Professional information

SCHEDULING STATUS

S4

1. NAME OF THE MEDICINE

BAXIMO 25 mg powder for concentrate for solution for infusion

BAXIMO 100 mg powder for concentrate for solution for infusion

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

BAXIMO 25 mg: One vial contains bendamustine hydrochloride monohydrate equivalent to 25 mg bendamustine hydrochloride.

Contains sugar (40 mg mannitol per vial).

BAXIMO 100 mg: One vial contains bendamustine hydrochloride monohydrate equivalent to 100 mg bendamustine hydrochloride.

Contains sugar (160 mg mannitol per vial).

1 mL of the concentrate contains 2,5 mg bendamustine hydrochloride when reconstituted.

For the full list of excipients, see section 6.1.

3. PHARMACEUTICAL FORM

BAXIMO 25 mg or 100 mg powder for concentrate for solution for infusion.

White to off-white freeze-dried powder (microcrystalline lyophilizate).

4. CLINICAL PARTICULARS

4.1 Therapeutic indications

- First-line treatment of chronic lymphocytic leukaemia (Binet stage B or C) in patients for whom fludarabine combination chemotherapy is not appropriate.
- First-line treatment of indolent CD 20 positive non-Hodgkin's lymphoma in combination with rituximab.
- Indolent non-Hodgkin's lymphoma as monotherapy in patients who have progressed during or within 6 months following treatment with rituximab or a rituximab-containing regimen.
- Front line treatment of multiple myeloma (Durie-Salmon stage II with progress or stage III) in combination with prednisone for patients older than 65 years who are not eligible for autologous stem cell transplantation and who have clinical neuropathy at time of diagnosis precluding the use of thalidomide or bortezomib-containing treatment.

4.2 Posology and method of administration

Posology:

Monotherapy for chronic lymphocytic leukaemia

100 mg/m² body surface area **BAXIMO** on days 1 and 2; every 4 weeks.

Combination treatment for first-line indolent non-Hodgkin's lymphoma

90 mg/m2 body surface area **BAXIMO** on days 1 and 2 in combination with 375 mg/m2 body surface area rituximab as a slow intravenous infusion on day 1 every 4 weeks.

Monotherapy for indolent non-Hodgkin's lymphoma refractory to rituximab

120 mg/m² body surface area **BAXIMO** on days 1 and 2 every 3 weeks.

Multiple myeloma

120 – 150 mg/m² body surface area **BAXIMO** on days 1 and 2, 60 mg/m² body surface area prednisone intravenous or orally on days 1 to 4; every 4 weeks.

Hepatic impairment

On the basis of pharmacokinetic data, no dose adjustment is necessary in patients with mild hepatic impairment [serum bilirubin < 34,2 µmol/L (2,0 mg/dL)].

A 30 % dose reduction is recommended in patients with moderate hepatic impairment [serum bilirubin 34,2 µmol/L – 51,3 µmol/L (2 – 3,0 mg/dL)].

No data is available in patients with severe hepatic impairment [serum bilirubin values of > 51,3 µmol/L (3,0mg/dL)]. See section 4.3.

Renal impairment

On the basis of pharmacokinetic data, no dose adjustment is necessary in patients with a creatinine clearance of > 10 mL/min. Experience in patients with severe renal impairment is limited.

Paediatric patients

There is no experience in children and adolescents with **BAXIMO**.

Elderly patients

There is no evidence that dose adjustments are necessary in elderly patients (see section 5.2).

Method of administration:

For intravenous infusion over 30 – 60 minutes.

Infusion must be administered under the supervision of a medical practitioner qualified and experienced in the use of chemotherapeutic medicines.

Poor bone marrow function is related to increased chemotherapy-induced haematological toxicity. Treatment should not be started if leukocyte and/or platelet values dropped to < 3 x 10^9/L or < 75 x 10^9/L, respectively (see section 4.3).

Treatment should be terminated or delayed if leukocyte and/or platelet values dropped to ≤ 3 x 10^9/L or ≤ 75 x 10^9/L, respectively. Treatment can be continued after leukocyte values have increased to > 4 x 10^9/L and platelet values to > 100 x 10^9/L.

The leukocyte and platelet nadir is reached after 14 – 20 days with regeneration after 3 – 5 weeks. During therapy-free intervals strict monitoring of the blood count is recommended (see section 4.4).

