APPROVED PROFESSIONAL INFORMATION

SCHEDULING STATUS

S3

1. NAME OF THE MEDICINE

DYNACAZ 30 mg MR modified release tablets

DYNACAZ 60 mg MR modified release tablets

DYNACAZ 90 mg MR modified release tablets

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

DYNACAZ 30 mg MR: Each modified release tablet contains 30 mg gliclazide.

Each 30 mg tablet contains sugar (73,50 mg lactose monohydrate).

DYNACAZ 60 mg MR: Each modified release tablet contains 60 mg gliclazide.

Each 60 mg tablet contains sugar (93,40 mg lactose monohydrate).

DYNACAZ 90 mg MR: Each modified release tablet contains 90 mg gliclazide.

Each 90 mg tablet contains sugar (140,10 mg lactose monohydrate).

For the full list of excipients, see section 6.1

3. PHARMACEUTICAL FORM

Modified release tablets.

DYNACAZ 30 mg MR: White to almost white, oval, slightly biconvex tablets (length: 11 mm x width: 5,5 mm) with bevelled edges.

DYNACAZ 60 mg MR: White to almost white, oval, biconvex tablets, scored on both sides, of 13 mm.

DYNACAZ 90 mg MR: White to almost white, capsule shaped, biconvex tablets of 17 - 17,5 mm with two score lines around the tablet. Dynacaz 60 mg and 90 mg MR tablets may be subdivided in parts to improve patients' compliance with all the dosing regimens. Dissolution studies in different media at pH 0,1; 4,5 and 7,4, and uniformity of mass studies of divided parts were conducted.

4. CLINICAL PARTICULARS

4.1 Therapeutic indications

DYNACAZ MR is indicated in Type 2 diabetic patients, in association with dietary measures, lifestyle changes and exercise, when dietary measures, lifestyle and exercise alone are not sufficient to control blood glucose.

4.2 Posology and method of administration

Posology

For adult use only:

DYNACAZ 30 mg MR: The daily dose may vary from 1 to 4 tablets a day, i.e. 30 to 120 mg taken as a single daily dose.

DYNACAZ 60 MR: The daily dose may vary from one half to 2 tablets a day, i.e. 30 to 120 mg taken as single daily dose. It is recommended that DYNACAZ MR be taken with breakfast.

If a dose is forgotten, the dose taken on the next day should not be increased. The dose should be adjusted according to the individual patient's metabolic response (blood glucose levels and/or glycosylated haemoglobin HbA_{1c}).

Initial dose:

The initial recommended dose is 30 mg once daily, taken with breakfast.

Dose adjustments:

If fasting blood glucose levels have not decreased satisfactorily, the dosage can be increased progressively to 60, 90 or 120 mg per day, by successive increments, respecting an interval of at least one month between each increment, except in patients whose blood glucose levels have not decreased after 15 days of treatment. In this case, the dosage may be increased at the end of the 2nd week of treatment.
The daily dose should not exceed 120 mg. Previously untreated patients should commence with a dose of 30 mg.
One DYNACAZ 60 mg MR modified release tablet is equivalent to two DYNACAZ 30 mg MR modified release tablets.

Replacement of gliclazide 80 mg with DYNACAZ MR:

In patients stabilised on gliclazide 80 mg, the replacement of gliclazide 80 mg by DYNACAZ MR may initially be based on: 1 tablet gliclazide 80 mg = 1 x 30 mg tablet of DYNACAZ MR.

Replacement of another sulphonylurea with DYNACAZ MR:

For replacement of another sulphonylurea treatment with DYNACAZ MR, it is recommended that the dosage and the half-life of the previous oral hypoglycaemic medicine must be taken into account.

If a patient is changed from another oral sulphonylurea with a prolonged half-life, a therapeutic window of a few days may prove to be necessary to avoid the additive effect of the two products and the subsequent risk of hypoglycaemia. During such a changeover, it is recommended that the initiation of treatment be the same as for the initial DYNACAZ MR dosage, start with daily doses of 30 mg per day and then increase the dosage by increments, according to the patient's metabolic response.

Association with other oral antidiabetic medicines:

DYNACAZ MR may be given concurrently with alpha glucosidase inhibitors or insulin; however, diabetic control should be checked with blood sugar readings because of the possibility of hypoglycaemia. In combined therapy with biguanides, there may be an increased risk of cardiovascular mortality than with the use of DYNACAZ MR alone.

