1.3.1.1 PROFESSIONAL INFORMATION FOR MEDICINES FOR HUMAN USE

SCHEDULING STATUS

S4

1. NAME OF THE MEDICINE

ASPEPRAZ 40 mg INJECTION lyophilized powder for solution for infusion/injection

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

ASPEPRAZ 40 mg INJECTION contains esomeprazole sodium equivalent to esomeprazole 40 mg

Sugar free

3. PHARMACEUTICAL FORM

Powder for solution for infusion/injection.

ASPEPRAZ 40 mg INJECTION: White or almost white, uniform, porous cake.

4. CLINICAL PARTICULARS

4.1. Therapeutic indications

ASPEPRAZ 40 mg INJECTION is indicated for:

- Gastro-oesophageal Reflux Disease (GORD) as an alternative to oral therapy and for the shortest possible time.

Gastro-oesophageal reflux disease:

- Treatment of erosive reflux oesophagitis.
- Long-term management of patients with healed oesophagitis to prevent relapse.
- Treatment of severe symptoms of reflux disease.

ASPEPRAZ 40 mg INJECTION is also indicated for the short-term maintenance of haemostasis and prevention of rebleeding in patients who have undergone therapeutic endoscopy for acute bleeding gastric or duodenal ulcers.

4.2. Posology and method of administration

Posology

Adults

Treatment of Gastro-oesophageal Reflux Disease (GORD):

Treatment with ASPEPRAZ 40 mg INJECTION can be given for up to seven days as part of a full treatment period for the specified indications. When oral therapy is possible or appropriate, intravenous therapy should be discontinued and oral therapy should be continued.

Treatment of erosive reflux oesophagitis:

Patients should be given 40 mg once daily. The duration of treatment should be 4 weeks. An additional four weeks treatment is recommended for patients in whom the oesophagitis has not healed or who have persistent symptoms.

Long-term management of patients with healed oesophagitis to prevent relapse and treatment of severe symptoms of reflux disease:

Patients should be given 20 mg once daily.

Maintenance of haemostasis and prevention of rebleeding of gastric or duodenal ulcers:

The treatment will be administered as a 80 mg bolus infusion over 30 minutes followed by a continuous intravenous infusion of 8 mg/hr given over 3 days.

The parenteral treatment period should be followed by acid-suppression therapy with 40 mg esomeprazole orally once daily for 4 weeks.

Special populations

Renal impairment

Dose adjustment is not required in patients with impaired renal function. However, such patients should be treated with caution.

Hepatic impairment

Gastro-oesophageal Reflux Disease (GORD):

Dose adjustment is not required in patients with mild to moderate liver impairment (Child-Pugh class A, B). For patients with severe liver impairment (Child-Pugh class C), a maximum daily dose of 20 mg esomeprazole should not be exceeded.

Bleeding ulcers:

Dose adjustment is not required in patients with mild to moderate liver impairment. For patients with severe liver impairment, following an initial bolus dose of 80 mg/hour may be sufficient to maintain adequate acid control.

Elderly population

Dose adjustment is not required in the elderly.

Paediatric population

ASPEPRAZ 40 mg INJECTION should not be used in children.

Method of administration

For instructions on reconstitution of the medicinal product before administration, see section 6.6.

Injection

40 mg dose:

The reconstituted solution should be given as an intravenous injection over a period of at least 3 minutes (see section 6.6).

20 mg dose:

Half of the reconstituted solution should be given as an intravenous injection over a period of approximately 3 minutes (see section 6.6).

Infusion

40 mg dose:

The reconstituted solution should be given as an intravenous infusion over a period of 10 to 30 minutes (see section 6.6).

20 mg dose:

Half of the reconstituted solution should be given as an intravenous infusion over a period of 10 to 30 minutes (see section 6.6).

