เอกสารกำกับยาสำหรับบุคลากรทางการแพทย์

VOCINTI

1. Name of the Medicinal Product

Vocinti (Tablet) 10 MG.

Vocinti (Tablet) 20 MG.

ATC CODE : Not assigned.

2. Qualitative and Quantitative Composition

Vocinti (Tablet) 10 MG :

Each film-coated tablet contains 10 mg of vonoprazan (as 13.36 mg vonoprazan fumarate)

Vocinti (Tablet) 20 MG :

Each film-coated tablet contains 20 mg of vonoprazan (as 26.72 mg vonoprazan fumarate)

For excipients, see section 6.1.

3. Pharmaceutical Form

Available Pharmaceutical Forms	Stengths	Color	Shape	Markings (upperside)
Film-coated Tablet	10 mg	Pale yellow	Oval tablet	B217
	20 mg	Pale red	Oval scored tablet	B218

4. Clinical Particulars

4.1. Therapeutic indication

- Treatment of gastric ulcer (GU)
- Treatment of duodenal ulcer (DU)
- Treatment of reflux esophagitis (RE) (erosive esophagitis EE)
- Prevention of recurrence of gastric ulcer or duodenal ulcer during low-dose aspirin administration.

- Prevention of recurrence of gastric ulcer or duodenal ulcer during NSAIDs administration.
- Adjunct to *Helicobacter pylori* eradication associated with: Gastric ulcer, duodenal ulcer, gastric MALT lymphoma, idiopathic thrombocytopenic purpura, the stomach after endoscopic resection of early stage cancer, or *Helicobacter pylori* gastritis

4.2. Posology and method of administration

Dosage

Adults

- *Gastric ulcer*

  The usual dose is 20 mg of vonoprazan once a day. Administration should be limited to 8 weeks.

- *Duodenal ulcer*

  The usual dose is 20 mg of vonoprazan once a day. Administration should be limited to 6 weeks.

- *Reflux esophagitis (erosive esophagitis)*

  The usual dose is 20 mg of vonoprazan once a day. Administration should be limited to 4 weeks. However, when the effect is insufficient, treatment may be continued for up to 8 weeks.

- *Prevention of recurrence of gastric ulcer or duodenal ulcer during low-dose aspirin administration*

  The usual dose is 10 mg of vonoprazan once a day.

- *Prevention of recurrence of gastric ulcer or duodenal ulcer during NSAIDs administration*

  The usual dose is 10 mg of vonoprazan once a day.

- *Adjunct to Helicobacter pylori eradication*

  Usually, the following 3 drugs are orally administered at the same time twice daily for 7 days:—20 mg vonoprazan, 750 mg amoxicillin hydrate, and 200 mg clarithromycin. The dose of clarithromycin may be appropriately increased as required, however, the upper limit is 400 mg twice daily or physician judgement.

When *Helicobacter pylori* eradication treatment with 3 drugs consisting of a proton pump inhibitor, amoxicillin hydrate, and clarithromycin fails, alternative treatment with the following 3 drugs is recommended; 20 mg vonoprazan, 750 mg amoxicillin hydrate, and 250 mg metronidazole, orally administered at the same time twice daily for 7 days. The doses of antibiotic should follow the respective label recommendations for H. pylori eradication.

Method of Administration

Vonoprazan can be taken without regard to food or timing of food.

Special Patient Populations

Elderly Patients

Since the physiological functions such as hepatic or renal function are decreased in elderly patients in general, vonoprazan should be carefully administered. (See Impaired Renal Function and Impaired Hepatic Function sections below.)

Pediatric Patients

Vonoprazan has not been studied in patients under 18 years of age.

