezolid, lithium, tramadol, or St. John's Wort)	· Caution is advised when escitalopram is concomitantly given with other drugs that may affect the serotonergic neurotransmitter systems because of potentially life-threatening serotonin syndrome.
Drugs that interfere with hemostasis (e.g., NSAIDs, aspirin, warfarin clopidogrel, ticlopidine, dipyridamole)	· Concomitant use of drugs that interfere with hemostasis potentiated the risk of upper gastrointestinal bleeding. Exercise caution in patients concomitantly taking these drugs with escitalopram.
Drugs lowering seizure threshold (e.g., TCAs, phenothiazines, thioxanthenes, butyrophenones, mefloquine, bupropion, tramadol)	· SSRIs can lower the seizure threshold. Exercise caution when using escitalopram with other drugs capable of lowering the seizure threshold.
Drugs metabolized by CYP2D6 [e.g., antidepressants (desipramine, clomipramine, nortriptyline); antipsychotics (risperidone, thioridazine, haloperidol); flecainide, propafenone, metoprolol]	· Concomitant use of escitalopram 20 mg/day with desipramine resulted in a 40% increase in C_{max} and a 100% increase in AUC of desipramine. Exercise caution when giving escitalopram with other drugs metabolized by CYP2D6. · Caution is advised when escitalopram is given concomitantly with drugs that have a narrow therapeutic index such as flecainide, propafenone and metoprolol (when used in cardiac failure).
CYP3A4 Inhibitors (e.g., ritonavir, triazolam, carbamazepine, ketoconazole)	· Concomitant use of escitalopram 20 mg and ritonavir 600 mg did not significantly affect the pharmacokinetics of escitalopram. · Concomitant use of racemic citalopram and triazolam did not significantly affect the pharmacokinetics of either citalopram or triazolam. · Given the enzyme inducing properties of carbamazepine, the possibility that carbamazepine might increase the clearance of escitalopram should be considered if the two drugs are given concomitantly**.** · Concomitant use of racemic citalopram 40 mg and ketoconazole 200 mg decreased the C_{max} and AUC of ketoconazole by 21% and 10%, respectively, and did not significantly affect the pharmacokinetics of citalopram.
CYP2C19 Inhibitors (e.g., omeprazole, esomeprazole, fluoxetine, fluvoxamine, lansoprazole, ticlopidine)	· Concomitant use of escitalopram with omeprazole resulted in moderate (approximately 50%) increase in the plasma concentrations of escitalopram. · Exercise caution at the upper end of the dose range of escitalopram when used concomitantly with CYP2C19 inhibitors. A reduction in escitalopram dose may be necessary based on clinical judgment.
Cimetidine	· In patients who received racemic citalopram 40 mg/day for 21 days, combined administration of cimetidine 400 mg/day for eight days resulted in an increase in citalopram AUC and C_{max} of 43% and 39%, respectively**.**
Theophylline	· Concomitant use did not affect the pharmacokinetics of theophylline. The effect of theophylline on the pharmacokinetics of citalopram was not evaluated.
Digoxin	· Concomitant use did not significantly affect the pharmacokinetics of either citalopram or digoxin.
Other CNS drugs	· Caution should be exercised when escitalopram is taken in combination with other centrally acting drugs.

Other Interaction:

Electroconvulsive Therapy (ECT) - There are no clinical studies on the combined use of ECT and escitalopram; therefore, caution is advised.

STATEMENT ON USAGE FOR HIGH RISK GROUPS

PREGNANCY AND LACTATION

Pregnancy
Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women; therefore, escitalopram should be used in pregnancy only if the potential benefit justifies the potential risks to the fetus.

Labor and Delivery
The effect of escitalopram on labor and delivery in humans is unknown.

Lactation
Escitalopram, like citalopram is excreted into human breast milk. Studies in breastfeeding mothers have shown that the mean combined dose of citalopram and demethylcitalopram transmitted to infants via breast milk (expressed as a percentage of the weight-adjusted maternal dose) is 4.4 to 5.1%. Plasma concentrations of these drugs in infants were very low or absent and there were no adverse effects. While citalopram data support the safety of use of escitalopram in breastfeeding women, the decision to breastfeed should always be made as an individual risk/benefit analysis.

PEDIATRICS
Safety and effectiveness of escitalopram in pediatric patients have not been established.

GERIATRICS
Experience in those 65 years or older is insufficient to determine whether they respond differently from younger adults; increased sensitivity cannot be ruled out.

A reduced risk of suicidality was observed in adults 65 years or older with antidepressant therapy compared with placebo.

ADVERSE EFFECTS/UNDESIRABLE EFFECTS
Body as a Whole:
Influenza-like symptoms, fatigue, allergic reaction, anaphylaxis, pain in limb, toothache, fever, edema of extremities, chills, asthenia, malaise, fall, lymphadenopathy cervical

Cardiovascular:
Palpitation, hypertension, postural hypotension, hypotension, bradycardia, tachycardia, abnormal electrocardiogram (ECG), ECG QT prolongation, flushing, hot flushes, chest pain, syncope, atrial fibrillation, cardiac failure, myocardial infarction, *torsade de pointes*, ventricular arrhythmia, ventricular tachycardia, varicose vein, deep vein thrombosis, thrombosis, phlebitis