Continuous infusion (40 mg vial)

80 mg bolus dose:

The reconstituted solution containing 80 mg esomeprazole should be given as an intravenous infusion over a period of 30 minutes (see section 6.6).

8 mg/hour dose:

The reconstituted solution should be given as a continuous intravenous infusion over a period of 71,5 hours (calculated rate of infusion of 8 mg/hr).

4.3. Contraindications

ASPEPRAZ 40 mg INJECTION is contraindicated:

- In patients with hypersensitivity to esomeprazole, substituted benzimidazoles or to

any of the excipients in ASPEPRAZ 40 mg INJECTION (see section 6.1).

- In children (see section 4.4).
- In concomitant use with nelfinavir and atazanavir (see section 4.5).
- In concomitant use with clopidogrel (see section 4.5).
- Pregnancy and lactation (see section 4.6).

4.4. Warnings and special precautions

In the presence of alarm symptoms

In the presence of any alarm symptom (e.g. significant unintentional weight loss, recurrent vomiting, dysphagia, haematemesis or melaena) and when gastric ulcer is suspected or present, malignancy should be excluded, as treatment with ASPEPRAZ 40 mg INJECTION may alleviate symptoms and delay diagnosis.

Gastrointestinal infections

Treatment with proton pump inhibitors, such as ASPEPRAZ 40 mg INJECTION, may lead to slightly increased risk of gastrointestinal infections such as *Salmonella* and *Campylobacter* and possibly also Clostridium difficile in hospitalised patients.

Increased risk of subclinical acute or chronic interstitial nephritis associated with proton pump inhibitors (PPIs)

There is an increased risk of subclinical acute or chronic interstitial nephritis associated with PPIs such as ASPEPRAZ 40 mg INJECTION, leading to chronic renal inflammation and reduced renal function. The preferred term to describe the histological findings of tubular injury being “tubulointerstitial nephritis”. Acute tubulointerstitial nephritis is characterised by an inflammatory reaction within the tubulointerstitial space of the kidney. Acute interstitial inflammatory reactions are associated with damage to the tubulointerstitium, leading to acute kidney injury. Tubulointerstitial nephritis may be

medicine-related, infectious, systemic, autoimmune, genetic, and idiopathic with the most common cause being related to a medication or drug exposure.
The risk of tubulointerstitial nephritis leading to chronic inflammation and reduced renal function associated with the use of PPIs such as ASPEPRAZ 40 mg INJECTION, is a class effect.

Absorption of vitamin B_{12}

ASPEPRAZ 40 mg INJECTION as with all acid-blocking medicines may reduce the absorption of vitamin B_{12} (cyanocobalamin) due to hypo- or achlorhydria. This should be considered in patients with reduced body stores or risk factors for reduced vitamin B_{12} absorption on long-term therapy (see section 4.5).

Hypomagnesaemia

Severe hypomagnesaemia has been reported in patients treated with proton pump inhibitors (PPIs) like ASPEPRAZ 40 mg INJECTION for at least three months, and in most cases for a year. Serious manifestations of hypomagnesaemia such as fatigue, tetany, delirium, convulsions, dizziness and ventricular dysrhythmia can occur but they may begin insidiously and be overlooked. In most affected patients, hypomagnesaemia improved after magnesium replacement and discontinuation of ASPEPRAZ 40 mg INJECTION. For patients expected to be on prolonged treatment or who take ASPEPRAZ 40 mg INJECTION with digoxin or medicines that may cause hypomagnesaemia (e.g. diuretics), healthcare professionals should consider measuring magnesium levels before starting ASPEPRAZ 40 mg INJECTION treatment and periodically during treatment.

Subacute cutaneous lupus erythematosus (SCLE)

Proton pump inhibitors, such as ASPEPRAZ 40 mg INJECTION are associated with very infrequent cases of SCLE. If lesions occur, especially in sun-exposed areas of the skin, and if accompanied by arthralgia, the patient should seek medical help promptly and the healthcare professional should consider stopping esomeprazole. SCLE after previous treatment with a proton pump inhibitor may increase the risk of SCLE with other proton pump inhibitors.