In case of non-haematological toxicity dose reductions have to be based on the worst CTC (common toxicity criteria) grades in the preceding cycle. A 50 % dose reduction is recommended in case of CTC grade 3 toxicity. An interruption of treatment is recommended in case of CTC grade 4 toxicity.
If a patient requires a dose modification, the individually calculated reduced dose must be given on day 1 and 2 of the respective treatment cycle.

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

4.3 Contraindications

- Hypersensitivity to bendamustine hydrochloride or to any of the excipients in **BAXIMO** (see section 6.1).
- Pregnancy and lactation (see section 4.6).
- Severe hepatic impairment [serum bilirubin > 34,2 µmol/L (2,0 mg/dL)].
- Jaundice.

- Severe bone marrow suppression and severe blood count alterations (leukocyte and/or platelet values dropped to < 3 x 10^9/L or < 75 x10^9/L, respectively).
- Major surgery less than 30 days before start of treatment.
- Infections, especially involving leukocytopenia.
- Yellow fever vaccination or any other live (attenuated) vaccination.
- Congenital QT prolongation.
- Concomitant medicines causing QT prolongation (see section 4.5).

4.4 Special warnings and precautions for use

Myelosuppression

Patients treated with bendamustine hydrochloride as in **BAXIMO** may experience myelosuppression. In the event of treatment-related myelosuppression, leukocytes, platelets, haemoglobin, and neutrophils must be monitored at least weekly. Prior to the initiation of the next cycle of therapy, the following parameters are recommended: Leukocyte and/or platelet values > 4 x 10^9/L or > 100 x 10^9/L, respectively.

Infections

Serious and fatal infections have occurred with bendamustine hydrochloride, including bacterial (sepsis, pneumonia) and opportunistic infections such as Pneumocystis jirovecii pneumonia (PJP), varicella zoster virus (VZV) and cytomegalovirus (CMV). **BAXIMO** may cause prolonged lymphocytopenia (< 600/µL) and low CD4-positive T-cell (T-helper cell) counts (< 200/µL) for at least 7 – 9 months after the completion of treatment.

Lymphocytopenia and CD4-positive T-cell depletion are more pronounced when **BAXIMO** is combined with rituximab.

Patients with lymphopenia and low CD4-positive T-cell count following treatment with **BAXIMO** are more susceptible to (opportunistic) infections, including tuberculosis. In case of low CD4-positive T-cell counts (< 200/µL). Pneumocystis jirovecii pneumonia (PJP) prophylaxis should be considered. All patients should

be monitored for respiratory signs and symptoms throughout treatment. Patients should be advised to report new signs of infection, including fever or respiratory symptoms promptly. Discontinuation of **BAXIMO** should be considered if there are signs of (opportunistic) infections.

Infection, including pneumonia and sepsis, has been reported. Infection has been associated with hospitalisation, septic shock and death. Patients with neutropenia and/or lymphopenia following treatment with **BAXIMO** are more susceptible to infections, including tuberculosis. Patients with myelosuppression following **BAXIMO** treatment should be advised to contact a medical practitioner if they have symptoms or signs of infection, including fever or respiratory symptoms. The presence of tuberculosis should be excluded before treatment with **BAXIMO** is commenced.

Hepatitis B reactivation

Reactivation of hepatitis B in patients who are chronic carriers of this virus may occur after patients received bendamustine hydrochloride, as in **BAXIMO**. Some cases resulted in acute hepatic failure or a fatal outcome. Patients should be tested for HBV infection before initiating treatment with **BAXIMO**. Experts in liver disease and in the treatment of hepatitis B should be consulted before treatment is initiated in patients with positive hepatitis B tests (including those with active disease) and for patients who test positive for HBV infection during treatment. Carriers of HBV who require treatment with **BAXIMO** should be closely monitored for signs and symptoms of active HBV infection throughout therapy and for several months following termination of therapy (see section 4.8).