Special populations

Elderly patients:

The dosage is identical to that recommended for adults under the age of 65 years, and for patients with normal renal function, with careful patient monitoring.

Patients with mild to moderate renal failure (creatinine clearance 30 - 80 mL/min):

A reduction in dosage may be necessary in patients with renal dysfunction.

The dosage is identical to that recommended for patients with normal renal function, with careful monitoring. Use of DYNACAZ MR is contraindicated in patients with severe renal impairment (see section 4.3).

Patients at risk of hypoglycaemia:

It is recommended that the minimum starting dose of 30 mg is used in these patients (see section 4.4).

Paediatric population

The safety and efficacy of DYNACAZ MR in children and adolescents have not been established. No data is available.

Method of administration

It is recommended that the tablet(s) be swallowed whole.

4.3 Contraindications

- hypersensitivity to gliclazide, sulphonylureas, sulphonamides or to any of the ingredients of DYNACAZ MR
- type 1 diabetes mellitus (Juvenile Insulin Dependent Diabetes Mellitus), diabetic ketoacidosis, diabetic pre-coma and coma
- significant acidosis, severe burns, severe infection or hyperosmolar nonketotic coma.
- major surgery or severe trauma
- severe renal or hepatic insufficiency, in these cases the use of insulin is recommended
- treatment with miconazole (see section 4.5)
- children
- pregnancy and lactation (see section 4.6).

4.4 Special warnings and precautions for use

Increased risk of cardiovascular mortality:

The administration of oral hypoglycaemics may be associated with increased cardiovascular mortality, as compared to treatment with diet alone or diet with insulin.

A reduction in dosage may be necessary in patients with mild to moderate renal dysfunction (see sections 4.2 and 4.3).

Clinical signs of a still insufficiently lowered blood glucose (i.e. hyperglycaemia, polyuria, polydipsia, dry mouth) may require dose adjustment of DYNACAZ MR.

Hypoglycaemia:

Hypoglycaemia may occur following administration of sulphonylureas including DYNACAZ MR (see section 4.8). Some cases may be severe and prolonged. Hospitalisation may be necessary and glucose administration may need to be continued for several days.

Careful selection of patients, of the dose used, and clear patient directions are necessary to reduce the risk of hypoglycaemic episodes.
The administration of oral hypoglycaemics, such as DYNACAZ MR, may be associated with increased cardiovascular mortality as compared to treatment with diet alone or diet with insulin.

Treatment with DYNACAZ MR can cause hypoglycaemia if mealtimes are irregular and, in particular, if meals are skipped. Possible symptoms of hypoglycaemia are:

headache, intense hunger, nausea, vomiting, lassitude, sleep disorders, agitation, aggression, poor concentration, reduced awareness and slowed reactions, depression, confusion, visual and speech disorders, aphasia, tremor, paresis, sensory disorders, dizziness, feeling of powerlessness, loss of self-control, delirium, convulsions, shallow respiration, bradycardia, drowsiness, and loss of consciousness, possibly resulting in coma and lethal outcome.

In addition, signs of adrenergic counter-regulation may be observed, sweating, clammy skin, anxiety, tachycardia, hypertension, palpitations, angina pectoris and cardiac dysrhythmia.

Usually, symptoms disappear after intake of carbohydrates (sugar), however, artificial sweeteners have no effect. Experience with other sulphonylureas shows that hypoglycaemia can recur even when measures prove effective initially.

If a hypoglycaemic episode is severe, or is prolonged, and even if it is temporarily controlled by intake of sugar, immediate medical treatment or even hospitalisation is required.

In the initial weeks of treatment, the risk of hypoglycaemia may increase, and careful monitoring is necessary. At risk patients and/or factors favouring hypoglycaemia include: (see section 4.2)

- patients (particularly elderly patients) refusing or unable to co-operate
- patients who are malnourished or undernourished, with irregular mealtimes, skipping meals, periods of fasting or dietary changes
- imbalance between physical exercise and carbohydrate intake
- certain endocrine disorders: thyroid disorders, hypopituitarism and

adrenocorticotrophic insufficiency, which should be controlled appropriately before therapy starts

- withdrawal of prolonged and/or high dose corticosteroid treatment
- severe vascular disease (severe coronary heart disease, severe carotid impairment, diffuse vascular disease)
- severe hepatic disease
- renal insufficiency
- concomitant administration of certain other medicines (see section 4.5)
- overdose of DYNACAZ MR.