Risk of fracture

Proton pump inhibitors, such as ASPEPRAZ 40 mg INJECTION, especially if used in high doses and over long durations (> 1 year), may increase the risk of hip, wrist and spine fracture, predominantly in the elderly or in presence of other recognised risk factors. ASPEPRAZ 40 mg INJECTION may increase the overall risk of fracture by 10 to 40 %. Some of this increase may be due to other risk factors. Patients at risk of osteoporosis should receive care according to current clinical guidelines and they should have an adequate intake of vitamin D and calcium.

Combination with other medicines

Co-administration of ASPEPRAZ 40 mg INJECTION with atazanavir and nelfinavir is not recommended (see section 4.3).

Clopidogrel

ASPEPRAZ 40 mg INJECTION is a CYP2C19 inhibitor. When starting or ending treatment with ASPEPRAZ 40 mg INJECTION, the potential for interactions with medicines metabolised through CYP2C19 should be considered. An interaction is observed between clopidogrel and esomeprazole (see section 4.3). The clinical relevance of this interaction is uncertain. As a precaution, concomitant use of

ASPEPRAZ 40 mg INJECTION and clopidogrel should be discouraged.

Clostridium difficile-associated diarrhoea (CDAD)

A diagnosis of CDAD should be considered for patients treated with ASPEPRAZ 40 mg INJECTION with diarrhoea that does not improve. Patients should be advised to seek immediate help from a healthcare professional if they experience watery stools, abdominal pain and fever whilst ASPEPRAZ 40 mg INJECTION is being administered. Patients should receive the lowest dose of ASPEPRAZ 40 mg INJECTION for the shortest duration appropriate to the condition being treated.

Interference with laboratory tests

Increased Chromogranin A (CgA) level may interfere with investigations for neuroendocrine tumours. To avoid this interference, ASPEPRAZ 40 mg INJECTION treatment should be stopped for at least 5 days before CgA measurements. If CgA and gastrin levels have not returned to reference range after initial measurement, measurements should be repeated 14 days after cessation of proton pump inhibitor treatment.

Incompatibilities

The degradation of the reconstituted solution is highly pH dependant and the product must therefore only be reconstituted with 0,9 % sodium chloride for intravenous use according to the instructions given (see sections 4.2 and 6). The reconstituted solution should not be mixed or co-administered in the same infusion set with any other medicine.

Other effects related to acid inhibition

During treatment with ASPEPRAZ 40 mg INJECTION serum gastrin increases, in response to decrease acid secretion. During long-term treatment with ASPEPRAZ 40 mg

INJECTION gastric glandular cysts occur. These changes are a physiological consequence of pronounced inhibition of acid secretion, are benign, and appear to be reversible.

Paediatric population

ASPEPRAZ 40 mg INJECTION should not be used in children.

4.5. Interaction with other medicines and other forms of interaction

Effects of ASPEPRAZ 40 mg INJECTION on the pharmacokinetics of other medicines

Protease inhibitors

Omeprazole has been reported to interact with some protease inhibitors. The clinical importance and the mechanisms behind these reported interactions are not always known. Increased gastric pH during omeprazole treatment may change the absorption of the protease inhibitors. Other possible interaction mechanisms are via inhibition of CYP 2C19.

For atazanavir and nelfinavir, decreased serum levels have been reported when given together with omeprazole and concomitant administration is not recommended. Due to the similar pharmacodynamic effects and pharmacokinetic properties of omeprazole and esomeprazole, concomitant administration with ASPEPRAZ 40 mg INJECTION and atazanavir is not recommended (see section 4.3) and concomitant administration with ASPEPRAZ 40 mg INJECTION and nelfinavir is contraindicated (see section 4.3).

