SUMMARY OF PRODUCT CHARACTERISTICS

1. NAME OF THE PRODUCT

Rolac® **(Itraconazole) 100mg Capsules**

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

Rolac® 100mg Capsules
Each capsule contains:
Itraconazole Immediate Release Coated
Pellets MS Eq. to Itraconazole.....100mg

3. PHARMACEUTICAL FORM

Capsule

Appearance: Light brown opaque cap printed "**Rolac 100**" and off white colored body printed "" three times on them.

4. CLINICAL PARTICULARS

4.1. THERAPEUTIC INDICATIONS:

- Vulvovaginal candidosis
- Pityriasis versicolor
- Dermatophytoses caused by organisms susceptible to itraconazole
- Oral candidosis
- Fungal keratitis
- Systemic mycoses
- Onychomycosis

4.2. POSOLOGY AND METHOD OF ADMINISTRATION:

Posology:
Treatment schedules in adults for each indication are as follows:
Short-term usage:

Indications	Dose
Vulvovaginal candidosis	200mg twice daily for 1 day or 200mg once daily for 3 days
Pityriasis versicolor	200mg once daily for 7 days
Tinea corporis, tinea cruris	100mg once daily for 2 weeks or 200mg once daily for 7 days
Tinea pedis, tinea manuum	100mg once daily for 4 weeks
Oral candidosis	100mg once daily for 2 weeks
Fungal keratitis	200mg once daily for 3 weeks Treatment should not exceed 4 weeks

Long-term usage:
Dosage recommendations vary according to the infection treated.

Indication	Dose	Median duration
Onychomycosis	200mg od	3 months
Aspergillosis	200mg od	2-5 months
Candidosis	100-200mg od	3 weeks-7 months
Non-meningeal cryptococcosis	200mg od	1-6 months
Cryptococcal meningitis	200mg bid	2 months- 1 year
Histoplasmosis	200mg od -200mg bid	8 months
Sporotrichosis	100mg od	3 months
Paracoccidioidomycosis	100mg od	6 months
Chromomycosis	100-200mg od	6 months
Blastomycosis	100mg od – 200mg bid	6 months

Use in Children (below 12 years): Clinical data on the use of Itraconazole capsules in paediatric patients are limited. Itraconazole capsules should not be used in children unless the potential benefit outweighs the potential risks.
Use in Elderly: As for use in children.
Use in patients with renal impairment: Limited data are available on the use of oral itraconazole in patients with renal impairment. Caution should be exercised when this drug is administered in this patient population.
Use in patients with hepatic impairment: Limited data are available on the use of oral itraconazole in patients with hepatic impairment. Caution should be exercised when this drug is administered in this patient population.
Method of administration:
Itraconazole is for oral administration and must be taken immediately after a meal for maximal absorption. The capsule must be swallowed whole.

4.3. CONTRAINDICATIONS:

Itraconazole is also contraindicated in patients who have shown hypersensitivity to the drug or to any of its excipients. Co-administration of the following drugs is contraindicated with Itraconazole capsules.

- CYP3A4 metabolised substrates that can prolong the QT-interval e.g. astemizole, bepridil, cisapride, dofetilide, levacetylmethadol (levomethadyl), mizolastine, pimozide, quinidine, sertindole and terfanadine are contraindicated with Itraconazole capsules. Co-administration may result in increased plasma concentrations of these substrates, which can lead to QT prolongation and rare occurrences of torsades de pointes.
- CYP3A4 metabolised HMG-CoA reductase inhibitors such as lovastatin and simvastatin.
- Triazolam and oral midazolam.
- Ergot alkaloids such as dihydroergotamine, ergometrine (ergonovine), ergotamine and methylergometrine (methylergonovine).
- Eletriptan.
- Nisoldipine.

Itraconazole capsules should not be administered to patients with evidence of ventricular dysfunction such as congestive heart failure (CHF) or a history of CHF except for the treatment of life-threatening or other serious infections. Itraconazole must not be used during pregnancy (except for life-threatening cases). Women of childbearing potential taking Itraconazole should use contraceptive precautions. Effective contraception should be continued until the menstrual period following the end of Itraconazole therapy.