It is recommended that the minimum starting dose of 30 mg be used.

DYNACAZ MR should be prescribed only if the patient is likely to have a regular food intake (including breakfast). It is important to have a regular carbohydrate intake due to the increased risk of hypoglycaemia, if a meal is taken late, if an inadequate amount of food is consumed or, if the food is low in carbohydrate. Hypoglycaemia is more likely to occur during low-calorie diets, following prolonged or strenuous exercise, alcohol intake or if a combination of hypoglycaemic medicine is being used.

In an exceptional stress situation e.g. trauma, fever, infection or surgical intervention, blood glucose regulation may deteriorate, and a temporary change to insulin may be necessary to maintain good metabolic control.

Gastrointestinal side effects can be avoided if DYNACAZ MR is taken with breakfast.

Hepatobiliary symptoms may disappear after discontinuation of treatment. Discontinue treatment if cholestatic jaundice appears.

Beta-blockers may decrease the efficacy of DYNACAZ MR by impairing the release of insulin. Beta-blockers may mask the typical sympathomimetic warning signs and symptoms of hypoglycaemia and may inhibit the normal physiological response to hypoglycaemia.

Patient information:

The risk of hypoglycaemia, together with its symptoms (see section 4.8), treatment and conditions that predispose to its development, should be explained to the patient and to family members. The patient should be informed of the importance of following dietary advice, of taking regular exercise and of regular monitoring of blood glucose levels.

Poor blood glucose control:

Blood glucose control may deteriorate under certain conditions, despite compliance from the patient. This occurs with exceptional stressors like fever, trauma, infection, surgery and febrile illnesses as well as St. John's wort (*Hypericum perforatum)* preparations (see section 4.5). Under these circumstances, it is prudent to convert the patient to insulin therapy temporarily to maintain good metabolic control.

The hypoglycaemic efficacy of DYNACAZ MR may be attenuated over time in many patients. This may be due to progression in the severity of the diabetes, or to a reduced response to treatment. This phenomenon is known as secondary failure,

which is distinct from primary failure, when an active substance is ineffective as first-line treatment. Adequate dose adjustment and dietary compliance should be considered before classifying the patient as secondary failure.

Dysglycaemia:

Disturbances in blood glucose, including hypoglycaemia and hyperglycaemia have been reported, in diabetic patients receiving concomitant treatment with fluoroquinolones, especially in elderly patients. Careful monitoring of blood glucose is recommended in all patients receiving DYNACAZ MR and a fluoroquinolone together.

***Renal and hepatic insufficiency*:**

The pharmacokinetic and/or pharmacodynamic properties of DYNACAZ MR may be altered in patients with hepatic insufficiency or severe renal failure. A hypoglycaemic episode occurring in these patients may be prolonged, so appropriate management should be initiated.

Skin reactions:

There is a potential for the occurrence of erythema multiforme, toxic dermal necrolysis and allergic vasculitis.

Laboratory tests:

Measurement of glycosylated haemoglobin levels (for fasting venous plasma glucose) is recommended in assessing blood glucose control.

Blood glucose self-monitoring may also be useful.

Treatment of patients with G6PD-deficiency with sulphonylurea agents can lead to haemolytic anaemia. Since gliclazide belongs to the chemical class of sulfonylurea medicines, caution should be used in patients with G6PD-deficiency and a non-sulfonylurea alternative should be considered.

Lactose:

DYNACAZ 30/60/90 mg MR contain 73,50 mg, 93,40 mg and 140,10 mg lactose monohydrate per tablet, respectively. This should be taken into account in patients with diabetes mellitus. Patients with the rare hereditary conditions of galactose intolerance, total lactase deficiency or glucose-galactose malabsorption should not take DYNACAZ MR.

Paediatric population

The safety and efficacy of DYNACAZ MR in children has not been established (see section 4.3).

4.5 Interaction with other medicines and other forms of interaction

Hypoglycaemia may occur with concomitant use of DYNACAZ MR and the following medicines:

Combination which is contraindicated:

Miconazole (systemic route, oromucosal gel) — increases the hypoglycaemic effect with possible onset of hypoglycaemic symptoms, or even coma and is therefore contraindicated (see section 4.3).

Combinations which are not recommended:

Phenylbutazone (systemic route) – increases the hypoglycaemic effect of sulphonureas (displaces their binding to plasma proteins and/or reduces their elimination). It is preferable to use a different anti-inflammatory medicine, or else to warn the patient and emphasise the importance of self-monitoring. Where necessary, adjust the dose during and after treatment with the anti-inflammatory medicine.

