PROFESSIONAL INFORMATION (APPROVED)

SCHEDULING STATUS

S4

1. NAME OF THE MEDICINE

MEROJECT 500 mg sterile powder for injection

MEROJECT 1 g sterile powder for injection

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

Active ingredients:

MEROJECT 500 mg: Each vial contains 500 mg meropenem anhydrous (as trihydrate).

MEROJECT 1 g: Each vial contains 1000 mg meropenem anhydrous (as trihydrate).

Sodium content:

MEROJECT 500 mg: 45 mg sodium/vial

MEROJECT 1 g: 90 mg sodium/vial

MEROJECT contains sodium which should be taken into consideration by patients on a controlled sodium diet.

MEROJECT is sugar free.

Each mL of reconstituted vial contains 50 mg Meropenem.

For the full list of excipients, see section 6.1

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3. PHARMACEUTICAL FORM

White to light yellow crystalline sterile powder for injection.

The reconstituted solution is a clear, pale yellow solution practically free from particulate matter.

4. CLINICAL PARTICULARS

4.1 Therapeutic indications

MEROJECT is indicated for the treatment of the following infections, caused by single or multiple susceptible bacteria and as empiric therapy prior to the identification of the causative organisms:

- **Acute exacerbation of chronic bronchitis and pneumonia due to:**

  *Staphylococcus aureus (*methicillin-susceptible strains only*), Streptococcus pneumoniae, Streptococcus spp., Escherichia coli, Haemophilus influenzae, Haemophilus parainfluenzae, Pseudomonas aeruginosa, Moraxella (Branhamella) catarrhalis, Klebsiella* spp*., Enterobacter cloacae, Enterobacter* spp., Acinetobacter spp.
- **Pneumonia in children due to:**

  *Staphylococcus aureus (*methicillin-susceptible strains only*), Streptococcus pneumoniae, Haemophilus influenzae, Pseudomonas aeruginosa.*
- **Urinary tract infections in adults and children, including complicating infections due to:**

Enterobacter cloacae, Escherichia coli, Pseudomonas aeruginosa, Morganella morganii, Proteus mirabilis, Serratia marcescens, Citrobacter freundii.

- **Pelvic Inflammatory Disease (including tubo-ovarian abscess) and endometritis due to:**

  Staphylococcus aureus (methicillin-susceptible strains only), *Staphylococcus epidermidis*, *Streptococcus haemolyticus*, *Staphylococcus* spp. (coagulase negative), *Streptococcus agalactiae* Group B, *Pseudomonas aeruginosa, Streptococcus beta-haemolytic, Streptococcus faecalis, Staphylococcus gamma haemolyticus,* Group D Streptococcus (enterococcus and non-enterocossus*), Streptococcus viridans, Acinetobacter anitratus, Acinetobacter lwoffii, Enterobacter aerogenes, Enterobacter cloacae, Escherichia coli, Gardnerella vaginalis, Klebsiella pneumoniae, Neisseria gonorrhoeae, Proteus mirabilis, Enterococcus faecalis, Bacteroides fragilis group, Peptostreptococcus anaerobius, Peptostreptococcus asaccharolyticus, Peptostreptococcus magnus*

- **Skin and skin structure infections in adults due to:**

  *Escherichia coli, Klebsiella pneumoniae, Proteus mirabilis, Pseudomonas aeruginosa, Staphylococcus aureus (*methicillin-susceptible strains only*), Coagulase-negative Staphylococcus* spp*. (*methicillin-susceptible strains only*), Streptococcus agalactiae, Enterococcus faecalis,* (Group A) *Streptococcus, Streptococcus viridans, Bacteroides fragilis, Peptostreptococcus* spp.

- **Meningitis in adults and children due to:**

Streptococcus pneumoniae, Haemophilus influenzae, Neisseria meningitidis

- **Septicaemia in adults and children due to:**

  Streptococcus pneumoniae, Escherichia coli, Klebsiella pneumoniae
- **Empiric treatment, including initial monotherapy, for presumed bacterial infections in host-compromised neutropenic patients due to:**

  Staphylococcus aureus, Micrococcus spp., Streptococcus sanguis, Streptococcus epidermidis, Streptococcus mitis, Escherichia coli, Pseudomonas aeruginosa.
- **Intra-abdominal abscess and peritonitis due to:** *Streptococcus milleri, Streptococcus mitior, Enterococcus faecalis, Escherichia coli, Klebsiella pneumoniae, Pseudomonas aeruginosa, Bacteroides fragilis, Bacteroides ovatus, Bacteroides distasonis, Bacteroides thetaiotaomicron, Bacteroides vulgatus, Klebsiella oxytoca, Clostridium perfringens.*
- **Polymicrobial infections**

In the treatment of infections caused by *Pseudomonas aeruginosa*, an aminoglycoside should be administered concomitantly.