For saquinavir (with concomitant ritonavir), increased serum levels (80 to 100 %) have been reported during concomitant omeprazole treatment (40 mg daily). Treatment with omeprazole 20 mg daily had no effect on the exposure of darunavir (with concomitant ritonavir) and amprenavir (with concomitant ritonavir). Treatment with esomeprazole 20 mg daily had no effect on the exposure of amprenavir (with and without concomitant ritonavir). Treatment with omeprazole 40 mg daily had no effect on the exposure of

lopinavir (with concomitant ritonavir).

Methotrexate

When given together with proton pump inhibitors as contained in ASPEPRAZ 40 mg INJECTION, methotrexate levels have been reported to increase. In high-dose methotrexate administration a temporary withdrawal of ASPEPRAZ 40 mg INJECTION may need to be considered.

Tacrolimus

Concomitant administration of ASPEPRAZ 40 mg INJECTION has been reported to increase the serum levels of tacrolimus. A reinforced monitoring of tacrolimus concentrations as well as renal function (creatinine clearance) should be performed, and dosage of tacrolimus adjusted if needed.

Medicines with pH dependent absorption

Gastric acid suppression during treatment with ASPEPRAZ 40 mg INJECTION and other PPIs might decrease or increase the absorption of medicines with a gastric pH dependent absorption. As with other medicines that decrease intragastric acidity, the absorption of medicines such as ketoconazole, itraconazole and erlotinib can decrease and the absorption of digoxin can increase during treatment with ASPEPRAZ 40 mg INJECTION. Digoxin toxicity has been reported. However, caution should be exercised when ASPEPRAZ 40 mg INJECTION is given at high doses in elderly patients. Therapeutic medicines monitoring of digoxin should then be reinforced.

Medicines metabolised by CYP2C19

ASPEPRAZ 40 mg INJECTION inhibits CYP2C19, the major esomeprazole-metabolising enzyme. Thus, when ASPEPRAZ 40 mg INJECTION is combined with medicines

metabolised by CYP2C19, such as diazepam, citalopram, imipramine, clomipramine, phenytoin etc., the plasma concentrations of these medicines may be increased and a dose reduction could be needed. The effect of ASPEPRAZ 40 mg INJECTION on medicines metabolised by CYP2C19 may be more pronounced during this regimen, and patients should be monitored closely for adverse effects, during the 3 day intravenous treatment period.

Diazepam

Concomitant oral administration of esomeprazole as contained in ASPEPRAZ 40 mg INJECTION resulted in a 45 % decrease in clearance of the CYP2C19 substrate diazepam.

Phenytoin

Concomitant oral administration of 40 mg esomeprazole as contained in ASPEPRAZ 40 mg INJECTION and phenytoin resulted in a 13 % increase in trough plasma levels of phenytoin in epileptic patients. It is recommended to monitor the plasma concentrations of phenytoin when treatment with ASPEPRAZ 40 mg INJECTION is introduced or withdrawn.

Voriconazole

Omeprazole (40 mg once daily) increased voriconazole (a CYP2C19 substrate) concentration.

Cilostazol

Omeprazole as well as esomeprazole as contained in ASPEPRAZ 40 mg INJECTION act as inhibitors of CYP2C19. Omeprazole, given in doses of 40 mg increased the concentration for cilostazol and one of its active metabolites.

Cisapride

In healthy volunteers, concomitant oral administration of 40 mg esomeprazole and cisapride resulted in a 32% increase in area under the plasma concentration-time curve (AUC) and a 31% prolongation of elimination half-life (t1/2), but no significant increase in peak plasma levels of cisapride. The slightly prolonged QTc interval observed after administration of cisapride alone, was not further prolonged when cisapride was given in combination with esomeprazole.

Warfarin

Elevated INR of clinical significance have been reported during concomitant treatment with esomeprazole as contained in ASPEPRAZ 40 mg INJECTION. Monitoring is recommended when initiating and ending concomitant ASPEPRAZ 40 mg INJECTION treatment during treatment with warfarin or other coumarin derivatives.

