Floximox®

Moxifloxacin HCl

FORMS AND PRESENTATION

Floximox®: Film coated tablets: Box of 7.

COMPOSITION

Floximox®: Each film coated tablet contains Moxifloxacin Hydrochloride equivalent to Moxifloxacin 400mg.

Excipients: microcrystalline cellulose, croscarmellose sodium, colloidal silicon dioxide, povidone, magnesium stearate, red iron oxide, polyethylene glycol, yellow iron oxide, titanium dioxide, hydroxypropyl methylcellulose.

PHARMACOLOGICAL PROPERTIES

Pharmacodynamic properties

Therapeutic class: Antibacterials for systemic use.

ATC code: J01MA14.

Moxifloxacin has in vitro activity against a wide range of Gram-positive and Gram-negative pathogens.

The bactericidal action of Moxifloxacin results from the inhibition of both type II topoisomerases (DNA gyrase and topoisomerase IV) required for bacterial DNA replication, transcription and repair. It appears that the C8-methoxy moiety contributes to enhanced activity and lower selection of resistant mutants of Gram-positive bacteria compared to the C8-H moiety. The presence of the bulky bicycloamine substituent at the C-7 position prevents active efflux, associated with the norA or pmrA genes seen in certain Gram-positive bacteria.

Pharmacodynamic investigations have demonstrated that Moxifloxacin exhibits a concentration dependent killing rate. Minimum bactericidal concentrations (MBC) were found to be in the range of the minimum inhibitory concentrations (MIC).

Pharmacokinetic properties

Absorption

Following oral administration Moxifloxacin is rapidly and almost completely absorbed. The absolute bioavailability amounts to approximately 91%.

Pharmacokinetics are linear in the range of 50 - 800 mg single dose and up to 600 mg once daily dosing over 10 days. Following a 400 mg oral dose peak concentrations of 3.1 mg/l are reached within 0.5 - 4 h post administration. Peak and trough plasma concentrations at steady-state (400 mg once daily) were 3.2 and 0.6 mg/l, respectively. At steady-state the exposure within the dosing interval is approximately 30% higher than after the first dose.

Distribution

Moxifloxacin is distributed to extravascular spaces rapidly; after a dose of 400 mg an AUC of 35 m·gh/l is observed. The steady-state volume of distribution (Vss) is approximately 2 l/kg. In vitro and ex vivo experiments showed a protein binding of approximately 40 - 42% independent of the concentration of the drug. Moxifloxacin is mainly bound to serum albumin.

Biotransformation

Moxifloxacin undergoes Phase II biotransformation and is excreted via renal and biliary/fecal pathways as unchanged drug as well as in the form of a sulpho-compound (M1) and a glucuronide (M2). M1 and M2 are the only metabolites relevant in humans, both are microbiologically inactive.

In clinical Phase I and in vitro studies no metabolic pharmacokinetic interactions with other drugs undergoing Phase I biotransformation involving cytochrome P450 enzymes were observed. There is no indication of oxidative metabolism.

Elimination

Moxifloxacin is eliminated from plasma with a mean terminal half life of approximately 12 hours.

Total body clearance following a 400 mg dose ranges from 179 to 246 ml/min. Renal clearance amounted to about 24 - 53 ml/min suggesting partial tubular reabsorption of the drug from the kidneys.

After a 400 mg dose, recovery from urine (approximately 19% for unchanged drug, approximately 2.5% for M1, and approximately 14% for M2) and feces (approximately 25% of unchanged drug, approximately 36% for M1, and no recovery for M2) totaled to approximately 96%.

Concomitant administration of Moxifloxacin with ranitidine or probenecid did not alter renal clearance of the parent drug.

INDICATIONS

Floximox® is indicated for the treatment of bacterial infections in patients of 18 years and older caused by bacteria susceptible to Moxifloxacin, only when it is considered inappropriate to use antibacterial agents that are commonly recommended for the initial treatment of these infections or when these have failed:

- Acute bacterial sinusitis (adequately diagnosed).
- Acute exacerbations of chronic bronchitis (adequately diagnosed).
- Community acquired pneumonia, except severe cases.
- Mild to moderate pelvic inflammatory disease (i.e. infections of female upper genital tract, including salpingitis and endometritis), without an associated tubo-ovarian or pelvic abscess.