4.2 Posology and method of administration

Posology

Adults

Usual dose: Administration of 500 mg to 1 g by intravenous infusion every 8 hours.

Dose Exceptions

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a) Dose of 1 g every 8 hours for febrile episodes in neutropenic patients.

b) Dose of 2 g every 8 hours for meningitis.

In critically ill patients with known or suspected *Pseudomonas aeruginosa* lower respiratory tract infections, concomitant use of an aminoglycoside is recommended, and regular sensitivity testing is recommended.

Special populations

Impaired renal function – Adult dosage schedule:

In adult patients with creatinine clearance below 51 mL/min the dosage of MEROJECT should be reduced as follows:

Creatinine Clearance (ml/min)	**Dose**
26 - 50	1 g every 12 hours
10 - 25	500 mg every 12 hours
< 10	500 mg every 24 hours

Meropenem is cleared by haemodialysis. If continued use with MEROJECT is necessary, the unit dose based on the infection type and severity is recommended at the completion of the haemodialysis procedure to re-institute effective treatment.

There is no experience with peritoneal dialysis.

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Impaired hepatic function

MEROJECT dosage need not be adjusted in patients with impaired hepatic function.

Elderly

MEROJECT dosage need not be adjusted for the elderly with normal renal function or creatinine clearance values above 50 ml/min.

Paediatric population

No data on meropenem is available for children.

In children over 50 kg weight, the adult dosage schedule should be used.

Children older than three months and up to 12 years are to be administered an intravenous dose of 10 to 40 mg/kg every 8 hours, depending on the type and severity of the infection, the condition of the patient and known susceptibility of the organism(s).

Exceptions:

Meningitis: An 8 hourly 40 mg/kg dose should be given.

There is no experience in children with renal impairment.

Method of administration

MEROJECT is intended for intravenous injection administered by intravenous infusion over 15 to 30 minutes or by rapid intravenous injection of 3 to 5 minutes every 8 hours.

In the treatment of beta-haemolytic streptococcal infections, a therapeutic dose should be administered for at least 10 days.

4.3 Contraindications

MEROJECT is contraindicated in:

- Patients with hypersensitivity to meropenem or any of the other ingredients of MEROJECT (see section 6.1)
- Patients hypersensitive (allergic) to carbapenems, penicillins or other beta-lactam antibacterials (e.g., cephalosporins, imipenem) may be hypersensitive to meropenem.
- Pregnancy and lactation (see section 4.6).

4.4 Special warnings and precautions for use

The appropriateness of using a carbapenem antibacterial medicine (as MEROJECT) should be based on factors such as severity of the infection, the prevalence of resistance to other suitable antibacterial medicines and the risk of selecting for carbapenem-resistant bacteria.

***Enterobacteriaceae, Pseudomonas aeruginosa and Acinetobacter spp*. resistance:**

Prescribers are advised to consider the local prevalence of resistance in these bacteria to penem antibiotics.

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Hypersensitivity reactions

Serious and occasionally fatal hypersensitivity reactions have been reported (see sections 4.3 and 4.8).

Patients who have a history of hypersensitivity to carbapenems, penicillins or other beta-lactam antibiotics may also be hypersensitive to MEROJECT.

Before initiating therapy with MEROJECT, careful inquiry should be made concerning previous hypersensitivity reactions to beta-lactam antibiotics.

If a severe allergic reaction occurs, MEROJECT should be discontinued, and appropriate measures taken.

Severe cutaneous adverse reactions (SCAR), such as Stevens-Johnson syndrome (SJS), toxic epidermal necrolysis (TEN), drug reaction with eosinophilia and systemic symptoms (DRESS), erythema multiforme (EM) and acute generalised exanthematous pustulosis (AGEP) have been reported in patients receiving meropenem (see section 4.8). If signs and symptoms suggestive of these reactions appear, MEROJECT should be withdrawn immediately, and an alternative treatment should be considered.