Skin reactions

A number of skin reactions have been reported. These events have included rash, severe cutaneous reactions and bullous exanthema. Cases of Stevens-Johnson syndrome (SJS) and toxic epidermal necrolysis (TEN) and drug reaction with eosinophilia and systemic symptoms (DRESS), some fatal, have been reported with the use of **BAXIMO**. Patients should be advised of the signs and symptoms of these reactions by their medical practitioner and should be told to seek medical attention immediately if they develop these

symptoms. Some events occurred when **BAXIMO** was given in combination with other anticancer medicines, so the precise relationship is uncertain. When skin reactions occur, they may be progressive and increase in severity with further treatment. If skin reactions are progressive, **BAXIMO** should be withheld or discontinued. For severe skin reactions with suspected relationship to **BAXIMO**, treatment should be discontinued.

Cardiac disorders

During treatment with **BAXIMO** the concentration of potassium in the blood of patients with cardiac disorders must be closely monitored and potassium supplement must be given when K+ < 3,5 mEq/L and ECG measurement must be performed.

Fatal cases of myocardial infarction and cardiac failure have been reported with bendamustine hydrochloride treatment. Patients with concurrent or history of cardiac disease should be observed closely.

Nausea and vomiting

An antiemetic may be given for the symptomatic treatment of nausea and vomiting.

Tumour lysis syndrome

Tumour lysis syndrome (TLS) associated with **BAXIMO** treatment has been reported. The onset tends to be within 48 hours of the first dose of **BAXIMO** and, without intervention, may lead to acute renal failure and death. Preventative measures include adequate fluid volume status and close monitoring of blood chemistry, particularly potassium and uric acid levels. The use of hypouricaemic medicines (allopurinol and rasburicase) during the first one to two weeks of **BAXIMO** therapy can be considered. However, there have been cases of Stevens-Johnson syndrome and toxic epidermal necrolysis reported when bendamustine, as in **BAXIMO**, and allopurinol were administered concomitantly.

Anaphylaxis

Infusion reactions to bendamustine hydrochloride, as in **BAXIMO**, have occurred. Symptoms include fever, chills, pruritus and rash. Severe anaphylactic and anaphylactoid reactions have occurred. Patients must be asked about symptoms suggestive of infusion reactions after their first cycle of therapy. Measures to prevent severe reactions, including antihistamines, antipyretics and corticosteroids must be considered in subsequent cycles in patients who have previously experienced infusion reactions.

In patients who experienced grade 3 or worse allergic-type reactions, **BAXIMO** should be discontinued.

Contraception

Bendamustine hydrochloride, as in **BAXIMO**, is teratogenic and mutagenic.

Women should not become pregnant during treatment. Women of childbearing potential must use effective contraception to avoid pregnancy while they are receiving **BAXIMO**. The recommended duration of contraception in female patients of childbearing potential is until the end of the relevant systemic exposure to **BAXIMO** including potential metabolites (i.e.: five half-life's after the last dose) plus 6 months. On this basis, female patients of childbearing potential should be advised to use effective contraception during treatment with **BAXIMO** and for at least 6 months after the final dose.

Male patients should not father a child during treatment and should be advised on the use of effective contraception to avoid conception. The recommended duration of contraception in male patients is until the end of the relevant systemic exposure to **BAXIMO** including potential metabolites (i.e.: five half-life's after the last dose) plus 3 months. On this basis male patients should be advised on the use of effective contraception during treatment with **BAXIMO** and for at least 3 months after the final dose (see section 4.6). They should seek advice about sperm conservation prior to treatment with bendamustine hydrochloride, as in **BAXIMO**, because of possible irreversible infertility.

Extravasation

An extravasal injection should be stopped immediately. The needle should be removed after a short aspiration. Thereafter the affected area of tissue should be cooled. The arm should be elevated. Additional treatments like the use of corticosteroids are not of clear benefit.

There have been reports of necrosis after accidental extravascular administration and toxic epidermal necrosis, tumour lysis syndrome and anaphylaxis. There have been reports of secondary tumours, including myelodysplastic syndrome, myeloproliferative disorders, acute myeloid leukaemia and bronchial carcinoma.

4.5 Interaction with other medicines and other forms of interaction

No in-vivo interaction studies have been performed.

When **BAXIMO** is combined with myelosuppressive medicines, the effect of **BAXIMO** and/or the co-administered medicines on the bone marrow may be potentiated. Any treatment reducing the patient's performance status or impairing bone marrow function can increase the toxicity of **BAXIMO**.