Floximox® is not recommended for use in monotherapy of mild to moderate pelvic inflammatory disease but should be given in combination with another appropriate antibacterial agent (e.g. a cephalosporin) due to increasing Moxifloxacin resistance of *Neisseria gonorrhoeae* unless Moxifloxacin-resistant *Neisseria gonorrhoeae* can be excluded.

Floximox® may also be used to complete a course of therapy in patients who have shown improvement during initial treatment with intravenous Moxifloxacin for the following indications:

- Community-acquired pneumonia.
- Complicated skin and skin structure infections.

Floximox® should not be used to initiate therapy for any type of skin and skin structure infection or in severe community-acquired pneumonia.

Consideration should be given to official guidance on the appropriate use of antibacterial agents.

CONTRAINDICATIONS

- Hypersensitivity to Moxifloxacin, other quinolones or to any of the excipients.
- Pregnancy and lactation.
- Patients below 18 years of age.
- Patients with a history of tendon disease/disorder related to quinolone treatment.

Both in preclinical investigations and in humans, changes in cardiac electrophysiology have been observed following exposure to Moxifloxacin, in the form of QT prolongation. For reasons of drug safety, Moxifloxacin is therefore contraindicated in patients with:

- Congenital or documented acquired QT prolongation.
- Electrolyte disturbances, particularly in uncorrected hypokalemia.
- Clinically relevant bradycardia.
- Clinically relevant heart failure with reduced left-ventricular ejection fraction.
- Previous history of symptomatic arrhythmias.

Moxifloxacin should not be used concurrently with other drugs that prolong the QT interval.

Due to limited clinical data, Moxifloxacin is also contraindicated in patients with impaired liver function (Child Pugh C) and in patients with transaminases increase > 5fold ULN.

PRECAUTIONS

The use of Moxifloxacin should be avoided in patients who have experienced serious adverse reactions in the past when using quinolone or fluoroquinolone containing products . Treatment of these patients with Moxifloxacin should only be initiated in the absence of alternative treatment options and after careful benefit/risk assessment.

The benefit of Moxifloxacin treatment especially in infections with a low degree of severity should be balanced with the information contained in the precautions section.

- Prolongation of QTc interval and potentially QTc-prolongation-related clinical conditions: Moxifloxacin has been shown to prolong the QTc interval on the electrocardiogram in some patients. In the analysis of ECGs obtained in the clinical trial program, QTc prolongation with Moxifloxacin was 6 msec ± 26 msec, 1.4% compared to baseline. As women tend to have a longer baseline QTc interval compared with men, they may be more sensitive to QTc-prolonging medications. Elderly patients may also be more susceptible to drug-associated effects on the QT interval.

Medication that can reduce potassium levels should be used with caution in patients receiving Moxifloxacin.

Moxifloxacin should be used with caution in patients with ongoing pro-arrhythmic conditions (especially women and elderly patients), such as acute myocardial ischemia or QT prolongation as this may lead to an increased risk for ventricular arrhythmias (incl. torsade de pointes) and cardiac arrest. The magnitude of QT prolongation may increase with increasing concentrations of the drug. Therefore, the recommended dose should not be exceeded.

If signs of cardiac arrhythmia occur during treatment with Moxifloxacin, treatment should be stopped and an ECG should be performed.

- Hypersensitivity/allergic reactions: Hypersensitivity and allergic reactions have been reported for fluoroquinolones including Moxifloxacin after first administration. Anaphylactic reactions can progress to a life-threatening shock, even after the first administration. In these cases Moxifloxacin should be discontinued and suitable treatment (e.g. treatment for shock) initiated.
- Severe liver disorders: Cases of fulminant hepatitis potentially leading to liver failure (including fatal cases) have been reported with Moxifloxacin. Patients should be advised to contact their doctor prior to continuing treatment if signs and symptoms of fulminant hepatic disease develop such as rapidly developing asthenia associated with jaundice, dark urine, bleeding tendency or hepatic encephalopathy.

Liver function tests/investigations should be performed in cases where indications of liver dysfunction occur.