Impaired Renal Function

Vonoprazan should be administered with care in patients with renal disorders as a delay in the excretion of vonoprazan may occur, which may result in an increase in the concentration of vonoprazan in the blood. (See Section 5.2)

Impaired Hepatic Function

Vonoprazan should be administered with care in patients with hepatic disorders as a delay in the metabolism and excretion of vonoprazan may occur, which may result in an increase in the concentration of vonoprazan in the blood. (See Section 5.2)

4.3. Contraindication

Hypersensitivity to the active ingredients or to any of the excipients.

4.4 Special Warnings and Special Precautions for Use

Hepatotoxicity

Hepatic function abnormalities including liver injury have been reported in clinical studies (see Section 4.8). Post marketing reports have also been received in patients treated with vonoprazan, many of which occurred shortly after initiation of treatment, Discontinuation of

vonoprazan is recommended in patients who have evidence of liver function abnormalities or if they develop signs or symptoms suggestive of liver dysfunction.

Elevation of intragastric pH

Administration of vonoprazan results in elevation of intragastric pH and is therefore not recommended to be taken with drugs for which absorption is dependent on acidic intragastric pH. (See Section 4.5).

Symptomatic response to vonoprazan does not preclude the presence of gastric malignancy.

4.5 Interaction with Other Medications and Other Forms of Interaction

Administration of vonoprazan results in elevation of intragastric pH, suggesting that it may interfere with the absorption of drugs where gastric pH is an important determinant of oral bioavailability. Use of vonoprazan is therefore not recommended with some of these drugs for which absorption is dependent on acidic intragastric pH such as Atazanavir and nelfinavir, due to significant reduction in their bioavailability.

Vonoprazan is metabolized mainly by hepatic drug-metabolizing enzyme CYP3A4 and partially by CYP2B6, CYP2C19 and CYP2D6.

With strong CYP3A4 inhibitors, e.g., clarithromycin, blood concentration of vonoprazan may increase. It has been reported that blood concentration of vonoprazan increased in concomitant use with clarithromycin by 1.5-fold, but no dose adjustment of vonoprazan is considered necessary.

Co-administration of vonoprazan with the antibiotic regimen clarithromycin and amoxicillin increased concentrations of vonoprazan by up to 1.9-fold. No increase was observed with the antibiotic regimen of metronidazole and amoxicillin. No dose adjustment of vonoprazan is considered necessary.

There were no clinically significant effects of low-dose aspirin or NSAIDs on the pharmacokinetics of vonoprazan, and no clinically significant effects of vonoprazan on the pharmacokinetics of low-dose aspirin or NSAIDs. The effect on platelet-aggregating inhibitory activity of low-dose aspirin was not considered clinically meaningful.

4.6 Pregnancy and Lactation

No clinical studies have been conducted to date to evaluate vonoprazan in subjects who are pregnant or lactating. In a rat toxicology study, embryo-foetal toxicity was observed following exposure of more than approximately 28 times of the exposure (AUC) at the maximum clinical dose (40 mg/day) of vonoprazan. It is unknown whether vonoprazan is excreted in human milk. In animal studies it has been shown that vonoprazan was excreted in milk.

As a precaution, vonoprazan should not be administered to women who are or may be pregnant, unless the expected therapeutic benefit is thought to outweigh any possible risk.
During treatment with vonoprazan, nursing should be avoided if the administration of this drug is necessary for the mother.

4.7 Effects on Ability to Drive and Use Machines

The influence of vonoprazan on the ability to drive or use machines is unknown.

4.8 Undesirable Effects

The following convention is used for the classification of the frequency of an adverse drug reaction (ADR) and is based on the Council for International Organizations of Medical Sciences (CIOMS) guidelines: very common (≥ 1/10); common (≥ 1/100 to < 1/10); uncommon (≥ 1/1,000 to < 1/100); rare (≥ 1/10,000 to< 1/1,000); very rare (< 1/10,000); not known (cannot be estimated from the available data).