4.4. SPECIAL WARNINGS AND PRECAUTIONS FOR USE:

Cardiac effects: In a healthy volunteer study with Itraconazole IV, a transient asymptomatic decrease of the left ventricular ejection fraction was observed; this resolved before the next infusion. The clinical relevance of these findings to the oral formulations is unknown. Itraconazole has been shown to have a negative inotropic effect and Itraconazole has been associated with reports of CHF. Heart failure was more frequently reported among spontaneous reports of 400mg total daily dose than among those of lower total daily doses, suggesting that the risk of heart failure might increase with the total daily dose of itraconazole. Itraconazole should not be used in patients with CHF or with a history of CHF unless the benefit clearly outweighs the risk. This individual benefit/risk assessment should take into consideration factors such as the severity of the indication, the dosing regimen (e.g. total daily dose), and individual risk factors for CHF. These risk factors include cardiac disease, such as ischaemic and valvular disease; significant pulmonary disease, such as chronic obstructive pulmonary disease; and renal failure and other oedematous disorders. Such patients should be informed of the signs and symptoms of CHF, should be treated with caution, and should be monitored for signs and symptoms of CHF during treatment; if such signs or symptoms do occur during treatment, Itraconazole should be discontinued. Calcium channel blockers can have negative inotropic effects which may be additive to those of itraconazole. In addition, itraconazole can inhibit the metabolism of calcium channel blockers. Therefore, caution should be used when co-administering itraconazole and calcium channel blockers due to an increased risk of CHF.
Interaction potential: Itraconazole has a potential for clinically important drug interactions.
Reduced gastric acidity: Absorption of itraconazole from Itraconazole is impaired when gastric acidity is decreased. In patients also receiving acid neutralising medicines (e.g. aluminium hydroxide), these should be administered at least 2 hours after the intake of Itraconazole. In patients with achlorhydria such as certain AIDS patients and patients on acid secretion suppressors (e.g. H2-antagonists, proton pump inhibitors), it is advisable to administer Itraconazole with a cola beverage.
Use in children: Clinical data on the use of Itraconazole capsules in paediatric patients is limited. Itraconazole capsules should not be used in paediatric patients unless the potential benefit outweighs the potential risks.

Hepatic effects: Liver function monitoring should be considered in patients receiving Itraconazole treatment. Very rare cases of serious hepatotoxicity, including some cases of fatal acute liver failure, have occurred with the use of Itraconazole. Most of these cases involved patients who had pre-existing liver disease, were treated for systemic indications, had significant other medical conditions and/or were taking other hepatotoxic drugs. Some patients had no obvious risk factors for liver disease. Some of these cases have been observed within the first month of treatment, including some within the first week. Patients should be instructed to promptly report to their physician signs and symptoms suggestive of hepatitis such as anorexia, nausea, vomiting, fatigue, abdominal pain or dark urine. In these patients, treatment should be stopped immediately and liver function testing should be conducted. In patients with raised liver enzymes or active liver disease, or who have experienced liver toxicity with other drugs, treatment should not be started unless the expected benefit exceeds the risk of hepatic injury. In such cases liver enzyme monitoring is necessary.
Hepatic impairment: Limited data are available on the use of oral itraconazole in patients with hepatic impairment. Caution should be exercised when the drug is administered in this patient population.
Immunocompromised patients: In some immunocompromised patients (e.g. neutropenic, AIDS or organ transplant patients), the oral bioavailability of Itraconazole capsules may be decreased.
Patients with immediately life-threatening systemic fungal infections: Due to the pharmacokinetic properties, Itraconazole capsules are not recommended for initiation of treatment with immediately life-threatening systemic fungal infections.
Patients with AIDS: In patients with AIDS having received treatment for a systemic fungal infection such as sporotrichosis, blastomycosis, histoplasmosis or cryptococcosis (meningeal and non-meningeal) and who are considered at risk for relapse, the treating physician should evaluate the need for a maintenance treatment.
Neuropathy: If neuropathy occurs that may be attributable to Itraconazole, treatment should be discontinued.
Renal impairment: Limited data are available on the use of oral itraconazole in patients with renal impairment. Caution should be exercised when this drug is administered in this patient population.
Cross Hypersensitivity: There is no information regarding cross hypersensitivity between itraconazole and other azole antifungal agents. Caution should be used in prescribing Itraconazole to patients with hypersensitivity to other azoles. Patients with rare hereditary problems of fructose intolerance, glucose-galactose malabsorption or sucrase-isomaltase insufficiency should not take this medicine.
Hearing Loss: Transient or permanent hearing loss has been reported in patients receiving treatment with itraconazole. Several of these reports included concurrent administration of quinidine which is contraindicated. The hearing loss usually resolves when treatment is stopped, but can persist in some patients.