Combination of **BAXIMO** with ciclosporin or tacrolimus may result in excessive immunosuppression with risk of lymphoproliferation.

Cytostatics can reduce antibody formation following live-virus vaccination and increase the risk of infection which may lead to fatal outcome. This risk is increased in subjects who are already immunosuppressed by their underlying disease.

BAXIMO metabolism involves cytochrome P450 (CYP) 1A2 isoenzyme (see section 5.2). Therefore, the potential for interaction with CYP1A2 inhibitors such as fluvoxamine, ciprofloxacin, aciclovir and cimetidine exists.

4.6 Fertility, pregnancy and lactation

Pregnancy

There are insufficient data from the use of **BAXIMO** in pregnant women. In nonclinical studies **BAXIMO** was embryo-/fetolethal, teratogenic and genotoxic. Therefore, **BAXIMO** is contraindicated during pregnancy (see section 4.3).

Women of childbearing potential

Women of childbearing potential must use effective methods of contraception to avoid pregnancy while they are receiving **BAXIMO**, and for at least 6 months following completion of treatment (i.e.: after the final dose).

Male Fertility

BAXIMO can have genotoxic effects. Men being treated with **BAXIMO** are advised not to father a child during and for up to 3 months following cessation of treatment (i.e.: after the final dose). Advice on conservation of sperm should be sought prior to treatment because of the possibility of irreversible infertility due to therapy with **BAXIMO**.

Breastfeeding

It is not known whether **BAXIMO** passes into human breast milk, therefore, **BAXIMO** is contraindicated during breastfeeding (see section 4.3). Breastfeeding must be discontinued during treatment with **BAXIMO**.

4.7 Effects on ability to drive and use machines

BAXIMO has a major influence on the ability to drive a vehicle and use machines. Ataxia, peripheral neuropathy and somnolence have been reported during treatment with **BAXIMO** (see section 4.8). Patients should be instructed that if they experience these symptoms they should avoid potentially hazardous tasks such as driving and using machines.

4.8 Undesirable effects

MedDRA System Organ Class	Frequency and description
Infections and infestations	*Frequent:* infection (not otherwise specified), including opportunistic infection (e.g. Herpes zoster, cytomegalovirus, hepatitis B) *Less frequent: Pneumocystis jirovecii* pneumonia, sepsis, primary atypical pneumonia, tuberculosis
Neoplasms benign, malignant and unspecified (including cysts and polyps)	*Frequent:* tumour lysis syndrome *Less frequent:* myelodysplastic syndrome, acute myeloid leukaemia
Blood and lymphatic system disorders	*Frequent:* leukopenia (not otherwise specified), thrombocytopenia, lymphopenia, haemorrhage, anaemia, neutropenia *Less frequent:* pancytopenia, bone marrow failure, haemolysis
Immune system disorders	*Frequent:* hypersensitivity (not otherwise specified) *Less frequency*: anaphylactic reaction, anaphylactoid reaction, anaphylactic shock
Nervous system disorders	*Frequent:* headache, insomnia, dizziness *Less frequent:* somnolence, aphonia, dysgeusia, paraesthesia, peripheral sensory neuropathy, anticholinergic syndrome, neurological disorders, ataxia, encephalitis

Cardiac disorders	*Frequent:* cardiac dysfunction, such as palpitations, angina pectoris, dysrhythmia, QT prolongation *Less frequent:* pericardial effusion, myocardial infarction, cardiac failure, tachycardia *Frequency unknown:* atrial fibrillation
Vascular disorders	*Frequency:* hypotension, hypertension *Less frequent:* acute circulatory failure, phlebitis
Respiratory, thoracic and mediastinal disorders	*Frequent:* pulmonary dysfunction *Less frequent:* pulmonary fibrosis *Frequency unknown:* pneumonitis, pulmonary alveolar haemorrhage
Gastrointestinal disorders	*Frequent:* nausea, vomiting, diarrhoea, constipation, stomatitis *Less frequent*: haemorrhagic oesophagitis, gastrointestinal haemorrhage
Hepatobiliary disorders	*Less frequent:* hepatic failure
Skin and subcutaneous tissue disorders	*Frequent:* alopecia, skin disorders (not otherwise specified), urticaria *Less frequent:* erythema, dermatitis, pruritus, maculopapular rash, hyperhidrosis *Frequency unknown:* Stevens-Johnson syndrome, toxic epidermal necrolysis (TEN), drug reaction with eosinophilia and systemic symptoms (DRESS) (combination therapy with rituximab)
Renal and urinary disorders	*Frequency unknown:* renal failure