Clinical Trials

Clinical trial data for expected adverse events is based on pooled safety analysis from the following studies: EE healing (CCT-001 and CCT-002), EE maintenance therapy (CCT-003 and OCT-001), GU healing (CCT-101), DU healing (CCT-102), prevention of recurrence of peptic ulcer associated with NSAID use (CCT-301, OCT-301 and OCT-303), prevention of recurrence of peptic ulcer associated with LDA use (CCT-302, OCT-302 and OCT-304) and treatment of non-erosive reflux disease (NERD; CCT-201). Although the study in patients with NERD has the placebo arm and is considered as the best data, the number of patients (N=449 and 278 for TAK-438 and placebo, respectively) is relatively small compared to the number of patients of all other active-comparator studies combined (N=3162 and 1392 for TAK-438 and AG-1749 [Lansoprazole], respectively). Therefore, the pooled safety data of active-comparator studies are

used for the primary analysis. The safety data of CCT-201 study are analyzed separately. (Note: AG-1749 (Lansoprazole) is the only comparator used in the comparator studies.)

Table 1. Adverse reactions with vonoprazan in clinical studies

Frequency/ System Organ Class	**Very Common**	**Common**	**Uncommon**	**Rare**
Gastrointestinal disorders		Diarrhoea Constipation	Nausea Abdominal distension	
Hepatobiliary disorders			Gamma-glutamyl transferase increased AST increased Liver function test abnormal ALT increased	

Post-marketing

Following is a list of ADRs which have been observed in post-marketing (Frequency unknown):

Table 2. Adverse reactions with vonoprazan in post-marketing setting System Organ Class

System Organ Class	Preferred Term
Immune system disorders	Drug hypersensitivity (including anaphylactic shock) Drug eruption Urticaria
Hepatobiliary disorders	Hepatotoxicity Jaundice
Skin and Subcutaneous tissue disorders	Rash

4.9 Overdose

There is no experience of overdose with vonoprazan.

Vonoprazan is not removed from the circulation by hemodialysis. If overdose occurs, treatment should be symptomatic and supportive.

Drug Abuse and Dependence

Vonoprazan has no known potential for abuse or dependence.

5. Pharmacological Properties

5.1. Pharmacodynamic Properties

Mechanism of Action

Vonoprazan is a potassium competitive acid blocker (PCAB) and inhibits H+, K+-ATPase in a reversible and potassium-competitive manner. It does not require activation by acid. Vonoprazan is a strong base with a high affinity for the acid pump of gastric cells inhibiting gastric acid production.

Clinical Studies

The efficacy of vonoprazan has been demonstrated in a number of clinical studies across several indications including GU, DU, RE, prevention of GU/DU during low-dose aspirin or

NSAID administration and as an adjunct to *H. pylori* eradication (see Section 4.1). Clinical efficacy in completed phase 2 and 3 studies is summarized in Table 3. These data are divided into the categories based upon the specific indication, including GU, DU, RE, prevention of recurrence of gastric or duodenal ulcer during low-dose aspirin or NSAID administration, and *H. pylori* eradication.

Following administration of vonoprazan at a dose of 10 mg or 20 mg in healthy adult male subjects for 7 days, pH 4 HTR (pH 4 holding time ratio) (percentage of time pH is maintained at a level ≥ 4 in 24 hours) was 63±9% and 83±17% respectively.

A phase 1 open-label pharmacodynamics study to investigate the acid-inhibitory effect of vonoprazan 20 mg compared with esomeprazole 20 mg or rabeprazole sodium 10 mg in healthy adult male Japanese subjects showed that the acid-inhibitory effect of vonoprazan was greater than that of esomeprazole or rabeprazole17). After all treatments, the mean 24-hour pH 4 HTRs increased from Baseline to Day 1 and from Day 1 to Day 7. The mean pH 4 HTRs were higher after administration of vonoprazan on Day 1 than after administration of esomeprazole or rabeprazole on Day 7. The mean 24-hour pH 4 HTRs for vonoprazan and rabeprazole at Baseline were both 8.9%, and on Day 1 and on Day 7 were 84.16% vs 26.29%, and 93.79% vs 65.09%, respectively.