4.5. INTERACTION WITH OTHER MEDICINAL PRODUCTS AND OTHER FORMS OF INTERACTION:
Drugs affecting the absorption of itraconazole: Drugs that reduce the gastric acidity impair the absorption of itraconazole from Itraconazole capsules.
Drugs affecting the metabolism of itraconazole: Itraconazole is mainly metabolised through cytochrome CYP3A4. Interaction studies have been performed with rifampicin, rifabutin and phenytoin, which are potent enzyme inducers of CYP3A4. Since the bioavailability of itraconazole and hydroxy-itraconazole was decreased in these studies to such an extent that efficacy may be largely reduced, the combination of itraconazole with these potent enzyme inducers is not recommended. No formal study data are available for other enzyme inducers, such as carbamazepine, Hypericum perforatum (St John's Wort), phenobarbital and isoniazid, but similar effects should be anticipated. Potent inhibitors of this enzyme such as ritonavir, indinavir, clarithromycin and erythromycin may increase the bioavailability of itraconazole.
Effects of itraconazole on the metabolism of other drugs: Itraconazole can inhibit the metabolism of drugs metabolised by the cytochrome 3A family. This can result in an increase and/or a prolongation of their effects, including side effects. When using concomitant medication, the corresponding label should be consulted for information on the route of metabolism. After stopping treatment, itraconazole plasma concentrations decline gradually, depending on the dose and duration of treatment. This should be taken into account when the inhibitory effect of itraconazole on co-administered drugs is considered.
Examples are: The following drugs are contraindicated with itraconazole:
- Astemizole, bepridil, cisapride, dofetilide, levamethadol (levomethadyl), mizolastine, pimozide, quinidine, sertindole and terfenadine are contraindicated with Itraconazole since co-administration may result in increased plasma concentrations of these substrates, which can lead to QT prolongation and rare occurrences of torsades de pointes.
- CYP3A4 metabolised HMG-CoA reductase inhibitors such as lovastatin and simvastatin.
- Triazolam and oral midazolam.
- Ergot alkaloids such as dihydroergotamine, ergometrine (ergonovine), ergotmaine and methylergometrine (methylergonovine).
- Nisoldipine.

Caution should be used when co-administering itraconazole with calcium channel blockers due to an increased risk of congestive heart failure. In addition to possible pharmacokinetic interactions involving the drug metabolizing enzyme CYP3A4, calcium channel blockers can have inotropic effects which may be additive to those of itraconazole. The following drugs should be used with caution, and their plasma concentrations, effects or side effects should be monitored. Their dosage, if co-administered with itraconazole, should be reduced if necessary:
- Oral anticoagulants;
- HIV protease inhibitors such as ritonavir, indinavir, saquinavir;
- Certain antineoplastic agents such as vinca alkaloids, busulphan, docetaxel and trimetrexate;
- CYP3A4 metabolised calcium channel blockers such as dihydropyridines and verapamil;
- Certain immunosuppressive agents: ciclosporin, tacrolimus, rapamycin (also known as sirolimus);
- Certain CY3A4 metabolised HMG-CoA reductase inhibitors such as atorvastatin;
- Certain glucocorticosteroids such as budesonide, dexamethasone, methylprednisolone and fluticasone;
- Digoxin (via inhibition of P-glycoprotein);
- Others: carbamazepine, cilostazol, buspirone, alfentanil, alprazolam, brotizolam, midazolam IV, disopyramide, eletriptan, fentanyl, halofantrine, rifabutin, repaglinide, ebastine, reboxetine. No interaction of itraconazole with zidovudine (AZT) and fluvastatin has been observed. No inducing effects of itraconazole on the metabolism of ethinyloestradiol and norethisterone were observed.

Effect on protein binding: In vitro studies have shown that there are no interactions on the plasma protein binding between itraconazole and imipramine, propranolol, diazepam, cimetidine, indomethacin, tolbutamide or sulfamethazine.