Clopidogrel

A pharmacokinetic (PK)/ pharmacodynamic (PD) interaction between clopidogrel and esomeprazole as contained in ASPEPRAZ 40 mg INJECTION has been shown. This results in decreased exposure to the active metabolite of clopidogrel by an average of 40 % and resulting in decreased maximum inhibition of (ADP induced) platelet aggregation by an average of 14 %. As a precaution concomitant use of clopidogrel should be discouraged (see section 4.3).

Investigated medicines with no clinically relevant interaction

Amoxicillin or quinidine

ASPEPRAZ 40 mg INJECTION has been shown to have no clinically relevant effects on the pharmacokinetics of amoxicillin or quinidine.

Naproxen or rofecoxib

Studies evaluating concomitant administration of esomeprazole and either naproxen or rofecoxib did not identify any clinically relevant pharmacokinetic interactions during short-term studies.

Effects of other medicines on the pharmacokinetics of ASPEPRAZ 40 mg INJECTION

Medicines which inhibit CYP2C19 and/or CYP3A4

Esomeprazole is metabolised by CYP2C19 and CYP3A4. Concomitant oral administration of esomeprazole as contained in ASPEPRAZ 40 mg INJECTION and a CYP3A4 inhibitor, clarithromycin (500 mg twice daily), resulted in a doubling of the exposure (AUC) to esomeprazole. Concomitant administration of esomeprazole and a combined inhibitor of CYP2C19 and CYP 3A4 may result in more than doubling of the esomeprazole exposure. The CYP2C19 and CYP3A4 inhibitor voriconazole increased omeprazole AUC. A dose adjustment of ASPEPRAZ 40 mg INJECTION is not regularly required in either of these situations. However, dose adjustment should be considered in patients with severe hepatic impairment and if long-term treatment is indicated.

Medicines which induce CYP2C19 and/or CYP3A4

Medicines known to induce CYP2C19 or CYP3A4 or both (such as rifampicin and St. John's wort) may lead to decreased esomeprazole serum levels by increasing the esomeprazole metabolism.

4.6. Fertility, pregnancy and lactation

Pregnancy

Safety in pregnancy and lactation has not been established (see section 4.3).

4.7. Effects on ability to drive and use machines

ASPEPRAZ 40 mg INJECTION will be administered in a hospital setting. Since adverse reactions such as blurred vision and dizziness have been reported in patients receiving ASPEPRAZ 40 mg INJECTION, patients should not drive, use machinery or perform any tasks that require concentration, until they are certain that ASPEPRAZ 40 mg INJECTION does not adversely affect their ability to do so (see section 4.8).

4.8. Undesirable effects

a) Summary of the safety profile

Headache, abdominal pain, diarrhoea and nausea are among those adverse reactions that have been most commonly reported in clinical trials (and also from post-marketing use). In addition, the safety profile is similar for different formulations, treatment indications, age groups and patient populations. No dose-related adverse reactions have been identified.

b) Tabulated list of adverse reactions

System organ class	Frequent	Less frequent	Frequency unknown (cannot be estimated from the available data)
Blood and the lymphatic system disorders		Leukopenia, thrombocytopenia, agranulocytosis, pancytopenia	
Immune system disorders		Hypersensitivity reactions e.g. angioedema and anaphylactic reaction or shock	
Metabolism and nutrition disorders		Peripheral oedema and hyponatraemia, hypomagnesaemia (severe hypomagnesaemia can correlate with hypocalcaemia), hypomagnesaemia may also be associated with hypokalaemia.	
Psychiatric disorders		Insomnia, agitation, confusion, depression, aggression, hallucinations	