- Serious bullous skin reactions: Cases of bullous skin reactions like Stevens-Johnson syndrome or toxic epidermal necrolysis have been reported with Moxifloxacin. Patients should be advised to contact their doctor immediately prior to continuing treatment if skin and/or mucosal reactions occur.
- Patients predisposed to seizures: Quinolones are known to trigger seizures. Use should be with caution in patients with CNS disorders or in the presence of other risk factors which may predispose to seizures or lower the seizure threshold. In case of seizures, treatment with Moxifloxacin should be discontinued and appropriate measures instituted.
- Peripheral neuropathy: Cases of sensory or sensorimotor polyneuropathy resulting in paraesthesias, hypoesthesias, dysesthesias, or weakness have been reported in patients receiving quinolones including Moxifloxacin. Patients under treatment with Moxifloxacin should be advised to inform their doctor prior to continuing treatment if symptoms of neuropathy such as pain, burning, tingling, numbness, or weakness develop.
- Psychiatric reactions: Psychiatric reactions may occur even after the first administration of quinolones, including Moxifloxacin. In very rare cases depression or psychotic reactions have progressed to suicidal thoughts and self-injurious behavior such as suicide attempts. In the event that the patient develops these reactions, Moxifloxacin should be discontinued and appropriate measures instituted. Caution is recommended if Moxifloxacin is to be used in psychotic patients or in patients with history of psychiatric disease.
- Antibiotic-associated diarrhea incl. colitis: Antibiotic-associated diarrhea (AAD) and antibiotic-associated colitis (AAC), including pseudomembranous colitis and *Clostridium difficile*-associated diarrhea, has been reported in association with the use of broad spectrum antibiotics including Moxifloxacin and may range in severity from mild diarrhea to fatal colitis. Therefore it is important to consider this diagnosis in patients who develop serious diarrhea during or after the use of Moxifloxacin. If AAD or AAC is suspected or confirmed, ongoing treatment with antibacterial agents, including Moxifloxacin, should be discontinued and adequate therapeutic measures should be initiated immediately. Furthermore, appropriate infection control measures should be undertaken to reduce the risk of transmission. Drugs inhibiting peristalsis are contraindicated in patients who develop serious diarrhea.
- Patients with myasthenia gravis: Moxifloxacin should be used with caution in patients with myasthenia gravis because the symptoms can be exacerbated.
- Tendon inflammation, tendon rupture: Tendon inflammation and rupture (especially Achilles tendon), sometimes bilateral, may occur with quinolone therapy including Moxifloxacin, even within 48 hours of starting treatment and have been reported up to several months after discontinuation of therapy. The risk of tendinitis and tendon rupture is increased in elderly patients and in those treated concurrently with corticosteroids. At the first sign of pain or inflammation, patients should discontinue treatment with Moxifloxacin, rest the affected limb(s) and consult their doctor immediately in order to initiate appropriate treatment (e.g. immobilization) for the affected tendon.
- Patients with renal impairment: Elderly patients with renal disorders should use Moxifloxacin with caution if they are unable to maintain adequate fluid intake, because dehydration may increase the risk of renal failure.
- Vision disorders: If vision becomes impaired or any effects on the eyes are experienced, an eye specialist should be consulted immediately.
- Prevention of photosensitivity reactions: Quinolones have been shown to cause photosensitivity reactions in patients. However, studies have shown that Moxifloxacin has a lower risk to induce photosensitivity. Nevertheless patients should be advised to avoid exposure to either UV irradiation or extensive and/or strong sunlight during treatment with Moxifloxacin.
- Patients with glucose-6-phosphate dehydrogenase deficiency: Patients with a family history of, or actual glucose-6-phosphate dehydrogenase deficiency are prone to hemolytic reactions when treated with quinolones. Therefore, Moxifloxacin should be used with caution in these patients.
- Patients with pelvic inflammatory disease: For patients with complicated pelvic inflammatory disease (e.g. associated with a tubo-ovarian or pelvic abscess), for whom an intravenous treatment is considered necessary, treatment with Moxifloxacin is not recommended.

Pelvic inflammatory disease may be caused by fluoroquinolone-resistant *Neisseria gonorrhoeae*. Therefore in such cases empirical Moxifloxacin should be co-administered with another appropriate antibiotic (e.g. a cephalosporin) unless Moxifloxacin-resistant *Neisseria gonorrhoeae* can be excluded. If clinical improvement is not achieved after 3 days of treatment, the therapy should be reconsidered.