4.6. FERTILITY, PREGNANCY AND LACTATION:
Fertility: Women of childbearing potential taking itraconazole capsules should use contraceptive precautions. Effective contraception should be continued until the menstrual period following the end of itraconazole therapy.
Pregnancy: Itraconazole must not be used during pregnancy except for life-threatening cases where the potential benefit to the mother outweighs the potential harm to the foetus. In animal studies itraconazole has shown reproductive toxicity. There is limited information on the use of itraconazole during pregnancy. During post-marketing experience, cases of congenital abnormalities have been reported. These cases included skeletal, genitourinary tract, cardiovascular and ophthalmic malformations as well as chromosomal and multiple malformations. A causal relationship with itraconazole has not been established. Epidemiological data on exposure to itraconazole during the first trimester of pregnancy – mostly in patients receiving short-term treatment for vulvovaginal candidosis – did not show an increased risk for malformations as compared to control subjects no exposed to any known teratogens.
Breast-feeding: A very small amount of itraconazole is excreted in human milk. The expected benefits of itraconazole therapy should be weighed against the risks of breast-feeding. In case of doubt, the patient should not breast feed.

4.7. EFFECTS ON ABILITY TO DRIVE AND USE MACHINES:
No studies on the effects on the ability to drive and use machines have been performed. When driving vehicles and operating machinery the possibility of adverse reactions such as dizziness, visual disturbances and hearing loss, which may occur in some instances, must be taken into account.

4.8. UNDESIRABLE EFFECTS
Adverse drug reactions from spontaneous reports during worldwide postmarketing experience with Itraconazole (all formulations) . The adverse drug reactions are ranked by frequency, using the following convention: Very common ≥1/10, Common ≥1/100 and < 1/10, Uncommon ≥1/1000 and <1/100, Rare ≥1/10000 and < 1/1000, Very rare <1/10000 including isolated reports. The frequencies below reflect reporting rates for adverse drug reactions from spontaneous reports, and do not represent more precise estimates of incidence that might be obtained in clinical or epidemiological studies.
Blood and lymphatic system disorders: ***Very Rare:*** Leukopenia, neutropenia, thrombocytopenia.
Immune system disorders: ***Very Rare:*** Serum sickness angioneurotic oedema anaphylactic, anaphylactoid and allergic reactions.
Metabolism and nutrition disorders: ***Very Rare:*** Hypertriglyceridemia, hypokalemia.
Nervous system disorders: ***Very Rare:*** Peripheral neuropathy, paraesthesia, hypoaesthesia, headache, dizziness.
Eye disorders: ***Very Rare:*** Visual disturbances, including vision blurred and diplopia.
Ear labyrinth disorders: ***Very Rare:*** Tinnitus, transient or permanent hearing loss.
Cardiac disorders: ***Very Rare:*** Congestive heart failure.
Respiratory, thoracic and mediastinal disorders: ***Very Rare:*** Pulmonary oedema.
Gastrointestinal disorders: ***Very Rare:*** Diarrhoea, nausea, vomiting, abdominal pain, dysgeusia, dyspepsia
Hepatobiliary disorders: ***Very Rare:*** Serious hepatotoxicity (including some cases of fatal acute liver failure), hepatitis, reversible increases in hepatic enzymes.
Skin and subcutaneous tissue disorders: ***Very Rare:*** Toxic epidermal necrolysis, Stevens-Johnson syndrome, erythema multiforme, exfoliative dermatitis, leukocytoclastic vasculitis, urticaria, alopecia, photosensitivity, rash, pruritus.
Renal and urinary disorders: ***Very Rare:*** Pollakiuria, urinary incontinence.
General disorders and administration site conditions: ***Very Rare:*** Oedema.
Musculoskeletal and connective tissue disorder: ***Very Rare:*** Myalgia, arthralgia.
Reproductive system and disorders: ***Very Rare:*** Menstrual disorders, erectile dysfunction.

4.9. OVERDOSE:
No data are available. In the event of an overdose, supportive measures should be employed. Within the first hour after ingestion gastric lavage may be performed. Activated charcoal may be given if considered appropriate. Itraconazole cannot be removed by haemodialysis. No specific antidote is available.