Table 3. Overview of Clinical Efficacy of vonoprazan (TAK-438) and Comparators in Completed Phase 2 and 3 Studies

Study Name/Design	TAK-438 Dose(s)	Comparator	Duration (weeks)	Efficacy Endpoints	Efficacy Findings
RE (EE) (healing)					
CCT-001: Phase 2 dose-ranging in EE	5 mg (n=143), 10 mg (n=133), 20 mg (n=144), 40 mg (n=134	Lansoprazole 30 mg (n=132)	8	4-week EE healing rate	Non-inferior to lansoprazole at all doses 4-week EE healing rates: TAK-438 5 mg 92.3%, 10 mg 92.5%, 20 mg 94.4%, 40 mg 97.0%; lansoprazole 30 mg 93.2%
CCT-002: Phase 3 in EE	20 mg (n=205)	Lansoprazole 30 mg (n=199)	8	8-week EE healing rate	Non-inferior to lansoprazole: 99.0% vs 95.5% (p<0.0001)
CCT-003: Phase 3 in EE (treatment period)	20 mg (n=621)	N/A	8	EE healing rate during the treatment period	EE healing rate 98.9%
Gastric Ulcer					
CCT-101: Phase 3 in GU	20 mg (n=231)	Lansoprazole 30 mg (n=225)	8	8-week ulcer healing rate	Non-inferior to lansoprazole: 93.5% vs 93.8% (p=0.011)
Duodenal Ulcer					
CCT-102: Phase 3 in DU	20 mg (n=178)	Lansoprazole 30 mg (n=180)	6	6-week ulcer healing rate	Non-inferiority to lansoprazole not confirmed in Full Analysis Set (FAS) (p=0.0654) Non-inferiority confirmed in PPS
NSAID ulcer recurrence prevention					
CCT-301: Phase 3 in patients with healed ulcer receiving NSAIDs	10 mg (n=209), 20 mg (n=203)	Lansoprazole 15 mg (n=199)	24	24-week ulcer recurrence rate	Non-inferior to lansoprazole at both doses: 10 mg 3.3% vs 5.5% (p<0.0001) 20 mg 3.4% vs 5.5% (p<0.0001)
OCT-301: Phase 3 in patients with healed ulcer receiving NSAIDs (extension)	10 mg (n=209), 20 mg (n=203)	Lansoprazole 15 mg (n=199)	28-80	Ulcer recurrence rate	Ulcer recurrence rates were lower at all visits in the TAK-438 groups than in the lansoprazole group TAK-438 10 mg vs 20 mg vs lansoprazole 15 mg Week 52 3.8% vs 5.4% vs 7.0% Week 76 3.8% vs 5.9% vs 7.5% Week 104 3.8% vs 5.9% vs 7.5%

LDA ulcer recurrence prevention					
CCT-302	10 mg (n=197), 20 mg (n=196)	Lansoprazole 15 mg (n=213)	24	24-week ulcer recurrence rate	Non-inferior to lansoprazole at both doses: 10 mg 1.0% vs 2.8% (p<0.0001) 20 mg 1.5% vs 2.5% (p<0.0001)
CCT-302 (extension)	10 mg (n=197), 20 mg (n=196)	Lansoprazole 15 mg (n=213)	28-80	ulcer recurrence rate	Recurrence rate numerically lower in TAK-438 groups than in lansoprazole group. Rate was significantly lower in TAK-438 10 mg group than in the lansoprazole 15 mg group at Weeks 76 and 104 (p=0.0356 for each)
***H pylori* eradication**					
CCT-401 first-line: Phase 3 in *H. pylori*	20 mg + amoxicillin and clarithromycin (n=324)	Lansoprazole 30 mg + amoxicillin and clarithromycin (n=320)	1	4-week eradication rate	Non-inferior to lansoprazole: 92.6% vs 75.9% (p<0.0001)
CCT-401 second-line: Phase 3 in *H. pylori*	20 mg + amoxicillin and metronidazole (n=50)	N/A	1	4-week eradication rate	4-week eradication rate: 98%
NERD					
CCT-201: Phase 3 in NERD	10 mg (n=278), 20 mg (n=271)	Placebo (n=278)	4	Heartburn symptom relief	The proportion of days without heartburn was numerically higher in the TAK-438 treatment groups than in the placebo group