- Patients with special cSSSi: Clinical efficacy of intravenous Moxifloxacin in the treatment of severe burn infections, fasciitis and diabetic foot infections with osteomyelitis has not been established.
- Interference with biological tests: Moxifloxacin therapy may interfere with the *Mycobacterium* spp. culture test by suppression of mycobacterial growth causing false negative results in samples taken from patients currently receiving Moxifloxacin.
- Patients with MRSA infections: Moxifloxacin is not recommended for the treatment of MRSA infections. In case of a suspected or confirmed infection due to MRSA, treatment with an appropriate antibacterial agent should be started.
- Pediatric population: Due to adverse effects on the cartilage in juvenile animals the use of Moxifloxacin in children and adolescents < 18 years is contraindicated.

Information about excipients: Patients with rare hereditary problems of galactose intolerance, total lactase deficiency or glucose-galactose malabsorption should not take this medicine.

This medicine contains less than 1 mmol sodium (23 mg) per film-coated tablet, that is to say essentially “sodium-free”.

Ability to drive and use machines

No studies on the effects of Moxifloxacin on the ability to drive and use machines have been performed. However, fluoroquinolones including Moxifloxacin may result in an impairment of the patient's ability to drive or operate machinery due to CNS reactions (e.g. dizziness; acute, transient loss of vision) or acute and short lasting loss of consciousness (syncope). Patients should be advised to see how they react to Moxifloxacin before driving or operating machinery.

PREGNANCY AND LACTATION

The safety of Moxifloxacin in human pregnancy has not been evaluated. Animal studies have shown reproductive toxicity. The potential risk for humans is unknown. Due to the experimental risk of damage by fluoroquinolones to the weight-bearing cartilage of immature animals and reversible joint injuries described in children receiving some fluoroquinolones, Moxifloxacin must not be used in pregnant women.

There is no data available in lactating or nursing women. Preclinical data indicate that small amounts of Moxifloxacin are secreted in milk. In the absence of human data and due to the experimental risk of damage by fluoroquinolones to the weight-bearing cartilage of immature animals, breast-feeding is contraindicated during Moxifloxacin therapy.

Animal studies do not indicate impairment of fertility.

DRUG INTERACTIONS

Interactions with medicinal products

An additive effect on QT interval prolongation of Moxifloxacin and other medicinal products that may prolong the QTc interval cannot be excluded. This might lead to an increased risk of ventricular arrhythmias, including torsade de pointes. Therefore, co-administration of Moxifloxacin with any of the following medicinal products is contraindicated:

- Anti-arrhythmics class IA (e.g. quinidine, hydroquinidine, disopyramide).
- Anti-arrhythmics class III (e.g. amiodarone, sotalol, dofetilide, ibutilide).
- Antipsychotics (e.g. phenothiazines, pimozide, sertindole, haloperidol, sultopride).
- Tricyclic antidepressive agents.
- Certain antimicrobial agents (saquinavir, sparfloxacin, erythromycin IV, pentamidine, antimalarials particularly halofantrine).

- Certain antihistaminics (terfenadine, astemizole, mizolastine).
- Others (cisapride, vincamine IV, bepridil, diphemanil).

Moxifloxacin should be used with caution in patients who are taking medication that can reduce potassium levels (e.g. loop and thiazide-type diuretics, laxatives and enemas [high doses], corticosteroids, amphotericin B) or medication that is associated with clinically significant bradycardia.

An interval of about 6 hours should be left between administration of agents containing bivalent or trivalent cations (e.g. antacids containing magnesium or aluminium, didanosine tablets, sucralfate and agents containing iron or zinc) and administration of Moxifloxacin.

Concomitant administration of charcoal with an oral dose of 400 mg Moxifloxacin led to a pronounced prevention of drug absorption and a reduced systemic availability of the drug by more than 80%. Therefore, the concomitant use of these two drugs is not recommended (except for overdose cases).

After repeated dosing in healthy volunteers, Moxifloxacin increased C_{max} of digoxin by approximately 30% without affecting AUC or trough levels. No precaution is required for use with digoxin.

In studies conducted in diabetic volunteers, concomitant administration of oral Moxifloxacin with glibenclamide resulted in a decrease of approximately 21% in the peak plasma concentrations of glibenclamide. The combination of glibenclamide and Moxifloxacin could theoretically result in a mild and transient hyperglycemia. However, the observed pharmacokinetic changes for glibenclamide did not result in changes of the pharmacodynamic parameters (blood glucose, insulin). Therefore no clinically relevant interaction was observed between Moxifloxacin and glibenclamide.

