**SCHEDULING STATUS**

**S3**

## 1. NAME OF THE MEDICINE

**ADCO BISOCOR 5 mg** film-coated tablets
**ADCO BISOCOR 10 mg** film-coated tablets

## 2. QUALITATIVE AND QUANTITATIVE COMPOSITION

**ADCO BISOCOR 5 mg:** Each film-coated tablet contains 5 mg bisoprolol hemifumarate equivalent to 4,24 mg of bisoprolol.
Sugar free.

**ADCO BISOCOR 10 mg:** Each film-coated tablet contains 10 mg bisoprolol hemifumarate equivalent to 8,49 mg of bisoprolol.
Sugar free.

For the full list of excipients, see section 6.1.

## 3. PHARMACEUTICAL FORM

**ADCO BISOCOR 5 mg film-coated tablets** are light pink, round, biconvex film coated-tablets. The tablets are embossed with “BSL 5” on one side and scored on both sides.

**ADCO BISOCOR 10 mg film-coated tablets** are yellow to orange, round, biconvex film coated-tablets. The tablets are embossed with “BSL 10” on one side and scored on both sides.

## 4. CLINICAL PARTICULARS

### 4.1 Therapeutic indications

ADCO BISOCOR is indicated for the management of mild to moderate hypertension and angina pectoris. It may be used alone or in combination with other antihypertensive medicines.

### 4.2 Posology and method of administration

**Posology:**

**Hypertension and Angina pectoris**

***Adults*:** 5 to 10 mg once a day in the morning with or without food.
The dose must be individualised according to response and tolerance, in particular according to pulse rate and therapeutic success.
The maximum recommended daily dose is 20 mg.

***Special populations***

***Severe renal impairment (creatinine clearance < 30 mL/min) or severe hepatic impairment***:

Do not exceed the daily dose of 10 mg.

There is only limited experience with the use of ADCO BISOCOR in dialysis patients. There are no indications of the necessity to alter the dose regimen.

***Elderly*:**

No dose adjustment is required in elderly patients.

***Paediatric population***

There is no therapeutic experience with ADCO BISOCOR in children. Its use in children is therefore not recommended (See section 4.4).

***Method of administration***

The film-coated tablets are to be swallowed whole in some liquid in the morning before, during or after breakfast.

The duration of treatment is not limited. It depends upon the nature and severity of the disease.

ADCO BISOCOR therapy should not be stopped abruptly, particularly not in patients with ischaemic heart disease, as this may lead to acute deterioration of the patient's state of health (see section 4.4). If discontinuation of therapy becomes necessary, the dose should be gradually reduced (e.g. halving of the dose at weekly intervals).

**4.3 Contraindications**

- Hypersensitivity to bisoprolol or to any of the ingredients (see section 6.1).
- Uncontrolled cardiac failure or during episodes of heart failure decompensation requiring i.v. inotropic therapy
- Cardiogenic shock
- Symptomatic hypotension
- Uncontrolled asthma or chronic obstructive pulmonary disease. Severe forms of peripheral arterial occlusive disease and Raynaud's syndrome.
- Second and third degree heart (sinoarterial) block and sinus bradycardia (less than 50 beats per minute)
- Second or third degree AV block (without a pacemaker)
- Sick sinus syndrome
- Sinoatrial block
- Pregnancy (see section 4.6)
- Metabolic acidosis
- Sinus bradycardia (less than 50 beats per minute)
- Phaeochromocytoma before full alpha blockade is achieved (see section 4.4)
- Hyperthyroidism, as clinical manifestations may be masked.

## 4.4 Special warnings and precautions for use

Treatment with ADCO BISOCOR must not be withdrawn abruptly unless clearly indicated, since abrupt withdrawal of bisoprolol (as in ADCO BISOCOR) may lead to an acute deterioration of the patient's condition in particular in patients with ischaemic heart disease (see section 4.2). Discontinuation should be gradual over a period of 1 to 2 weeks, and patients should be advised to limit the extent of their physical activity during the period in which the medicine is being discontinued.
Caution is warranted when treating patients with hypertension or angina pectoris and concomitant heart failure with ADCO BISOCOR.