Alcohol — increases the hypoglycaemic reaction (by inhibiting compensatory reactions) that can lead to the onset of hypoglycaemic coma. Avoid alcohol or medicines containing alcohol.

Combinations requiring precautions during use:

Potentiation of the blood glucose lowering effect and thus, in some instances, hypoglycaemia may occur when one of the following medicines is taken:

- allopurinol
- anabolic steroids and androgens
- angiotensin-converting enzyme inhibitors: captopril and enalapril
- antidysrhythmics: disopyramide
- antibacterials: chloramphenicol, sulphonamides, fluoroquinolone antibiotics, tetracyclines, clarithromycin
- antidepressants and monoamine-oxidase inhibitors: fluoxetine
- appetite suppressants: fenfluramine
- azole antifungals: ketoconazole, itraconazole, voriconazole, fluconazole (systemic route, oral gel)
- H2 receptor antagonists – cimetidine and ranitidine
- fibrates: clofibrate

- insulin and other oral antidiabetic medicines (acarbose, metformin, thiazolidinediones, dipeptidyl peptidase-4 inhibitors, GLP-1 receptor agonists)
- salicylates or nonsteroidal anti-inflammatory medicines (NSAIDs)
- Probenecid or sulphinpyrazone
- sulphonamides.

Sympatholytic medicines (e.g. beta-blockers, clonidine) may blunt the signs of adrenergic response to hypoglycaemia, as well as impair mechanisms that control the normal physiological response to a fall in blood glucose, thereby increasing the risk of a severe hypoglycaemic reaction.

Hyperglycaemia may occur with concomitant use of DYNACAZ MR with the following:

Combination which is not recommended:

Danazol — diabetogenic effect of danazol. If the use of gliclazide, as in DYNACAZ MR, cannot be avoided, warn the patient and emphasise the importance of urine and blood glucose monitoring. It may be necessary to adjust the dose of DYNACAZ MR during and after treatment with danazol.

Combinations requiring precautions during use:

- epinephrine (adrenaline) and other sympathomimetic medicines
- corticosteroids
- calcium channel blocking medicines
- phenothiazines, chlorpromazine (neuroleptic medicine): high doses (> 100 mg/day) increase blood glucose levels (reduced insulin release)

- clonidine
- diazoxide, parenteral
- diuretics
- ephedrine, pseudoephedrine and common cold products
- glucagon
- glucocorticoids (systemic and local route: intra-articular, cutaneous and rectal preparations) and tetracosactrin: increase in blood glucose levels with possible ketosis
- isoniazid
- lithium
- oestrogens and progesterones
- phenytoin
- rifampicin
- thyroid hormones
- St. John's wort (*Hypericum performatum*) preparations: Gliclazide exposure is decreased by St. John's wort. Emphasise the importance of blood glucose level monitoring
- ritodrine, salbutamol, terbutaline (I.V.) and other beta-adrenergic medicines: increased blood glucose levels due to beta-2 agonist effects. Emphasise the importance of monitoring blood glucose levels. If necessary, switch to insulin.

Combinations which must be taken into account:

- barbiturates may prolong the effect of DYNACAZ MR.

The following products may cause dysglycaemia:

Combinations requiring precautions during use:

Fluoroquinolones: in case of a concomitant use of DYNACAZ MR and a fluoroquinolone, the patient should be warned of the risk of dysglycaemia, and the importance of blood glucose monitoring should be emphasised.

Anticoagulant therapy (coumarin derivatives such as warfarin): DYNACAZ MR may lead to weakening or potentiation of anticoagulation during concurrent treatment. Adjustment of the anticoagulant may be necessary, and INR should be monitored.

4.6 Fertility, pregnancy and lactation

Pregnancy

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

Breastfeeding

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

Fertility

No effect on fertility or reproductive performance has been reported.

4.7 Effects on ability to drive and use machines

DYNACAZ MR has no, or negligible influence, however, alertness and reactions may be impaired by hypo- or hyperglycaemia, especially when initiating treatment or altering doses. This may affect the ability to drive or operate machinery.

4.8 Undesirable effects

a) Summary of the safety profile

The most frequent adverse reaction with DYNACAZ MR is hypoglycaemia – especially if mealtimes are irregular and, in particular, if meals are skipped.