Antibiotic-associated colitis

Antibiotic-associated colitis and pseudomembranous colitis have been reported with MEROJECT and may range in severity from mild to life threatening. Therefore, it is important to consider this diagnosis in patients who present with diarrhoea during or subsequent to the administration of meropenem. Discontinuation of therapy with

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MEROJECT and the administration of specific treatment for *Clostridium difficile* should be considered. Medicines that inhibit peristalsis should not be given.

Seizures

Care is necessary in patients with CNS disorders such as epilepsy as seizures have been infrequently reported during the treatment with carbapenems, including meropenem, as contained in MEROJECT (see section 4.8).

Hepatic function monitoring

Liver function monitoring is essential in patients with pre-existing liver disorders during treatment with MEROJECT due to the risk of hepatic toxicity (hepatic dysfunction with cholestasis and cytolysis) and vanishing bile duct syndrome. There is no dose adjustment necessary.

Direct antiglobulin test (Coombs test) seroconversion

A positive direct or indirect antiglobulin (Coombs) test may develop.

Concomitant use with valproic acid/sodium valproate/valpromide

The concomitant use of MEROJECT (powder for injection) and valproic acid/sodium valproate/valpromide is not recommended (see section 4.5).

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MEROJECT contains sodium

MEROJECT 500 mg contains 45 mg sodium/vial, equivalent to approximately 2,25 % of the WHO recommended maximum daily intake of 2 g sodium for an adult.

MEROJECT 1 g contains 90 mg sodium/vial, equivalent to approximately 4,5 % of the WHO recommended maximum daily intake of 2 g sodium for an adult.

MEROJECT is considered high in sodium. This should be particularly considered for those on a low salt diet.

Paediatric population

MEROJECT is not recommended in infants under 3 months old because efficacy and tolerability have not been established.

4.5 Interaction with other medicines and other forms of interaction

Probenecid inhibits the renal excretion of MEROJECT thereby increasing its plasma concentrations and prolonging the elimination half-life.

As the potency and duration of action of MEROJECT dosed without probenecid are adequate, the co-administration of probenecid with MEROJECT is not recommended.

The potential effect of meropenem on the protein binding of other medicines or metabolism has not been studied. However, the protein binding is so low that no interactions with other compounds would be expected.

Meropenem has been administered concomitantly with many other medicines without

apparent adverse interactions.

Valproic acid plasma levels may be reduced by meropenem when it is co-administered with carbapenem medicines resulting in a 60 - 100 % decrease in valproic acid levels in about two days. Due to the rapid onset and the extent of the decrease, co-administration of valproic acid/sodium valproate/valpromide with carbapenem medicines is not considered to be manageable and therefore should be avoided (see section 4.4).

Simultaneous administration of MEROJECT with warfarin may augment its anti-coagulant effects. There have been many reports of increases in the anti-coagulant effects of orally administered anti-coagulant medicines (including warfarin) in patients who are concomitantly receiving antibacterial medicines. The risk may vary with the underlying infection, age, and general status of the patient so that the contribution of the antibiotic to the increase in INR (international normalised ratio) is difficult to assess. It is recommended that the INR should be monitored frequently during and shortly after co-administration of MEROJECT with an oral anti-coagulant medicine such as warfarin.

Paediatric population

Interaction studies have only been performed in adults. However, no specific data regarding other potential medicine interactions are available.

4.6 Fertility, pregnancy, and lactation

Pregnancy

The safety of MEROJECT has not been established during pregnancy and the use of MEROJECT is not recommended (see section 4.3).

Breastfeeding

The use of MEROJECT is not recommended during breastfeeding.

Fertility

There is no data on fertility and the use of MEROJECT.

4.7 Effects on ability to drive and use machines

Although no data is available, MEROJECT is not expected to affect the ability to drive or operate machinery.

However, when driving or operating machines, it should be considered that headache, paraesthesia, and convulsions have been reported for meropenem.

4.8 Undesirable effects

Summary of the safety profile

Adverse reactions most frequently reported in a conducted review of patients with meropenem treatment exposures, were diarrhoea (2,3 %), rash (1,4 %), nausea/vomiting (1,4 %) and injection site inflammation (1,1 %). The most commonly reported meropenem-related laboratory adverse events were thrombocytosis (1,6 %) and increased hepatic enzymes (1,5 - 4,3 %).