LDA=low-dose aspirin, N/A=not assessed, PPS=per protocol set

EE = Erosive Esophagitis = Reflux Esophagitis (RE).

5.2 Pharmacokinetic Properties

Following 7 day repeat once daily doses of vonoprazan at doses of 10-40 mg, in healthy adult male subjects, $AUC_{\tau,ss}$ and C_{max} increase in a slightly greater than dose proportional manner. Steady state has been reached by day 3 of administration, since the trough level of the blood concentration of vonoprazan is constant between day 3 and day 7 of administration.

In addition, vonoprazan does not exhibit time-dependent pharmacokinetics. The following table shows pharmacokinetic parameters of vonoprazan on day 7 of administration.

Dose	10 mg	20 mg
t_{max} (h)	1.5 (0.75, 3.0)	1.5 (0.75, 3.0)
C_{max} (ng/mL)	12.0±1.8	23.3±6.6
t1/2 (h)	7.0±1.6	6.1±1.2
$AUC_{\tau,ss}$ (h ng/mL)	79.5±16.1	151.6±40.3

Mean ± S.D. of 9 subjects (t_{max} is expressed by the median (minimum value, maximum value)

Absorption

Absolute bioavailability has not been determined. The pharmacokinetic parameters of vonoprazan following single administration of vonoprazan to healthy adult male subjects at 20 mg under fasting and fed conditions are presented in the table below

Dose Condition	Under fasting	After meal
t_{max}(h)	1.5 (1.0, 3.0)	3.0 (1.0, 4.0)
C_{max}(ng/mL)	24.3±6.6	26.8±9.6
$t_{1/2}$ (h)	7.7±1.0	7.7±1.2
AUC_{48}(h ng/mL)	222.1±69.7	238.3±71.1

Mean±S.D. of 12 subjects (t_{max} is expressed by the median (minimum value, maximum value))

Distribution

The mean binding rate is 85.2 to 88.0% when [14C] vonoprazan in the range of 0.1 to 10 µg/mL is added to human plasma (*in vitro*).

Metabolism

Vonoprazan is metabolized mainly by hepatic drug-metabolizing enzyme CYP3A4 and partially by CYP2B6, CYP2C19 and CYP2D6. Vonoprazan is also metabolized by sulfotransferase SULT2A1 (*in vitro*).

Vonoprazan exhibits time-dependent inhibitory effect on CYP2B6, CYP2C19 and CYP3A4/5 (*in vitro*). In addition, vonoprazan shows a slight concentration-dependent inductive effect on CYP1A2, but it shows little inductive effect on CYP2B6 and CYP3A4/5 (*in vitro*).

Excretion and Elimination

When radioactive-labeled drug (15 mg as vonoprazan) is orally administered to healthy adult male subjects, 98.5% of the radioactivity administered is excreted into urine and feces by 168 hours after administration: 67.4% into urine and 31.1% into feces.

Special Populations

Impaired Renal Function

The effect of renal disorders on pharmacokinetics of vonoprazan in subjects with normal renal function, patients with mild, moderate, and severe renal disorder and patients with end-stage renal disease (ESRD) when administered the drug as a single dose of vonoprazan 20 mg shows that $AUC_{\infty}$and Cmax were higher by 1.3 to 2.4 times and 1.2 to 1.8 times, respectively, in patients with mild, moderate, and severe renal disorder compared to subjects with normal renal function, showing an increase with a reduction in renal function. AUC_{∞} and Cmax were higher by 1.3 times and 1.2 times, respectively, in ESRD patients compared to those in subjects with normal renal function.