*ADCO BISOCOR may be used only with special caution in*:

- ADCO BISOCOR modifies the tachycardia associated with hypoglycaemia.
- A patient's normal tachycardic response to hypovolaemia or blood loss may be obscured during or after surgery. Particular caution should be taken in this regard and in diabetes mellitus, as symptoms and signs of hypoglycaemia may be masked, and as responses to hypoglycaemia is diminished.
- Strict fasting
- Ongoing desensitisation therapy. As with other beta-blockers, bisoprolol may increase both the sensitivity towards allergens and the severity of anaphylactic reactions. Epinephrine treatment may not always yield the expected therapeutic effect.
- First degree AV block
- Prinzmetal's angina; Cases of coronary vasospasm have been observed. Despite its high beta1-selectivity, angina attacks cannot be completely excluded when bisoprolol is administered to patients with Prinzmetal's angina. Utmost caution must be exercised.
- Peripheral arterial occlusive disease (intensification of complaints may occur especially when starting therapy)
- ADCO BISOCOR may aggravate the symptoms of peripheral arterial occlusive disease (PAOD) or Raynaud's syndrome (due to unopposed arteriolar alpha-sympathetic activation).
- Severe peripheral vascular disease and even peripheral gangrene may be precipitated.
- Digitalisation of patients receiving long-term ADCO BISOCOR therapy may be necessary if congestive cardiac failure is likely to develop. This combination can be considered despite the potentiation of the negative chronotropic effect of the two medicines. Careful control of dosages, and of the individual patient's response (and notably pulse rate), is essential in this situation.

Particular caution should be exercised with patients suffering from the following: asthma, bronchitis, chronic respiratory diseases, peripheral vascular diseases and Raynaud's phenomenon.

Tachycardia responses may be obscured. Particular caution should be taken in this regard.
The dosage of ADCO BISOCOR should be adjusted in severe renal impairment (see section 4.2).

ADCO BISOCOR should be used with caution in combination with verapamil in patients with impaired ventricular function. This combination should not be given to patients with conduction abnormalities. Neither drug should be administered intravenously within 48 hours of discontinuing the other. The intravenous administration of calcium antagonists and antiarrthythmic agents is not recommended during therapy with ADCO BISOCOR.

Care should be taken in prescribing ADCO BISOCOR together with Class 1 antidysrhythmic agents such as disopyramide, myocardial depressants and inhibitors of AV conduction such as calcium antagonists.

***Clonidine***
Caution should be exercised when transferring a patient from clonidine, as the withdrawal of clonidine may result in the release of large amounts of catecholamines, which may give rise to a hypertensive crisis.
If ADCO BISOCOR is administered in these circumstances, the unopposed alpha receptor stimulation may potentiate this effect. If ADCO BISOCOR and clonidine are given concurrently, the clonidine should not be discontinued until several days after the withdrawal of ADCO BISOCOR, as severe rebound hypertension may occur.

***Psoriasis***
Patients with psoriasis or with a history of psoriasis may have their conditions worsened by ADCO BISOCOR.

***Hyperthyrodism***
The symptoms of hyperthyroidism may be masked under treatment with ADCO BISOCOR.

***Thyrotoxicosis***
The symptoms of thyrotoxicosis may be masked under treatment with ADCO BISOCOR.

***Pheochromocytoma***
Patients with phaeochromocytoma usually require treatment with an alpha-adrenergic blocker. Abrupt discontinuation of therapy may cause exacerbation of angina pectoris in patients suffering from ischaemic heart disease. Discontinuation of therapy should be gradual, and patients should be advised to limit the extent of their physical activity during the period that the medicine is being discontinued.

***Paediatric population***
Safety and efficacy of ADCO BISOCOR have not been established in children.

***General Anaesthesia***
In patients undergoing general anaesthesia beta-blockade reduces the incidence of arrhythmias and myocardial ischaemia during induction and intubation, and the post-operative period. It is currently recommended that maintenance beta-blockade be continued peri-

operatively. The anaesthetist must be aware of beta-blockade because of the potential for interactions with other drugs, resulting in bradydysrhythmias, attenuation of the reflex tachycardia and the decreased reflex ability to compensate for blood loss.
If the decision is made to withdraw ADCO BISOCOR before anaesthesia, at least 48 hours should be allowed to elapse between the last dose and surgery. If the medicine is to be continued, care should be taken when using anaesthetics such as ether, cyclopropane and trichloroethylene. Atropine (1 to 2 mg IV) may be used to correct vagal dominance. The patient must be maintained on their usual dosage peri-operatively to avoid aggravation of angina pectoris or hypertension.

In the peri-operative period it is generally unwise to reduce the dosage to which the patient is accustomed, as there may be danger of aggravation of angina pectoris or hypertension. A patient's normal tachycardia response to hypovolaemia or blood loss may be obscured during or after surgery.
The normal dose should be reduced in patients suffering from renal dysfunction (see section 4.2).