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Tabulated list of adverse effects

System Organ Class	Frequency	Side effects
Infections and Infestations	Less frequent	Oral and vaginal candidiasis, pharyngitis
Blood and lymphatic system disorders	Frequent Less frequent	Thrombocythaemia Eosinophilia, neutropenia, leukopenia, agranulocytosis thrombocytopenia lymphadenopathy, haemolytic anaemia, positive direct or indirect antiglobulin test may develop
Immune system disorders	Less frequent	Angioedema, manifestations of anaphylaxis
Metabolism and nutrition disorders	Less frequent	Hypoglycaemia
Psychiatric disorders	Less frequent	Delirium
Nervous system disorders	Less frequent	Headache, paraesthesia, convulsions
Vascular disorders	Frequency unknown	Peripheral vascular disorder
Respiratory, thoracic, and mediastinal disorders	Less frequent	Epistaxis, apnoea

Gastrointestinal disorders	Frequent Less frequent Frequency unknown	Nausea, vomiting, constipation, diarrhoea, abdominal pain Pseudomembranous colitis Antibiotic-associated colitis (see section 4.4)
Hepatobiliary disorders	Frequent	Increases in serum transaminases, bilirubin, alkaline phosphatase, lactic dehydrogenase
Skin and subcutaneous tissue disorders	Frequent Less frequent Frequency unknown	Rash, pruritus, Urticarial, erythema multiforme, Stevens-Johnson syndrome, toxic epidermal necrolysis Drug Reaction with Eosinophilia and Systemic Symptoms, acute generalised exanthematous pustulosis (see section 4.4)
Renal and urinary disorders	Less frequent	Increased blood creatinine, increased blood urea
General disorders and administrative site conditions	Frequent	Inflammation, pain, thrombophlebitis

a. Paediatric population

MEROJECT can be used in children over 3 months of age. There is no reported evidence of an increased risk of any adverse drug reaction in children. All reported reactions were consistent with events observed in adult population.

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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 or https://www.sahpra.org.za/document/adverse-drug-reactions-and-quality-problem-reporting-form/.

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:

Renal impairment may lead to accidental overdosage of MEROJECT if the dose is not adjusted as described in Section 4.2.

Limited post-marketing experience indicates that if adverse reactions occur following overdose, they are consistent with the adverse reaction profile described in section 4.8 and are generally mild in severity and resolve on withdrawal or dose reduction.

Management of overdose:

The treatment is symptomatic and supportive, and haemodialysis is to be implemented in patients with renal impairment to remove meropenem and its metabolite.

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5. PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: Other beta-lactam antibacterials, Carbapenems

ATC code: J01DH02

Pharmacological classification: A20.1.1 Broad spectrum antibiotics

Mechanism of action

Meropenem is a carbapenem antibiotic which interferes with vital bacterial cell wall synthesis through binding to penicillin-binding proteins (PBPs) to exert its bacterial action. Meropenem has a high degree of stability to hydrolysis by almost all beta-latamases produced by gram-positive and gram-negative bacteria.

Meropenem has been shown *in vitro* to act synergistically with various antibiotics. A post-antibiotic effect has been demonstrated for meropenem *in vitro* and *in vivo*.

In vitro sensitivity does not necessarily imply clinical sensitivity.

Pharmacokinetic/Pharmacodynamic (PK/PD) relationship

Similar to other beta-lactam antibacterial medicines, the time that meropenem concentrations exceed the MIC (T>MIC) has been shown to best correlate with efficacy. In reported preclinical models meropenem demonstrated activity when plasma concentrations exceeded the MIC of the infecting organisms for approximately 40 % of the dosing interval. This target has not been established clinically.

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Mechanism of resistance

Bacterial resistance to meropenem may result from: (1) decreased permeability of the outer membrane of Gram-negative bacteria (due to diminished production of porins) (2) reduced affinity of the target penicillin-binding proteins (PBPs) (3) increased expression of efflux pump components, and (4) production of beta-lactamases that can hydrolyse carbapenems.

There is no target-based cross-resistance between meropenem and agents of the quinolone, aminoglycoside, macrolide, and tetracycline classes. However, bacteria may exhibit resistance to more than one class of antibacterial medicines when the mechanism involved include impermeability and/or an efflux pump(s).