Changes in INR

A large number of cases showing an increase in oral anticoagulant activity have been reported in patients receiving antibacterial agents, especially fluoroquinolones, macrolides, tetracyclines, cotrimoxazole and some cephalosporins. The infectious and inflammatory conditions, age and general status of the patient appear to be risk factors. Under these circumstances, it is difficult to evaluate whether the infection or the treatment caused the INR (international normalized ratio) disorder. A precautionary measure would be to more frequently monitor the INR. If necessary, the oral anticoagulant dosage should be adjusted as appropriate.

Clinical studies have shown no interactions following concomitant administration of Moxifloxacin with: ranitidine, probenecid, oral contraceptives, calcium supplements, morphine administered parenterally, theophylline, cyclosporine or itraconazole.

In vitro studies with human cytochrome P450 enzymes supported these findings. Considering these results a metabolic interaction via cytochrome P450 enzymes is unlikely.

Interaction with food

Moxifloxacin has no clinically relevant interaction with food including dairy products.

ADVERSE EFFECTS

Adverse reactions based on all clinical trials with Moxifloxacin 400 mg (oral and sequential therapy) sorted by frequencies are listed below:

Apart from nausea and diarrhea all adverse reactions were observed at frequencies below 3%. Within each frequency grouping, undesirable effects are presented in order of decreasing seriousness. Frequencies are defined as: common (≥ 1/100 to < 1/10); uncommon (≥ 1/1,000 to < 1/100); rare (≥ 1/10,000 to < 1/1,000); very rare (< 1/10,000).

- Infections and infestations: Superinfections due to resistant bacteria or fungi e.g. oral and vaginal candidiasis (common).
- Blood and lymphatic system disorders: Anemia, leucopenia(s), neutropenia, thrombocytopenia, thrombocythemia, blood eosinophilia, prolonged prothrombin time / increased INR (uncommon); increased prothrombin level / decreased INR, agranulocytosis (very rare).
- Immune system disorders: Allergic reaction (uncommon); anaphylaxis incl. very rarely life-threatening shock; allergic edema / angioedema (incl. laryngeal edema, potentially life-threatening) (rare).
- Metabolism and nutrition disorders: Hyperlipidemia (uncommon); hyperglycemia, hyperuricemia (rare); Hypoglycemia (very rare).
- Psychiatric disorders: Anxiety reactions, psychomotor hyperactivity/ agitation (uncommon); emotional lability, depression (in very rare cases potentially culminating in self-injurious behaviour, such as suicidal ideations/ thoughts, or suicide attempts), hallucination (rare); depersonalization, psychotic reactions (potentially culminating in self- injurious behaviour, such as suicidal ideations/ thoughts, or suicide attempts) (very rare).
- Nervous system disorders: Headache, dizziness (common); par- and dysesthesia, taste disorders (incl. ageusia in very rare cases), confusion and disorientation, sleep disorders (predominantly insomnia), tremor, vertigo, somnolence (uncommon); hypoesthesia, smell disorders (incl. anosmia), abnormal dreams, disturbed coordination (incl. gait disturbances, esp. due to dizziness or vertigo), seizures incl. grand mal convulsions, disturbed attention, speech disorders, amnesia, peripheral neuropathy and polyneuropathy (rare); hyperesthesia (very rare).
- Eye disorders: Visual disturbances incl. diplopia and blurred vision (especially in the course of CNS reactions) (uncommon); Photophobia (rare); transient loss of vision (especially in the course of CNS reactions) (very rare).
- Ear and labyrinth disorders: Tinnitus, hearing impairment incl. deafness (usually reversible) (rare).
- Cardiac disorders: QT prolongation in patients with hypokalemia (common); QT prolongation, palpitations, tachycardia, atrial fibrillation, angina pectoris (uncommon); ventricular tachy-arrhythmias, syncope (i.e., acute and short lasting loss of consciousness) (rare); unspecified arrhythmias, Torsade de Pointes, cardiac arrest (very rare).
- Vascular disorders: Vasodilatation (uncommon); hypertension, hypotension (rare); Vasculitis (very rare).
- Respiratory, thoracic and mediastinal disorders: Dyspnea (including asthmatic conditions) (uncommon).
- Gastrointestinal disorders: Nausea, vomiting, gastrointestinal and abdominal pains, diarrhea (common); decreased appetite and food intake, constipation, dyspepsia, flatulence, gastritis, increased amylase (uncommon); dysphagia, stomatitis, antibiotic associated colitis (incl. pseudo-membranous colitis, in very rare cases associated with life-threatening complications) (rare).
- Hepatobiliary disorders: Increase in transaminases (common); hepatic impairment (incl. LDH increase), increased bilirubin, increased gamma-glutamyl-transferase, increase in blood alkaline phosphatase (uncommon); jaundice, hepatitis (predominantly cholestatic) (rare); fulminant hepatitis potentially leading to life-threatening liver failure (incl. fatal cases) (very rare).
- Skin and subcutaneous tissue disorders: Pruritus, rash, urticaria, dry skin (uncommon); bullous skin reactions like Stevens-Johnson syndrome or toxic epidermal necrolysis (potentially life-threatening) (very rare).
- Musculoskeletal and connective tissue disorders: Arthralgia, myalgia (uncommon); tendonitis, muscle cramp, muscle twitching, muscle weakness (rare); tendon rupture, arthritis, muscle rigidity, exacerbation of symptoms of myasthenia gravis (very rare).
- Renal and urinary disorders: Dehydration (uncommon); renal impairment (incl. increase in BUN and creatinine), renal failure (rare).
- General disorders and administration site conditions: Feeling unwell (predominantly asthenia or fatigue), painful conditions (incl. pain in back, chest, pelvic and extremities), sweating (uncommon); edema (rare).