Hypoglycaemia may range from mild to severe and life threatening with possible symptoms that may include:

headache, intense hunger, nausea, vomiting, lassitude, sleep disorders, sleepiness, nightmares, agitation, aggression, poor concentration, reduced awareness and slowed reactions, restlessness, depression, delirium, apathy, confusion, visual and speech disorders, slurred speech, aphasia, seizures, tremor, paresis, sensory disorders, dizziness, feeling of powerlessness, behavioural changes that mimic drunkenness, loss of self-control, convulsions, shallow respiration, bradycardia, drowsiness, loss of consciousness, coma, adrenergic counter-regulation (cold sweats, sweating, clammy skin, anxiety, tremor, tachycardia, hypertension, palpitations, angina pectoris, cardiac dysrhythmia).

Usually, symptoms disappear after intake of carbohydrates (sugar). However, artificial sweeteners have no effect. Experience with other sulfonylureas shows that hypoglycaemia can recur even when measures prove effective initially (see section 4.4).

If a hypoglycaemic episode is severe or prolonged, even if temporarily controlled by the intake of sugar, immediate medical treatment or hospitalisation is required.

b) Tabulated summary of adverse reactions

System Organ Class	**Frequency**	**Side effects**

Blood and lymphatic system disorders	Less frequent	Leukopenia, thrombocytopenia, aplastic or haemolytic anaemia, agranulocytosis, pancytopenia, eosinophilia, blood dyscrasias, granulocytopenia, erythrocytopenia
Immune system disorders	Less frequent	Rash, allergic vasculitis
Endocrine disorders	Less frequent	Hypoglycaemia
Metabolism and nutrition disorders	Less frequent	Hyponatraemia, anorexia
Nervous system disorders	Frequent	Headache, dizziness, drowsiness
Eye disorders	Less frequent	Blurred vision and/or changes in accommodation

Gastrointestinal disorders	Frequent	Constipation, diarrhoea, dyspepsia, flatulence, heartburn, loss of or increase in appetite, weight gain, nausea, stomach pain, fullness or discomfort, vomiting, alterations in sense of taste (metallic taste)
Hepato-biliary disorders	Less frequent	Increased levels of hepatic enzymes (alanine amino-transferase, aspartate amino transferase, alkaline phosphatase), hepatitis, cholestasis, cholestatic jaundice, hepatic function impairment, hepatic porphyria, porphyria cutanea tarda, liver failure

Skin and subcutaneous tissue disorders	Frequency unknown:	Erythema multiforme, photosensitivity, pruritus, urticaria and maculopapular rashes, bullous reactions (such as Stevens-Johnson syndrome and toxic epidermal necrolysis), exfoliative dermatitis, erythema nodosum, angioedema, drug rash with eosinophilia and systemic symptoms (DRESS)
Renal and urinary disorders	Frequent:	Polyuria

c) Description of selected adverse reactions

Hypoglycaemia may be prevented if mealtimes are regular and, in particular, if no meals are skipped.

Usually, symptoms disappear after intake of carbohydrates (sugar).

If a hypoglycaemic episode is severe or prolonged, and even if it is temporarily controlled by intake of sugar, immediate medical treatment or even hospitalisation are required.

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.

Healthcare professionals are asked to report any suspected adverse reactions to SAHPRA via the online service for adverse drug reaction reporting by following the link: https://www.sahpra.org.za/Publications/Index/8. An email can be sent directly to the company, pharmacovigilance@pharmadynamics.co.za to ensure safety of the product.

4.9 Overdose

Signs and symptoms:

An overdose of DYNACAZ MR may cause hypoglycaemia which could be severe or prolonged. Moderate symptoms of hypoglycaemia, without any loss of consciousness, or neurological signs must be corrected by carbohydrate intake, dose adjustment and/or modification of diet.

Management of overdose:

Treatment is symptomatic and supportive.

Strict monitoring should be continued until the patient is out of danger. Severe hypoglycaemia reactions, with coma, convulsions or other neurological disorders should be treated as a medical emergency, requiring immediate hospitalisation.

If hypoglycaemic coma is diagnosed or suspected, the patient should be given a rapid IV injection of 50 mL of concentrated glucose solution (50 %). This should be followed by continuous infusion of a more dilute solution (10 %), at a rate necessary to maintain blood glucose levels above 5,5 mmol/L. Patients should be monitored closely, long enough to make sure that hypoglycaemia will not re-occur, and, depending on the patient's condition, the doctor will decide if further monitoring is necessary. Dialysis is of no benefit in these patients due to strong binding of gliclazide to proteins.

5. PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: Sulfonamides, urea derivative

ATC code: A10BB09

Pharmacological classification: A 21.2 Oral Hypoglycaemics

Mechanism of action:

Gliclazide, a second-generation sulphonylurea, lowers blood glucose concentrations by stimulating insulin release from pancreatic beta cells. In addition to this pancreatic action, it has been demonstrated that gliclazide administration may improve the metabolic utilisation of glucose at peripheral level.

5.2 Pharmacokinetic properties

Absorption:

Following oral administration, gliclazide is readily absorbed from the gastrointestinal tract. Food intake does not affect the rate or degree of absorption.

Maximum serum concentrations of gliclazide are reached approximately 6 hours after oral administration. Its effect is dose-dependent over the dosage range of 30 to 120 mg.

Distribution:

Gliclazide has very high plasma protein binding (~ 95 %).

The volume of distribution is around 30 litres.

A single dose of gliclazide maintains glucose lowering effects over 24 hours.

Biotransformation:

Gliclazide is mainly metabolised in the liver and excreted in the urine, less than 1 % of the unchanged form is found in the urine. No active metabolites have been detected in plasma.

Elimination:

The elimination half-life of gliclazide varies between 12 and 20 hours.

Linearity/non-linearity:

The relationship between the dose administered ranging up to 120 mg and the area under the concentration time curve is linear.

Pharmacokinetics in special patient groups

Elderly:

No clinically significant changes in pharmacokinetic parameters have been observed in elderly patients.

5.3 Preclinical safety data

Preclinical data reveal no special hazards for humans based on conventional studies of repeated dose toxicity and genotoxicity. Long term carcinogenicity studies have not been done. No teratogenic changes have been shown in animal studies, but lower foetal body weight was observed in animals receiving doses 25-fold higher than the maximum recommended dose in humans. Fertility and reproductive performance were unaffected after gliclazide administration in animal studies.

6. PHARMACEUTICAL PARTICULARS

6.1 List of excipients

DYNACAZ 30 mg MR:

Calcium carbonate

Colloidal silica dioxide

Hypromellose

Lactose monohydrate

Magnesium stearate

DYNACAZ 60 mg MR and DYNACAZ 90 mg MR:

Hypromellose

Lactose monohydrate

Magnesium stearate

Silica colloidal anhydrous.

6.2 Incompatibilities

Not applicable.

6.3 Shelf life

36 months

6.4 Special precautions for storage

Store at or below 30 °C in a dry place. Protect from light.

Keep the blister in the carton until required for use.

This medicine does not require any special storage conditions.

6.5 Nature and contents of container

DYNACAZ 30 mg MR tablets are packed into OPA/Al/PVC and aluminium foil blister strips. 60 (6x10) tablets will be packed into a cardboard box.

DYNACAZ 60 mg MR tablets are packed into clear OPA/Al/PVC and aluminium blister foil strips. 28 (2 x 14) or 30 (2 x 15) tablets will be packed into a cardboard box.

DYNACAZ 90 mg MR tablets are packed into OPA/Al/PVC and aluminium foil blister strips. Blister strips containing a total of either 30, 60 or 90 tablets will be packed into a cardboard box.

6.6 Special precautions for disposal

No special precautions required.

7. HOLDER OF THE CERTIFICATE OF REGISTRATION

Pharma Dynamics (Pty) Ltd

1st Floor Grapevine House, Steenberg Office Park

Silverwood Close

Westlake, Cape Town

7945, South Africa

8. REGISTRATION NUMBER(S)

DYNACAZ 30 mg MR: A42/21.2/0249*

DYNACAZ 60 mg MR: A48/21.2/1194**

DYNACAZ 90 mg MR: A53/21.2/0083**

9. DATE OF FIRST AUTHORISATION

DYNACAZ 30 mg MR: 11 November 2011

DYNACAZ 60 mg MR: 15 June 2021

DYNACAZ 90 mg MR: 15 June 2021

10. DATE OF REVISION OF THE TEXT

14 March 2023

DYNACAZ 30 mg MR Namibia: NAM NS2 12/21.2/0110*

DYNACAZ 60 MG MR MOZ: A6815**

DYNACAZ 90 MG MR MOZ: A6816**

*DYNACAZ 30 mg MR not marketed in Mozambique

**DYNACAZ 60 mg MR and DYNACAZ 90 mg MR not marketed in Namibia.