***Asthma and Chronic Obstructive Pulmonary Disease***
Although cardioselective (beta1) beta-blockers may have less effect on lung function than nonselective beta-blockers, as with all beta-blockers, these should be avoided in patients with obstructive airways diseases, unless there are compelling clinical reasons for their use. Where such reasons exist, ADCO BISOCOR may be used with caution. In bronchial asthma or other chronic obstructive pulmonary diseases, which may cause symptoms, concomitant bronchodilating therapy is recommended. Occasionally an increase of the airway resistance may occur in patients with asthma, therefore, the dose of $beta_2$-stimulants may have to be increased.

## 4.5 Interaction~~s~~ with other medicines and other forms of interaction

***Combinations not recommended***

- *Calcium antagonists of the verapamil type and to a lesser extent of the diltiazem type:* Negative effect on contractility and atrio ventricular conduction. Intravenous administration of verapamil in patients on ADCO BISOCOR treatment may lead to profound hypotension and atrioventricular block.
- *Centrally acting antihypertensive medicines (e.g. clonidine, methyldopa, moxonodine)*: Concomitant use of ADCO BISOCOR and centrally acting antihypertensive medicines may lead to a further reduction in heart rate and cardiac output and to vasodilation. Beta-blockers (e.g. ADCO BISOCOR) may exacerbate the "rebound hypertension" which can occur in case of abrupt withdrawal of centrally acting antihypertensive medicines (e.g. Clonidine). If the two medicines are co-administered, the β-blocker should be withdrawn several days before discontinuing clonidine. If replacing clonidine by β-blocker therapy, the introduction of β-blockers should be delayed for several days after clonidine administration has stopped.

***Combinations to be used with caution***

- *Calcium channel antagonists of the dihydropyridine type (e.g. nifedipine, amlodipine)*: Concomitant use of ADCO BISOCOR and dihydropyridine calcium channel antagonists may increase the risk of hypotension, and an increase in the risk of a further deterioration of the ventricular pump function in patients with heart failure cannot be excluded.
- Concomitant use of ADCO BISOCOR with hypoglycaemic agents. phenothiazines and various antiarrhythmic agents can have life-threatening consequences. e.g.
    - profound hypoglycaemia with oral hypoglycaemic agents and insulin;
    - myocardial depression with antiarrhythmic agents.
- *Class-III antidysrhythmic medicines (e.g. amiodarone)*: Effect on atrio-ventricular conduction time may be potentiated.
- *Class I antiarrhythmics (e.g. quinidine, disopyramide, lidocaine, phenytoin, flecainide, propafenone)*: Effect on atrio-ventricular conduction time and negative inotropic effect may be increased.
- *Parasympathomimetic medicines*: Concomitant use may increase atrio-ventricular conduction time and the risk of bradycardia.
- *Topical beta-blockers (e.g. eye drops for glaucoma treatment*) may add to the systemic effects of ADCO BISOCOR.
- *Insulin and oral antidiabetic medicines*: Increase of blood sugar lowering effect. Blockade of beta-adrenoceptors may mask symptoms of hypoglycaemia (see section 4.4).
- *Anaesthesia*: Attenuation of the reflex tachycardia and increase of the risk of hypotension.
- *Non-steroidal anti-inflammatory drugs (NSAIDs)*: NSAIDs may reduce the hypotensive effect of ADCO BISOCOR.
- *Beta-sympathomimetics (e.g. dobumamine)*: Combination with ADCO BISOCOR may reduce the effect of both agents. Higher doses of epinephrine (adrenaline) may be necessary for treatment of allergic reactions.
- *Beta-adrenoceptor stimulating agents (e.g. isoprenaline*) may antagonise the effects of ADCO BISOCOR.
- Alpha-adrenoceptor stimulants as well as adrenergic neurone blocking agents such as guanethidine and reserpine may lead to life-threatening vasoconstriction in combination with ADCO BISOCOR.
- *Sympathomimetics that activate both beta- and alpha-adrenoceptors [e.g. norepinephrine (noradrenaline), epinephrine (adrenaline)]*: Combination with ADCO BISOCOR may unmask the alpha-adrenoceptor-mediated vasoconstrictor effect of these medicines leading to blood pressure increase and exacerbated intermittent claudication.
- ADCO BISOCOR and digoxin may be used concomitantly for patients with congestive heart failure provided that the pulse rate and patient response is monitored.
- *Concomitant use with other antihypertensive medicines or with other medicinal products with blood pressure lowering potential (e.g. tricyclic antidepressants, barbiturates, phenothiazines*) may increase the risk of hypotension.