Impaired Hepatic Function

The effect of hepatic disorders on pharmacokinetics in subjects with normal hepatic function and patients with mild, moderate and severe hepatic disorder when administered the drug as a single dose of vonoprazan 20 mg shows that AUC_{∞} and Cmax were higher by 1.2 to 2.6 times and 1.2 to 1.8 times, respectively, in patients with mild, moderate and severe hepatic disorder, compared to subjects with normal hepatic function.

Age, Gender, Race

Vonoprazan has not been studied in patients under 18 years of age.

There are no clinically relevant gender effects of vonoprazan.

No dedicated ethnic comparison studies have been conducted with vonoprazan.

The ethnic sensitivity analysis based on the International Conference for Harmonization (ICH) E5 principles was conducted to assess whether the molecular properties of vonoprazan were sensitive to ethnic factor differences, and whether the diagnosis, medical practice, treatment options, and other epidemiological factors for acid-related disorders would vary dramatically in areas other than Japan. It was concluded that vonoprazan is insentitive to ethnic factor differences

Drug Interactions

Vonoprazan and clarithromycin

Healthy adult male subjects were administered with a single dose of vonoprazan (40 mg), 30 minutes after breakfast on day 1 and day 8, and with repeated dose of clarithromycin 500 mg (potency) 2 times daily 30 minutes before breakfast and dinner on day 3 – 9. The AUC_{∞} and

Cmax of vonoprazan increased by 1.6 times and 1.4 times, respectively, when concomitantly administered with clarithromycin compared to those of vonoprazan when administered alone.

Vonoprazan, amoxicillin hydrate and clarithromycin

The drug interaction study in healthy adult male subjects administered twice daily with vonoprazan 20 mg, amoxicillin hydrate 750 mg (potency) and clarithromycin 400 mg (potency) concomitantly for 7 days shows no effect on pharmacokinetics of unchanged amoxicillin, however, AUC_{12} and C_{max} of vonoprazan increased by 1.8 times and 1.9 times, respectively, and AUC_{12} and C_{max} of unchanged clarithromycin increased by 1.5 times and 1.6 times, respectively.

Vonoprazan, amoxicillin hydrate and metronidazole

The drug interaction study in healthy adult male subjects administered twice daily with vonoprazan 20 mg, amoxicillin hydrate 750 mg (potency) and metronidazole 250 mg concomitantly for 7 days showed little difference in the pharmacokinetics of vonoprazan, when administered alone or as triple therapy. No difference was observed in the pharmacokinetics of metronidazole or amoxicillin when administered alone or as triple therapy.

Vonoprazan and low-dose aspirin or vonoprazan and NSAIDs

The drug interaction study in healthy adult male subjects administered with vonoprazan 40 mg and aspirin 100 mg or NSAID (loxoprofen sodium 60 mg, diclofenac sodium 25 mg or meloxicam 10 mg) concomitantly showed no clear effect of low-dose aspirin or NSAIDs on pharmacokinetics of vonoprazan and of vonoprazan on pharmacokinetics of low-dose aspirin or NSAIDs.

5.3 Preclinical Safety data

Carcinogenesis

Vonoprazan was non-carcinogenic in a long term carcinogenicity study in mice administered the drug daily via oral gavage for up to 2 years at 0.6, 20, 60, and 200 mg/kg/day. Treatment-related tumors, related to exaggerated pharmacology or sepsis-specificity, were noted in the stomach and liver. In the stomach, benign and malignant neuroendocrine cell tumors were observed at ≥20 (males) and ≥60 (females) mg/kg/day and ≥6 (males) and ≥60 (females) mg/kg/day, respectively. In the liver, increased incidences of hepatocellular adenoma and

carcinoma were observed at ≥20 (males) and ≥60 (females) mg/kg/day, and at ≥60 (males) and 200 (females) mg/kg/day, respectively. Hyperplasia of the neuroendocrine cells and associated tumors in the stomach may be due to hypergastrinemia as a consequence of inhibiting gastric acid secretion. The hepatocellular tumors are likely rodent-specific findings that are attributed to prolonged induction of hepatic drug-metabolizing enzymes. The NOAEL was <6 mg/kg/day.