Nervous system disorders	Headache	Dizziness, paraesthesia, somnolence, taste disturbance	
Eye disorders		Blurred vision, eye disorders	
Ear and labyrinth disorders		Vertigo, tinnitus	
Cardiac disorders			Angina, tachycardia, bradycardia
Respiratory, thoracic and mediastinal disorders		Bronchospasm, coughing	
Gastrointestinal disorders	Abdominal pain, diarrhoea, flatulence, nausea, vomiting, constipation, fundic gland polyps (benign)	Dry mouth, stomatitis, gastrointestinal candidiasis, microscopic colitis, Clostridium difficile-associated diarrhea, pancreatitis	
Hepatobiliary disorders		Increased liver enzymes, hepatitis with or without jaundice, hepatic failure and hepatic encephalopathy	
Skin and subcutaneous tissue disorders		Dermatitis, pruritus, urticaria, rash, alopecia, photosensitivity, erythema multiforme, Stevens-Johnson syndrome and toxic epidermal necrolysis (TEN)	Subacute cutaneous lupus erythematosus (see section 4.4)
Musculoskeletal and connective tissue disorders		Arthralgia, myalgia, muscular weakness, fracture of the hip, wrists or spine, back pain	
Renal and urinary disorders		Interstitial nephritis (may lead to renal failure), renal failure, urinary disorders	
Reproductive system and breast disorders		Gynaecomastia, impotence	
General disorders and administrative site conditions		Malaise, hyperhidrosis, administration site reactions, fatigue	

* Administration site reactions have mainly observed in a study with high-dose exposure over 3 days (72 hours) (see section 5.3).

c) Description of selected adverse reactions

Irreversible visual impairment has been reported in isolated cases of critically ill patients who have received omeprazole (the racemate) intravenous injection, especially at high

doses, but no causal relationship has been established.

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.

Aspen Pharmacare:

E-mail: Drugsafety@aspenpharma.com

Tel: 0800 118 088

4.9. Overdose

Symptoms

Symptoms of overdose include drowsiness, headache and tachycardia.

Treatment

No specific antidote is known. Esomeprazole is extensively bound to plasma protein and is therefore not readily dialyzable. Treatment of overdosage should be symptomatic and supportive.

5. PHARMACOLOGICAL PROPERTIES

5.1. Pharmacodynamic properties

Category and Class: A 11.4.3 Medicines acting on the gastrointestinal tract. Other.

Pharmacotherapeutic group: Drugs for peptic ulcer and gastro-oesophageal reflux desease (GORD). Proton pump inhibitors. ATC code: A02BC05

Mechanism of action

Esomeprazole is the S-isomer of the proton pump inhibitor omeprazole. It reduces gastric acid secretion through inhibition of the enzyme H^+K^+-ATPase (hydrogen/potassium adenosine triphosphatase), the acid pump in the parietal cell, where it is concentrated and converted to the active form in the acidic environment of the secretory canaliculi. This effect on the final step of gastric acid secretion is dose-dependant and inhibits both basal and stimulated acid secretion. Esomeprazole is administered intravenously as the sodium salt.

5.2. Pharmacokinetic properties

Distribution

The apparent volume of distribution at steady state in healthy individuals is approximately 0,22 L/kg of body weight.

Plasma protein binding

Esomeprazole is about 97 % bound to plasma protein.

Metabolism

Esomeprazole is extensively metabolised in the liver by the cytochrome P450 isoenzyme CYP2C19 (responsible for the major part of metabolism) to hydroxy- and desmethyl metabolites. These metabolites have no effect on gastric acid secretion. The remainder is metabolised by the cytochrome P450 isoenzyme CYP3A4 to esomeprazole sulfone, the main metabolite found in plasma.