***Combinations to be considered***

- *Mefloquine*: Increased risk of bradycardia.

- *Monoamine oxidase inhibitors (except MAO-B inhibitors)*: Enhanced hypotensive effect of the beta-blockers but also risk of hypertensive crisis.
- *Rifampicin*: Slight reduction of the half-life of bisoprolol possible due to the induction of hepatic drug-metabolising enzymes. Normally no dosage adjustment is necessary.
- *Ergotamine derivatives*: Exacerbation of peripheral circulatory disturbances. In high-dose salicylate administration the toxic effect of salicylates on the central nervous system may be enhanced.

### 4.6 Fertility, pregnancy and lactation

***Pregnancy***

ADCO BISOCOR has pharmacological effects that may cause harmful effects on pregnancy and/or the foetus/newborn.
Administration of ADCO BISOCOR to pregnant mothers shortly before birth or during labour may result in hypotonia, collapse or hypoglycaemia in the newborn. (See section 4.3).

ADCO BISOCOR reduces placental perfusion, which has been associated with growth retardation, intrauterine death, abortion or early labour. Adverse effects (e.g. bradycardia and cardiovascular collapse) may occur in the foetus and newborn infant.

***Breastfeeding***

It is not known whether ADCO BISOCOR is excreted in human milk. Therefore, mothers on treatment with ADCO BISOCOR should not breastfeed their infants.

***Fertility***

No effect on fertility was observed in male or female rats treated with bisoprolol at oral doses up to 150 mg/kg/day

### 4.7 Effects on ability to drive and use machines

Bisoprolol, as contained in ADCO BISOCOR, may cause dizziness or fatigue and, therefore, it may adversely affect the patient's ability to drive or use machinery.

### 4.8 Undesirable effects

***Tabulated summary of adverse reactions***

| **MedDRA System Organ Class** | **Frequency** | **Side effects** |
|---|---|---|
| **Blood and the lymphatic system disorders** | *Less frequent* | Blood disorders such as agranulocytosis, leukopenia and thrombocytopenia |
| | *Unknown frequency* | Non-thrombocytopenic purpura, transient eosinophilia. |
| **Immune system disorders** | *Less frequent* | Hypersensitivity (allergic) reactions (itching, flush, rash and angioedema) |
| | *Unknown frequency* | Systemic Lupus Erythematosus (SLE). |

| | | |
|---|---|---|
| **Metabolism and nutrition disorders** | *Less frequent* | Increased triglycerides, raised liver enzymes (ALAT, ASAT) |
| | *Unknown frequency* | Metabolic disturbances, hypoglycaemia, increase in uric acid levels, hypercholesterolaemia, hyperglycemia. |
| **Psychiatric disorders** | *Less frequent* | Depression, sleep disorders, nightmares, hallucinations, vivid dreams and confusion, amnesia, anxiety, nervousness. |
| | *Unknown frequency* | Restlessness, psychosis. |
| **Nervous system disorders:** | *Frequent* | Dizziness*, mild headache*, drowsiness, unusual tiredness or weakness (Lassitude). |
| | *Less frequent* | Syncope, paraesthesia |
| **Eye disorders** | *Less frequent* | Dry, sore eyes, reduced tear flow (to be taken into consideration in patients wearing contact lenses), conjunctivitis,. |
| | *Unknown frequency* | Disturbances of vision |
| **Ear and labyrinth disorders** | *Less frequent* | Hearing disorders. |
| | *Unknown frequency* | Transient hearing loss. |
| **Cardiac disorders** | *Less frequent* | AV-conduction disturbances, worsening of pre-existing heart failure, dysrhythmias, bradycardia, congestive cardiac failure. |
| | *Unknown frequency* | Heart block |
| **Vascular disorders** | *Frequent* | Cold extremities or numbness in the extremities, hypotension |
| | *Less frequent* | Paradoxical hypertension, exacerbation of peripheral vascular disease or the development of Raynaud's phenomenon, peripheral gangrene may be precipitated and marked bradycardia may occur. |
| | *Unknown frequency* | Fluid retention |
| **Respiratory, thoracic and mediastinal disorders** | *Less frequent* | Bronchoconstriction may occur in patients suffering from asthma, bronchitis, shortness of breath or dyspnoea and other chronic pulmonary diseases. Allergic rhinitis, nasal congestion. Adverse reactions are more common in patients with renal decompensation. |