5. PHARMACOLOGICAL PROPERTIES
5.1. PHARMACODYNAMIC PROPERTIES:
Pharmacotherapeutic group: Antimycotic for systemic use, triazole derivatives. **ATC code:** J02A C02

SUMMARY OF PRODUCT CHARACTERISTICS

Mechanism of action: Itraconazole, a triazole derivative, has a broad spectrum of activity. In vitro studies have demonstrated that itraconazole impairs the synthesis of ergosterol in fungal cells. Ergosterol is a vital cell membrane component in fungi. Impairment of its synthesis ultimately results in an antifungal effect. For itraconazole, breakpoints have only been established for Candida spp. from superficial mycotic infections (CLSI M27-A2, breakpoints have not been established for EUCAST methodology). The CLSI breakpoints are as follows: susceptible 10g/mL. Interpretive breakpoints have not been established for the filamentous fungi. In vitro studies demonstrate that itraconazole inhibits the growth of a broad range of fungi pathogenic for humans at concentrations usually 1µg/ml. These include: dermatophytes (*Trichophyton* spp., *Microsporum* spp., *Epidermophyton floccosum*); yeasts (*Candida* spp., including *C. albicans*, *Cryptococcus neoformans*, *Malassezia* spp., *Trichosporon* spp., *Geotrichum* spp.); *Aspergillus* spp.; *Histoplasma* spp.; *Paracoccidioides brasiliensis; Sporothrix schenckii; Fonsecaea* spp.; *Cladosporium* spp.; *Blastomyces dermatitidis; Coccidioides immitis; Pseudallescheria boydii; Penicillium marneffei;* and various other yeasts and fungi. *Candida krusei, Candida glabrata* and *Candida tropicalis* are generally the least susceptible *Candida* species, with some isolates showing unequivocal resistance to itraconazole in vitro. The principal fungus types that are not inhibited by itraconazole are Zygomycetes (e.g. *Rhizopus* spp., *Rhizomucor* spp., *Mucor* spp. and *Absidia* spp.), *Fusarium* spp., *Scedosporium* spp. and *Scopulariopsis* spp. Azole resistance appears to develop slowly and is often the result of several genetic mutations. Mechanisms that have been described are overexpression of ERG11, which encodes the target enzyme 14 alpha-demethylase, point mutations in ERG11 that lead to decreased target affinity and/or transporter overexpression resulting in increased efflux. Cross-resistance between members of the azole class has been observed within Candida spp., although resistance to one member of the class does not necessarily confer resistance to other azoles. Itraconazole-resistant strains of *Aspergillus fumigatus* have been reported.

5.2. PHARMACOKINETICS:
General pharmacokinetic characteristics: The pharmacokinetics of itraconazole has been investigated in healthy subjects, special populations and patients after single and multiple dosing. In general, itraconazole is well absorbed. Peak plasma concentrations are reached within 2 to 5 hours following administration of the oral solution. Itraconazole undergoes extensive hepatic metabolism to give numerous metabolites. The main metabolite is hydroxy-itraconazole, with plasma concentrations about twice those of the unchanged drug. The terminal half-life of itraconazole is about 40 hours after repeated dosing. The pharmacokinetics of itraconazole is characterized by non-linearity and, consequently, shows accumulation in plasma after multiple dose administration. Steady-state concentrations are reached within 15 days, with C_{max} values of about 2µg/ml after oral administration of 200mg once daily. Itraconazole clearance decreases at higher doses due to a saturable mechanism of its hepatic metabolism. Itraconazole is excreted as inactive metabolites in urine (~35%) and in faeces (~54%).
Absorption: Itraconazole is rapidly absorbed after administration of the oral solution. Peak plasma concentrations of the unchanged drug are reached within 2 to 5 hours following an oral dose. The observed absolute bioavailability of itraconazole under fed conditions is about 55% Oral bioavailability is maximal when the capsules are taken immediately after a full meal.
Distribution: Most of the itraconazole in plasma is bound to protein (99.8%) with albumin being the main binding component (99.6% for the hydroxy-metabolite). It has also a marked affinity for lipids. Only 0.2% of the itraconazole in plasma is present as free drug. Itraconazole is distributed in a large apparent volume in the body (> 700L), suggesting its extensive distribution into tissues: Concentrations in lung, kidney, liver, bone, stomach, spleen and muscle were found to be two to three times higher than corresponding concentrations in plasma. Brain to plasma ratios were about 1. The uptake into keratinous tissues, skin in particular, is up to four times higher than in plasma.
Metabolism: Itraconazole is extensively metabolised by the liver into a large number of metabolites. The main metabolite is hydroxy-itraconazole which has in vitro antifungal activity comparable to itraconazole. Plasma concentrations of the hydroxy-metabolite are about twice those of itraconazole. As shown in in vitro studies, CYP 3A4 is the major enzyme that is involved in the metabolism of itraconazole.
Elimination: Itraconazole is excreted as inactive metabolites to about 35% in urine within one week and to about 54% with faeces. Renal excretion of the parent drug accounts for less than 0.03% of the dose, whereas faecal excretion of unchanged drug varies between 3-18% of the dose. As re-distribution of itraconazole from keratinous tissues appears to be negligible, elimination of itraconazole from these tissues is related to epidermal regeneration. Contrary to plasma, the concentration in skin persists for 2 to 4 weeks after discontinuation of a 4-week treatment and in nail keratin.
– where itraconazole can be detected as early as 1 week after start of treatment
– for at least six months after the end of a 3-month treatment period.