There have been very rare cases of the following side effects reported following treatment with other fluoroquinolones, which might possibly also occur during treatment with Moxifloxacin: hypernatremia, hypercalcemia, hemolytic anemia, rhabdomyolysis, and photosensitivity reactions.

DOSAGE AND ADMINISTRATION

Posology (adults)

The recommended dose is one Floximox® 400 mg film-coated tablet once daily.

- Renal/hepatic impairment: No adjustment of dosage is required in patients with mild to severely impaired renal function or in patients on chronic dialysis i.e. hemodialysis and continuous ambulatory peritoneal dialysis.

There is insufficient data in patients with impaired liver function.

- Other special populations: No adjustment of dosage is required in the elderly and in patients with low bodyweight.
- Pediatric population: Floximox® is contraindicated in children and adolescents (< 18 years). Efficacy and safety of Floximox® in children and adolescents have not been established.

Method of administration

Floximox® film-coated tablet should be swallowed whole with sufficient liquid and may be taken independent of meals.

Duration of administration

Floximox® 400 mg film-coated tablets should be used for the following treatment durations:

- Acute exacerbation of chronic bronchitis: 5 - 10 days;
- Community acquired pneumonia: 10 days;
- Acute bacterial sinusitis: 7 days;
- Mild to moderate pelvic inflammatory disease: 14 days.

Floximox® 400 mg film-coated tablets have been studied in clinical trials for up to 14 days treatment.

- Sequential (intravenous followed by oral) therapy: In clinical studies with sequential therapy most patients switched from intravenous to oral therapy within 4 days (community-acquired pneumonia) or 6 days (complicated skin and skin structure infections). The recommended total duration of intravenous and oral treatment is 7 -14 days for community-acquired pneumonia and 7 -21 days for complicated skin and skin structure infections.

The recommended dose (400 mg once daily) and duration of therapy for the indication being treated should not be exceeded.

OVERDOSAGE

No specific countermeasures after accidental overdose are recommended. In the event of overdose, symptomatic treatment should be implemented. ECG monitoring should be undertaken, because of the possibility of QT interval prolongation. Concomitant administration of charcoal with a dose of 400 mg oral Moxifloxacin will reduce systemic availability of the drug by more than 80%. The use of charcoal early during absorption may be useful to prevent excessive increase in the systemic exposure to Moxifloxacin in cases of oral overdose.

STORAGE CONDITIONS

Store below 30°C.

Keep in original pack in intact conditions.

Date of revision: March 2020.

This is a medicament

- A medicament is a product which affects your health, and its consumption contrary to instructions is dangerous for you
- Follow strictly the doctor's prescription, the method of use, and the instructions of the pharmacist who sold the medicament
- The doctor and the pharmacist are experts in medicine, its benefits and risks
- Do not by yourself interrupt the period of treatment prescribed for you
- Do not repeat the same prescription without consulting your doctor
- Medicament: keep out of reach of children

Council of Arab Health Ministers
Union of Arab Pharmacists

Benta S.A.L.
Dbayeh - Lebanon