Inherently resistant organisms:

Gram-negative aerobes:

Stenotrophomonas maltophilia, Legionella species

Other micro-organisms:

Chlamydophila pneumoniae, Chlamydophila psittaci, Coxiella burnetii

Mycoplasma pneumoniae

5.2 Pharmacokinetic properties

Peak serum concentration after a 30 minute intravenous infusion of a single dose of meropenem in normal volunteers reaches 23 µg/ml for the 500 mg dose, 49 µg/ml for the 1

g dose.

Peak serum concentration after a 5 minute intravenous bolus injection of meropenem in normal volunteer results' reaches of approximately 52 µg/ml for the 500 mg dose and 112 µg/ml for the 1 g dose.

When multiple doses are administered at 8 hourly intervals to subjects with normal renal function accumulation of meropenem dose do not occur.

Distribution:

Meropenem is well distributed in most body fluids and tissues with a low (2 %) protein binding.

After rapid administration (5 minutes or less) the pharmacokinetics are biexponential, but this is much less evident after 30 minutes infusion. Meropenem has been shown to penetrate well into several body fluids and tissues: including lung, bronchial secretions, bile, cerebrospinal fluid, gynaecological tissues, skin, fascia, muscle, and peritoneal exudates, achieving concentrations in excess of those required to inhibit most bacteria.

When multiple doses are administered at 8 hourly intervals to patients the concentrations at steady state are approximately 20 % higher than after a single dose.

Biotransformation:

Meropenem is metabolised by hydrolysis of the beta-lactam ring generating a microbiologically inactive metabolite.

In vitro meropenem shows reduced susceptibility to hydrolysis by human

dehydropeptidase-I (DHP-I) compared toimipenem and there is no requirement to co-administer a DHP-I inhibitor.

Elimination:

Approximately 70 % of an administered dose is recovered in the urine as unchanged meropenem over 12 hours. A further 28 % is recovered as the microbiologically inactive metabolite. Faecal elimination represents only approximately 2 % of the dose. The measured renal clearance and the effect of probenecid show that meropenem undergoes both filtration and tubular secretion.

Urinary concentrations of meropenem in excess of 10 µg/ml are maintained for up to 5 hours at the 500 mg dose.

The plasma elimination half-life of meropenem may be prolonged in patients with renal impairment.

Meropenem is primarily excreted unchanged, with one inactive metabolite having been identified.

Pharmacokinetics in special patient groups

Renal insufficiency

Renal impairment results in higher plasma AUC and longer half-life for meropenem. The AUC of the microbiologically inactive metabolite considerably increased in patients with renal impairment. Dose adjustment is recommended for patients with renal impairment (see Section 4.2).

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Meropenem is cleared by haemodialysis with clearance during haemodialysis being approximately 4 times higher than in anuric patients.

Hepatic insufficiency

A study in patients with alcoholic cirrhosis shows no effect of liver disease on the pharmacokinetics of meropenem after repeated doses.

Adult patients

Pharmacokinetic studies report patients have not shown significant pharmacokinetic differences versus healthy subjects with equivalent renal function. A population model developed from data in 79 patients with intra-abdominal infection or pneumonia, showed a dependence of the central volume on weight and the clearance on creatinine clearance and age.

Elderly

Pharmacokinetic studies in the elderly have shown a reduction in plasma clearance of meropenem which correlated with age-associated reduction in creatinine clearance.
No dose adjustment is required in elderly patients, except in cases of moderate to severe renal impairment (see section 4.2).

Paediatric population

Studies in children have shown that the pharmacokinetics of meropenem in children are essentially similar to those in adults. The pharmacokinetics in infants and children with infection at doses of 10, 20 and 40 mg/kg showed C_{max} values approximating to those

in adults following 500, 1000 and 2000 mg doses, respectively. Comparison showed consistent pharmacokinetics between the doses and half-lives similar to those observed in adults in all but the youngest subjects (<6 months $t_{1/2}$ 1,6 hours). The mean meropenem clearance values were 5,8 ml/min/kg (6-12 years), 6,2 ml/min/kg (2 5years), 5,3 ml/min/kg (6-23 months) and 4,3 ml/min/kg (2-5 months). Approximately 60 % of the dose is excreted in urine over 12 hours as meropenem with a further 12 % as metabolite. Meropenem concentrations in the CSF of children with meningitis are approximately 20 % of concurrent plasma levels although there is significant inter-individual variability.