| | | |
|---|---|---|
| | *Unknown frequency* | Pneumonitis, pulmonary fibrosis, pleurisy. |
| **Gastrointestinal disorders:** | *Frequent*: | Nausea, vomiting, diarrhoea, constipation, |
| | *Unknown frequency* | Mass gain, stomatitis, abdominal cramps, dry mouth. |
| **Hepato-biliary disorders** | *Less frequent* | Hepatitis, hepatotoxicity |
| **Skin and subcutaneous tissue disorders** | *Less frequent*: | Hypersensitivity reactions, skin rash (itching, flush, rash and angioedema), psoriasiform eruption (Beta-blockers can trigger psoriasis, aggravate the condition or lead to psoriasis form rash), reversible alopecia |
| | *Unknown frequency* | Perspiration, pruritus |
| **Musculoskeletal, connective tissue and bone disorders** | *Less frequent* | Muscle cramps, skeletal muscle weakness myopathy, back pain or joint pain, chest pain, muscle ache. |
| **Reproductive system and breast disorders** | *Frequent* | Decreased sexual ability |
| | *Less frequent* | Sexual impotence |
| **General disorders and administration site conditions** | *Frequent* | Fatigue*, |
| | *Less frequent* | Asthenia, oedema |
| | *Unknown frequency* | Sclerosing peritonitis, retroperitoneal fibrosis. |

*This symptom especially occurs at the beginning of therapy. It is generally mild and often disappears within 1 – 2 weeks.

***Reporting of suspected adverse reactions***

Reporting suspected adverse reactions after authorisation of the medicine is important. It allows continued monitoring of the benefit/risk balance of the medicine. Health care providers are requested to report any suspected adverse drug reactions to SAHPRA via the Med Safety APP (Medsafety X SAHPRA) and eReporting platform (who-umc.org) found on SAHPRA website.

For reporting of side effects directly to the HCR, contact +27 11 635 0134 or email Adcock.aereports@adcock.com.

## 4.9 Overdose

***Symptoms***

Overdosage may produce bradycardia and severe hypotension. Bronchospasm, hypoglycaemia and heart failure may be produced in certain individuals.

Coma and convulsions have also been reported, and some patients may develop severe and occasionally fatal cardiovascular depression.

There is limited experience with overdose of bisoprolol, only a few cases of overdose with bisoprolol have been reported. There is a wide inter-individual variation in sensitivity to one single high dose of bisoprolol and patients with heart failure are probably very sensitive.

***Treatment***
The data available suggest that bisoprolol is not dialyzable to any extent.
Cases of overdose should be observed for at least 4 hours, as apnoea and cardiovascular collapse may appear suddenly.
Repeated activated charcoal may be necessary in overdose.
*Bradycardia*: Atropine may be used to treat severe bradycardia. If the response is inadequate, isoprenaline or another agent with positive chronotropic properties may be given cautiously. Alternatively, dobutamine may required to reverse beta-blockade.
Cardiac pacing may be required for severe bradycardia.
*Hypotension*: Intravenous fluid replacement and administration of vasopressors. Glucagon may be given intravenously.
*Acute worsening of heart failure*: Intravenous administration of diuretics, positive inotropic medicines, as well as vasodilators.
*Hypoglycaemia*: Intravenous administration of glucose.
Bronchospasm should be treated with IV aminophylline or inhaled or IV beta-agonist e.g. salbutamol.

## 5. PHARMACOLOGICAL PROPERTIES

### 5.1 Pharmacodynamic properties

A 5.2 Adrenolytics (sympathicolytics)
ATC Code: C07A B07

***Mechanism of action***:
Bisoprolol is a selective β1 adrenoceptor antagonist devoid of intrinsic sympathomimetic and membrane-stabilising activity with low ß2-receptor affinity. It blocks beta-adrenergic receptors in the heart and the juxtaglomerular apparatus (kidneys), thus decreasing the excitability of the heart, the cardiac output, the oxygen myocardial consumption and the release of renin from the kidneys. Another factor that may be involved in contributing to the antihypertensive action is the decrease of the tonic sympathetic outflow from the vasomotor centres in the brain.
It has no intrinsic sympathomimetic activity nor membrane-stabilising properties. It reduces blood pressure, and by blockade of the cardiac ß1-receptors, reduces heart rate and depresses plasma renin levels.