Reproductive system and breast disorders	*Frequent:* amenorrhoea *Less frequent:* infertility
General disorders and administration site conditions	*Frequent:* mucosal inflammation, fatigue, pyrexia, pain, chills, dehydration, anorexia *Less frequent:* multi-organ failure
Investigations	*Frequent:* decreased: haemoglobin; increased: creatinine, urea, AST, ALT, alkaline phosphatase, bilirubin, hypokalemia

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 asked to report any suspected adverse reactions to SAHPRA via the Med Safety APP (Medsafety X SAHPRA) and eReporting platform (who-umc.org) found on the SAHPRA website

4.9 Overdose

After application of a 30 minute infusion of **BAXIMO** once every 3 weeks the maximum tolerated dose (MTD) was 280 mg/m². Cardiac events of CTC grade 2 which were compatible with ischaemic ECG changes occurred, which were regarded as dose limiting.

In a subsequent study with a 30 minute infusion of bendamustine hydrochloride at day 1 and 2 every 3 weeks the MTD was found to be 180 mg/m^2. The dose limiting toxicity was grade 4 thrombocytopenia. Cardiac toxicity was not dose limiting with this schedule.

There is no specific antidote. Bone marrow transplantation and transfusions (platelets, concentrated erythrocytes) may be made or haematological growth factors may be given as effective counter measures to control haematological side effects.

Bendamustine hydrochloride, as in **BAXIMO**, and its metabolites are dialysable to a small extent.

5. PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Category and class: A 26 Cytostatic agents

Bendamustine hydrochloride is an alkylating antitumour medicine. The antineoplastic and cytocidal effect of bendamustine hydrochloride is based essentially on a cross-linking of deoxyribonucleic acid (DNA) single and double strands by alkylation. As a result, DNA matrix functions and DNA synthesis and repair are impaired.

The antitumour effect of bendamustine hydrochloride has been demonstrated by several in vitro studies in different human tumour cell lines (breast cancer, non-small cell and small cell lung cancer, ovarian carcinoma and various leukaemias) and in vivo in different experimental tumour models with tumours of animal and human origin (melanoma, breast cancer, sarcoma, lymphoma, leukaemia and small cell lung cancer).

Bendamustine revealed no, or very low, cross-resistance in human tumour cell lines with different resistance mechanisms at least in part due to a comparatively persistent DNA interaction. Additionally, it was shown in clinical studies that there is no complete cross-resistance of bendamustine with anthracyclines, alkylating medicines or rituximab. However, the number of assessed patients is small.

5.2 Pharmacokinetic properties

Distribution

The elimination half-life t1/2β after 30 minutes intravenous (IV) infusion of 120 mg/m^2 area to 12 subjects was 28,2 minutes. Following 30 minutes IV infusion the central volume of distribution was 19,3 L. Under steady-state conditions following IV bolus injection the volume of distribution was 15,8 – 20,5 L.

More than 95 % of the substance is bound to plasma proteins (primarily albumin).

Biotransformation

A major route of clearance of bendamustine is the hydrolysis to monohydroxy- and dihydroxy-bendamustine. Formation of N-desmethyl-bendamustine and gamma-hydroxy-bendamustine by hepatic metabolism involves cytochrome P450 (CYP) 1A2 isoenzyme.

Another major route of clearance of bendamustine metabolism involves conjugation with glutathione.

In-vitro bendamustine does not inhibit CYP1A4, CYP2C9/10, CYP2D6, CYP2E1 and CYP3A4.

Elimination

The mean total clearance after a 30-minute IV infusion of 120 mg/m^2 body surface area to 12 subjects was 639,4 mL/minute. Approximately 20 % of the administered dose was recovered in urine within 24 hours. Amounts excreted in urine were in the order monohydroxy-bendamustine > bendamustine > dihydroxy-bendamustine > oxidised metabolite > N-desmethyl-bendamustine. Polar metabolites are primarily eliminated in the bile.