The pharmacokinetics of meropenem in neonates requiring anti-infective treatment showed greater clearance in neonates with higher chronological or gestational age with an overall average half-life of 2,9 hours. Monte Carlo simulation based on a population PK model showed that a dose regimen of 20 mg/kg 8 hourly achieved 60 % T>MIC for *P. aeruginosa* in 95 % of pre-term and 91 % of full term neonates.

5.3 Preclinical safety data

Animal studies indicate that meropenem is well tolerated by the kidney. Histological evidence of renal tubular damage was seen in mice and dogs only at doses of 2000 mg/kg and above after a single administration and above and in monkeys at 500 mg/kg in a 7-day study.

Meropenem is generally well tolerated by the central nervous system. Effects were seen in

acute toxicity studies in rodents at doses exceeding 1000 mg/kg.

The IV LD50 of meropenem in rodents is greater than 2000 mg/kg.

In repeat dose studies of up to 6 months duration only minor effects were seen including a decrease in red cell parameters in dogs.

There was no evidence of mutagenic potential in a conventional test battery and no evidence of reproductive toxicity including teratogenic potential in studies in rats up to 750 mg/kg and in monkeys up to 360 mg/kg.

There was no evidence of increased sensitivity to meropenem in juveniles compared to adult animals. The intravenous formulation was well tolerated in animal studies.

The sole metabolite of meropenem had a similar profile of toxicity in animal studies.

6. PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Anhydrous sodium carbonate

6.2 Incompatibilities

Compatibility of MEROJECT with other medicines has not been established and should not be mixed with other medicines except those mentioned in section 6.6.

6.3 Shelf life

48 months

For reconstituted solution, refer to section 6.4

6.4 Special precautions for storage

Powder

Store at or below 25 °C. Keep in the outer carton until required for use.

Reconstituted solution:

Diluent	Storage temperature 25˚C	Storage temperature 4 ˚C
Water for injection	2 h	12 h
Sodium chloride 0,9 %	4 h	24 h
Dextrose 5 %	1 h	4 h
Dextrose 10 %	1 h	2 h
Dextrose 5 % and Sodium chloride 0,225 %	2 h	4 h
Dextrose 5 % and Sodium chloride 0,9 %	1 h	4 h
Dextrose 5 % and Potassium chloride 0,15%	1 h	6 h
Mannitol 2,5 %	2 h	16 h
Mannitol 10 %	1 h	8 h

Normosol M in Dextrose 5 %	1 h	8 h
Dextrose 5 % and Sodium bicarbonate 0,02 %	1 h	6 h

Solutions of MEROJECT should not be frozen.

6.5 Nature and contents of container

MEROJECT 500 mg: 20 ml clear colourless Type I glass vials with Type I grey bromobutyl rubber closures and aluminium secure caps with a green plastic flip-top cover, available in pack size of one vial.

MEROJECT 1 g: 30 ml clear colourless Type I glass vials with Type I grey bromobutyl rubber closures and aluminium secure caps with a grey plastic flip-top cover, available in pack size of one and ten vials.

6.6 Special precautions for disposal and other handling

Preparation of MEROJECT:

Rapid intravenous injection:

Water for injection (5 ml/250 mg: 10 ml for 500 mg and 20 ml for 1 g MEROJECT respectively).

This provides an approximate available concentration of 50 mg/ml.

The reconstituted solution is a clear, pale yellow solution practically free from particulate matter

Intravenous infusion:

The MEROJECT vial may be reconstituted as above or with a compatible infusion fluid (see section 6.3) and the resultant solution added to an infusion container.

Single use only. Discard any unused portion.

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)

MEROJECT 500 mg: A42/20.1.1/0280

MEROJECT 1 g: A42/20.1.1/0281

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9. DATE OF FIRST AUTHORISATION

07 December 2012

10. DATE OF REVISION OF THE TEXT

25 January 2024

NAMIBIA:

MEROJECT 500 mg: NS3 13/20.1.1/0238

MEROJECT 1 g: NS3 13/20.1.1/0239

MOZAMBIQUE:

MEROJECT 500: J5669

MEROJECT 1000: J5668