### 5.2 Pharmacokinetic properties

*Absorption*
Bisoprolol is well absorbed following oral administration with a resultant bioavailability of about 90 %. Bisoprolol undergoes minimal hepatic first-pass metabolism. $T_{max}$ varies from 1 - 4 hours.

*Distribution*
The plasma protein binding of bisoprolol is about 30 %. The distribution volume is 3,5 l/kg. Total clearance is approximately 15 l/h.

*Biotransformation*
About 50% of a dose is metabolised in the liver and the remainder is excreted unchanged via the kidneys. None of the metabolites have ß1-receptor blocking action.

*Elimination*
Bisoprolol excreted predominantly via the urine as unaltered substance and metabolites. The plasma elimination half-life is approximately 10 to 12 hours and the duration of action is about 24 hours. Less than 2 % of the dose is excreted in the faeces.

## 6. PHARMACEUTICAL PARTICULARS

### 6.1 List of excipients

**ADCO BISOCOR 5 mg**

*Tablet core*
Calcium hydrogen phosphate anhydrous,
Colloidal anhydrous silica (areosol 200),
Crospovidone,
Microcrystalline cellulose (Avicel ® pH 1.01),
Magnesium stearate,
Pregelatinised starch,
*Tablet coating*
Hydroxypropylmethylcellulose,
Iron oxide red (E 172),
Iron oxide yellow (E 172),
Polyethylene glycol 400,
Titanium dioxide (E171).

**ADCO BISOCOR 10 mg**

*Tablet core*
Calcium hydrogen phosphate anhydrous,
Colloidal anhydrous silica (areosol 200),
Crospovidone,
Microcrystalline cellulose (Avicel ® pH 1.01),
Magnesium stearate,
Pregelatinised starch,
*Tablet coating*
Hydroxypropylmethylcellulose,
Iron oxide red (E 172),
Iron oxide yellow (E 172),
Polyethylene glycol 400,

Titanium dioxide (E171).

### 6.2 Incompatibilities
Not applicable

### 6.3 Shelf life
24 months.

### 6.4 Special precautions for storage
Store in the original package at or below 25 °C in a dry place.

### 6.5 Nature and contents of container:
Carton boxes of PVC/PE/PVDC/Al blisters either with or without aluminium sachets containing 14, 28, 30, 50, 56 or 100 tablets.

***ADCO BISOCOR 5 mg***

*a) Immediate container*

Pack sizes: 3, 5 or 10 PVC/PEIPVDC/Al-blisters containing 10 tablets
1, 2 or 4 PVC/PE/PVDC/Al-blisters containing 14 tablets

The tablets are packed into:

1. Carton boxes with 3, 5 or 10 PVC/PE/PVDC/Al-blisters with 10 tablets with or without Al sachets
2. Carton boxes with 1, 2 or 4 PVC/PE/PVDC/Al-blisters with 14 tablets each with or without Al sachets

***ADCO BISOCOR 10 mg***

Pack sizes: 3, 5 or 10 PVC/PE/PVDC/Al-blisters containing 10 tablets
1, 2 or 4 PVC/PE/PVDC/Al-blisters containing 14 tablets

The tablets are packed into:

1. Carton boxes with 3, 5 or 10 PVC/PE/PVDC/Al-blisters with 10 tablets with or without Al sachets.
2. Carton boxes with 1, 2 or 4 PVC/PE/PVDC/Al-blisters with 14 tablets each with or without Al sachets.

Not all pack sizes may be marketed.

### 6.6 Special precautions for disposal and other handling
Any unused product or waste material should be disposed of in accordance with local requirements.

## 7. HOLDER OF THE CERTIFICATE OF REGISTRATION
Adcock Ingram Limited
1 New Road
Erand Gardens

Midrand, 1685
Customer Care: 0860 ADCOCK / 232625

**8. REGISTRATION NUMBER (S):**
**ADCO BISOCOR 5 mg:** 37/5.2/0010
**ADCO BISOCOR 10 mg:** 37/5.2/0011

**9. DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUTHORISATION**
17 September 2004

**10. DATE OF REVISION OF THE TEXT**
11 September 2025

| **Botswana** | | |
|---|---|---|
| | **Product name** | **Registration number** |
| | ADCO BISOCOR 5 mg | BOT1202249A/B/C/D/E/F |
| | ADCO BISOCOR 10 mg | BOT1202248A/B/C/D/E/F |
| **Namibia** | | |
| | ADCO BISOCOR 5 mg | 06/5.2/0014 |
| | ADCO BISOCOR 10 mg | 06/5.2/0015 |