Vonoprazan was non-carcinogenic in a long term carcinogenicity study in rats administered the drug via oral gavage at 5, 15, 50, and 150 mg/kg/day. Treatment-related tumors, related to exaggerated pharmacology or species-specificity, were noted in the stomach and liver. In the stomach, benign and malignant neuroendocrine cell tumors were observed at ≥5 mg/kg/day except for malignant neuroendocrine tumor at 50 mg/kg/day (males). In some instances in benign and malignant neuroendocrine cell tumors, tumor cells showed eosinophilic change but these tumors were also judged to be of neuroendocrine cell origin. In the liver, increased incidences of hepatocellular adenoma and carcinoma were observed at ≥50 mg/kg/day except for hepatocellular carcinoma at 50 mg/kg/day (females). Tumor findings in the stomach and liver are believed to be due to hypergastrinemia as a consequence of inhibiting gastric acid secretion and rodent-specific induction of hepatic drug-metabolizing enzymes, respectively. The occurrence of 4 hepatocholangiocellular tumors at ≥50 mg/kg/day (males) were considered to be treatment-related because they were considered to be associated with induction of hepatocellular tumor, but pairwise comparison did not demonstrate a statistically significant effect.

Mutagenicity

Vonoprazan did not exhibit any mutagenic or clastogenic activity in the *in vitro* Ames assay, *in vitro* mammalian chromosome aberration assay, and *in vivo* rat micronucleus assay.

Impairment of Fertility

When administered daily via oral gavage to male and females rats, males were administered vonoprazan prior to and during mating and females dosed for 2 weeks pre-mating through Gestation Day (GD) 6, there were no effects on sperm analysis, estrous cycles or number of corpora lutea observed at doses up to 300 mg/kg/dose. The NOAEL for male and female general toxicity was 30 mg/kg/day and ≥300 mg/kg/day for reproductive function and early embryonic development.

6. Pharmaceutical Particulars

6.1 List of excipient

D-Mannitol

Microcrystalline cellulose

Hydroxypropylcellulose

Fumaric acid

Croscarmellose sodium

Magnesium stearate

Hypromellose

Macrogol 6000*

Titanium oxide

Red ferric oxide (20 mg tablet only)

Yellow ferric oxide (10 mg tablet only).

*Macrogol 6000 is a name in the Japanese Pharmacopoeia. Its average molecular mass is approximately 8300. Therefore it is different from Macrogol 6000 in European Pharmacopoeia (Ph.Eur.) or Polyethylene Glycol 6000 in US National Formulary (NF) whose average molecular mass is 6000 and it is equivalent to Macrogol 8000 in Ph. Eur. and Polyethylene Glycol 8000 in NF.

6.2 Incompatibilities

Not applicable

6.3 Shelf life

Please see outer carton.

6.4 Special precautions for storage

Store below 30°C

6.5 Nature and contents of container

Polyvinyl chloride (PVC) film/Aluminum foil blister, one blister contains 10 tablets.

7. Marketing Authorization Holder

Manufactured by TAKEDA PHARMACEUTICAL COMPANY LIMITED, Hikari Plant, Yamaguchi, Japan.

Repacked by KOKANDO CO. LTD, Toyama, Japan

Imported by Takeda (Thailand) Ltd., Bangkok, Thailand

8. Marketing Authorization Numbers

9. Date of authorization

10. Date of revision of the text