Special populations

- *Hepatic impairment*

  In patients with 30 to 70 % tumour infiltration of the liver, and mild or moderate hepatic impairment [serum bilirubin < 34,2 µmol/L (2,0 mg/dL)] the pharmacokinetic behaviour was not changed.

  There was no significant difference to patients with normal liver and kidney function with respect to Cmax, tmax, area under the curve (AUC), t1/2β, volume of distribution and clearance. AUC and total body clearance of bendamustine correlate inversely with serum bilirubin.

- *Renal impairment*

  In patients with a creatinine clearance > 10 mL/min, including dialysis- dependent patients, no significant difference to patients with normal liver and kidney function was observed with respect to Cmax, tmax, AUC, t1/2β, volume of distribution and clearance.

- *Elderly patients*

  Patients up to 84 years of age were studied. Higher age does not influence the pharmacokinetics of bendamustine.

6. PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Mannitol

6.2 Incompatibilities

BAXIMO must not be mixed with other medicines, except those mentioned in section 6.6.

6.3 Shelf life

Dry Powder:

- 3 years.

Reconstituted and infusion solutions:

- The powder should be reconstituted immediately after opening of the vial. The reconstituted concentrate should be diluted immediately with 0,9 % sodium chloride solution. After reconstitution and dilution, chemical and physical stability has been demonstrated for 3,5 hours at 25 °C and 2 days at 2 – 8 °C in polyethylene bags.
- From a microbiological point of view, **BAXIMO** 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 – 8 °C, unless reconstitution/dilution has taken place in controlled and validated aseptic conditions.

6.4 Special precautions for storage

Dry Powder:

- Store at or below 30 °C.
- Keep the vial in the outer carton in order to protect from light.

Reconstituted and infusion solutions:

- See section 6.3.
- Discard any unused portion.

6.5 Nature and contents of container

BAXIMO 25 mg: 25 mL amber type I glass vial with a bromobutyl rubber stopper and an aluminium cap with a flip-top.

Pack size: 1 or 5 vials per outer carton.

BAXIMO 100 mg: 50 mL amber type I glass vial with a bromobutyl rubber stopper and an aluminum cap with a flip-top.

Pack size: 1 or 5 vials per outer carton

Not all pack sizes may be marketed

6.6 Special precautions for disposal and other handling

When handling **BAXIMO**, inhalation, skin contact or contact with mucous membranes should be avoided (wear gloves and protective clothes). Contaminated body parts should be carefully rinsed with water and soap, the eyes should be rinsed with physiological saline solution. If possible it is recommended to work on special safety workbenches (laminar flow) with liquid-impermeable, absorbent disposable foil. Pregnant personnel should be excluded from handling cytostatics.

The powder for concentrate for solution for infusion has to be reconstituted with water for injection, diluted with sodium chloride 9 mg/mL (0,9 %) solution for injection and then administered by intravenous infusion. Aseptic technique is to be used.

1. Reconstitution

Reconstitute each vial of **BAXIMO** containing 25 mg bendamustine hydrochloride in 10 mL water for injection by shaking.

Reconstitute each vial of **BAXIMO** containing 100 mg bendamustine hydrochloride in 40 mL water for injection by shaking.

The reconstituted concentrate contains 2,5 mg bendamustine hydrochloride per mL and appears as a clear colourless solution.

2. Dilution

As soon as a clear solution is obtained (usually after 5 – 10 minutes) dilute the total recommended dose of **BAXIMO** immediately with 0,9 % NaCl solution to produce a final volume of about 500 mL.

BAXIMO must be diluted with 0,9 % NaCl solution only and not with any other injectable solution.

3. Administration

The solution is administered by intravenous infusion over 30 – 60 minutes.

The vials are for single use only.

Any unused product or waste material should be disposed of in accordance with local requirements.

7. HOLDER OF CERTIFICATE OF REGISTRATION

Adcock Ingram Limited,

1 New Road,

Erand Gardens,

Midrand,

1685

Customer Care: 0860 ADCOCK / 232625

8. REGISTRATION NUMBER

BAXIMO 25 mg: 53/26/0304

BAXIMO 100 mg: 53/26/0305

9. DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUTHORISATION

18 August 2020

10. DATE OF REVISION OF THE TEXT

05 June 2025