Elimination

The parameters below reflect mainly the pharmacokinetics in individuals with a functional CYP2C19 enzyme, i.e. extensive metabolisers. Total plasma clearance is about 17 litres/hour after a single dose and about 9 L/hour after repeated administration. The plasma elimination half-life is about 1,3 hours after repeated once-daily dosing. The area under the plasma concentration-time curve increases in a non-linear fashion with repeated administration of esomeprazole. Esomeprazole is completely eliminated from plasma between doses, with no tendency for accumulation during once-daily administration. The major metabolites of esomeprazole have no effect on gastric secretion. Less than 1 % of the parent compound is found in urine.

Special Populations

Elderly patients

The metabolism of esomeprazole is not significantly changed in elderly subjects (71 to 80 years of age). Following a single oral dose of esomeprazole 40 mg, the mean area under the plasma concentration-time curve is approximately 30 % higher in females than in males. No gender difference is seen after repeated once-daily administration. Similar differences have been seen for IV administration of esomeprazole. These findings have no implications for the dosage of esomeprazole.

Impaired renal function

No studies have been performed in patients with decreased renal function. Since the kidney is responsible for the excretion of the metabolites of esomeprazole but not for the elimination of the parent compound, the metabolism of esomeprazole is not expected to be changed in patients with impaired renal function.

Impaired hepatic function

In patients with severe liver impairment (Child-Pugh C) there is a doubling of the area under the plasma concentration-time curve of esomeprazole. A maximum of 20 mg

should not be exceeded in GORD (Gastro-oesophageal Reflux Disease) patients with severe impairment.

6. PHARMACEUTICAL PARTICULARS

6.1. List of excipients

Disodium edetate.

6.2. Incompatibilities

This medicinal product must not be mixed with other medicinal products except those mentioned in section 6.6.

6.3. Shelf life

24 months

6.4. Special precautions for storage

Store at or below 25 °C protected from light and moisture. Keep in original packaging until required for use.

For reconstituted and diluted solution:

Physical and chemical stability for the reconstituted solution has been proven for 12 hours at 25 °C. From a microbiological point of view, the product should be used immediately. If not used immediately, in-use storage times and conditions prior to use are the responsibility of the user and would normally not be longer than 24 hours at 2 °C to 8 °C, unless reconstitution/dilution has taken place in controlled and validated aseptic conditions.

For single use only. Discard any unused portion.

6.5. Nature and contents of container

ASPEPRAZ 40 mg INJECTION is packaged in a Ph.Eur type 1 15 ml clear glass vial, with an opaque gray Ph.Eur type 1 20 mm chlorobutyl stopper and an aluminium flip-off cap with a dark blue plastic cover.

10 vials are packed in a printed carton together with a leaflet.

6.6. Special precautions for disposal and other handling

ASPEPRAZ 40 mg INJECTION reconstituted solution is a clear solution free from particulate matter.

The reconstituted solution should be inspected visually for particulate matter and discoloration prior to administration. Only clear solution should be used. For single use only.

If the entire reconstituted content of the vial is not required, any unused solution should be disposed of in accordance with local requirements.

Injection (40 mg vial):

A solution for injection is prepared by adding 5 ml of 0,9 % sodium chloride (for intravenous use) to the vial.

Infusion (40 mg vial):

A solution for infusion is prepared by dissolving the contents of one vial in up to 100 ml 0,9 % sodium chloride (for intravenous use).

Continuous infusion (40 mg vial):

A solution for infusion is prepared by dissolving the contents of two vials of esomeprazole 40 mg in up to 100 ml of 0,9 % sodium chloride (for intravenous use).

7. HOLDER OF CERTIFICATE OF REGISTRATION

PHARMACARE LIMITED

Healthcare Park

Woodlands Drive

Woodmead 2191

8. REGISTRATION NUMBER

46/11.4.3/0079

9. DATE OF FIRST AUTHORISATION

25 November 2016

10. DATE OF REVISION OF TEXT

15 November 2024

Die Afrikaanse Professionele Inligting is op versoek beskikbaar.

Mediese Blitslyn: 0800 118 088.

ZA_ASPEINJ_2411_00