5.3. PRECLINICAL SAFETY DATA:
Itraconazole: Itraconazole has been tested in a standard battery of non-clinical safety studies. Acute toxicity studies with itraconazole in mice, rats, guinea pigs and dogs indicate a wide safety margin. Sub (chronic) oral toxicity studies in rats and dogs revealed several target organs or tissues: adrenal cortex, liver and mononuclear phagocyte system as well as disorders of the lipid metabolism presenting as xanthoma cells in various organs. At high doses, histological investigations of adrenal cortex showed a reversible swelling with cellular hypertrophy of the zona reticularis and fasciculata, which was sometimes associated with a thinning of the zona glomerulosa. Reversible hepatic changes were found at high doses. Slight changes were observed in the sinusoidal cells and vacuolation of the hepatocytes, the latter indicating cellular dysfunction, but without visible hepatitis or hepatocellular necrosis. Histological changes of the mononuclear phagosystem were mainly characterized by macrophages with increased proteinaceous material in various parenchymal tissues. There are no indications of a mutagenic potential of itraconazole. Itraconazole is not a primary carcinogen in rats or mice. In male rats, however, there was a higher incidence of soft-tissue sarcoma, which is attributed to the increase in non-neoplastic, chronic inflammatory reactions of the connective tissue as a consequence of raised cholesterol levels and cholesterosis in connective tissue. There is no evidence of a primary influence on fertility under treatment with itraconazole. Itraconazole was found to cause a dose-related increase in maternal toxicity, embryotoxicity, and teratogenicity in rats and mice at high doses. In rats, the teratogenicity consisted of major skeletal defects; in mice, it consisted of encephaloceles and macroglossia. A global lower bone mineral density was observed in juvenile dogs after chronic itraconazole administration. In three toxicology studies using rats, itraconazole induced bone defects. The induced defects included reduced bone plate activity, thinning of the zona compacta of the large bones, and increased bone fragility.

6. PHARMACEUTICAL PARTICULARS

6.1. LIST OF EXCIPIENTS:
● Sucrose ● Maize starch ● Hypermellose ● Polyethylene glycol ● Talcum powder

6.2. INCOMPATIBILITIES:
Not applicable.

6.3. SHELF LIFE:
See expiry on the pack.

6.4. SPECIAL PRECAUTIONS FOR STORAGE:
Do not store over 30°C, and protect from heat, light and moisture. Improper storage may deteriorate the medicine.
Keep out of reach of children.

6.5. NATURE AND CONTENTS OF CONTAINER:
Alu/PVC blister, pack size is 4's.

6.6. SPECIAL PRECAUTIONS FOR DISPOSAL OF A USED PRODUCT:
No special requirements.

6.7. DRUG PRODUCT SPECIFICATIONS:
BP Specs.

7. MARKETING AUTHORISATION HOLDER

Manufactured by:
SAMI Pharmaceuticals (Pvt.) Ltd.
F-140/A, S.I.T.E., Karachi-Pakistan
www.samipharmapk.com
Mfg Lic. No. 000938

8. MARKETING AUTHORISATION NUMBER(S)

024491

9. DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUTHORISATION

14th March, 2002

10. DATE OF REVISION OF THE TEXT

رولیک ۱۰۰ ملی گرام کیپسول
(اٹراکونازول)

ہدایات:

خوراک ڈاکٹر کی ہدایت کے مطابق استعمال کریں۔

صرف رجسٹرڈ ڈاکٹر کے نسخے کے مطابق فروخت کریں۔

بچوں کی پہنچ سے دور رکھیں۔

دوا کو ۳۰ ڈگری سینٹی گریڈ سے زیادہ درجہ حرارت پر نہ رکھیں،

گرمی، روشنی اور نمی سے محفوظ رکھیں ورنہ دوا خراب ہو جائیگی۔