Nervous system:
Dizziness, vertigo, insomnia, somnolence, headache, migraine, paresthesia, yawning, light-headed feeling, tremor, restless legs, shaking, twitching, dysequilibrium, tics, carpal tunnel syndrome, involuntary muscle contractions, sluggishness, abnormal coordination, faintness, hyperreflexia, increased muscular tone, extrapyramidal disorders, movement disorder, lethargy, irritability, impaired concentration, jitteriness, panic reaction, agitation, apathy, forgetfulness, amnesia, depression, aggravated depression, nervousness, tremulousness nervous, aggravated restlessness, anxiety attack, bruxism, confusion, depersonalization, disorientation, emotional lability, feeling unreal, abnormal crying, excitability, auditory hallucination, visual hallucination, suicidal tendency, suicide attempt, serotonin syndrome, dyskinesia, tardive dyskinesia, convulsions, seizures, akathisia, dysarthria, dystonia, hypoesthesia, myoclonus, nystagmus, abnormal gait, acute psychosis, aggression, anger, delirium, delusion, nightmare, abnormal dreaming, paranoia

Gastrointestinal:
Dry mouth, nausea, diarrhea, constipation, indigestion, abdominal pain, vomiting, flatulence, heartburn, abdominal cramps, gastroenteritis, gastroesophageal reflux, bloating, abdominal discomfort, dyspepsia, increased stool frequency, belching, gastritis, hemorrhoids, gagging, gastric polyposis, difficult swallowing, gastrointestinal hemorrhage, pancreatitis, rectal hemorrhage

Hematologic:
Bruise, anemia, nosebleed, hematoma, hemolytic anemia, leukopenia, thrombocytopenia, international normalized ratio (INR) increased, prothrombin decreased

Endocrine/Metabolic/Nutritional:
Increased weight, decreased weight, decreased appetite, increased appetite, carbohydrate craving, hyperglycemia, hypoglycemia, thirst, increased bilirubin, gout, hypercholesterolemia, hyperprolactinemia, hypokalemia, inappropriate ADH secretion, syndrome of inappropriate antidiuretic hormone (SIADH), ejaculation disorder, impotence, priapism, decreased libido, anorgasmia

Musculoskeletal:
Neck/shoulder pain, leg pain, arthralgia, myalgia, jaw stiffness, muscle cramps, muscle stiffness, arthritis, muscle weakness, back discomfort, arthropathy, jaw pain, joint stiffness, rhabdomyolysis

Respiratory:
Rhinitis, sinusitis, bronchitis, sinus congestion, coughing, nasal congestion, sinus headache, asthma, shortness of breath, laryngitis, pneumonia, tracheitis, epistaxis, tightness of chest, pulmonary embolism

Hepatic:
Abnormal liver function, hepatitis, fulminant hepatitis, hepatic failure, hepatic necrosis, hepatic enzymes increased

Skin and appendages:
Increased sweating, rash, pruritus, acne, alopecia, eczema, dermatitis, dry skin, folliculitis, lipoma, furunculosis, dry lips, skin nodule, ecchymosis, angioedema, urticaria, erythema multiforme, photosensitivity reaction, Stevens-Johnson Syndrome, toxic epidermal necrolysis

Special senses:
Blurred vision, conjunctivitis, vision abnormal, dry eyes, eye irritation, visual disturbance, eye infection, mydriasis, diplopia, glaucoma, choreoathetosis, earache, tinnitus, taste alteration, taste disturbance, metallic taste

Urogenital/Reproductive:
Menstrual disorder, menstrual cramps, menorrhagia, metrorrhagia, breast neoplasm, pelvic inflammation, premenstrual syndrome, spotting between menses, urinary frequency, urinary tract infection, urinary urgency, kidney stone, dysuria, blood in urine, galactorrhea, acute renal failure

Other:
Spontaneous abortion

OVERDOSAGE & MANAGEMENT
Fatal cases of escitalopram overdosage have rarely been reported with escitalopram alone; the majority of cases have involved overdose with concomitant medications. Doses between 400 and 800 mg of escitalopram alone have been taken without any severe symptoms.

Symptoms such as dizziness, tremor, agitation to rare cases of serotonin syndrome, convulsion, coma, nausea/vomiting, hypotension, tachycardia, QT prolongation, arrhythmia, hypokalemia and hyponatremia have been reported.

There is no specific antidote to escitalopram overdose. It is important to establish and maintain airway to ensure adequate oxygenation and respiratory function. Gastric lavage and the use of activated charcoal should be considered. Gastric lavage should be carried out as soon as possible after oral ingestion. Cardiac and vital signs monitoring are recommended along with general symptomatic supportive measures. Due to escitalopram's large volume of distribution, forced diuresis, dialysis, hemoperfusion and exchange transfusion are unlikely to be of benefit.

In managing overdose, consider the possibility of multiple drug involvement.

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.

AVAILABILITY
Box of 28 Film-Coated Tablets (Blister foil x 14's) -DR-XY36855

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

Store at temperatures not exceeding 30°C.

Manufactured by BILIM ILAC SANAYII VE TICARET A.S.
Gebze Organize Sanayi Bolgesi 1900 sokak,
No: 1904 41480 Gebze - KOCAELI, Turkey
Imported and Distributed by **UNILAB, Inc.**
No. 66 United Street, Mandaluyong City, Metro Manila, Philippines

MED152578IN02
*Reg.IPOPHIL

Date of Revision: **October 2009**
Date of first Authorization: **October 21,2009**

12015079