PROFESSIONAL INFORMATION

SCHEDULING STATUS S5

1. NAME OF THE MEDICINE

OMNITROPE 5 mg/1,5 ml (solution for injection)

OMNITROPE 10 mg/1,5 ml (solution for injection)

OMNITROPE 15 mg/1,5 ml (solution for injection)

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

OMNITROPE 5 mg/1,5 ml solution for injection:

Each ml of solution contains 3,3 mg of recombinant somatropin (corresponding to 10 IU).

One cartridge contains 1,5 ml corresponding to 5 mg somatropin (15 IU).

OMNITROPE 10 mg/1,5 ml solution for injection:

Each ml of solution contains 6,7 mg of somatropin (corresponding to 20 IU).

One cartridge contains 1,5 ml corresponding to 10 mg somatropin (30 IU).

OMNITROPE 15 mg/1,5 ml solution for injection:

Each ml of solution contains 10 mg of recombinant somatropin (corresponding to 30 IU).

One cartridge contains 1,5 ml corresponding to 15 mg somatropin (45 IU).

For the full list of excipients, see section 6.1.

3. PHARMACEUTICAL FORM

Solution for injection.

OMNITROPE 5 mg/1,5 ml: The solution is clear and colourless. Solution for injection in a cartridge for SurePal 5.

OMNITROPE 10 mg/1,5 ml: The solution is clear and colourless. Solution for injection in a cartridge for SurePal 10.

OMNITROPE 15 mg/1,5 ml: The solution is clear and colourless. Solution for injection in a cartridge for SurePal 15.

OMNITROPE solution for injection is practically free from visible particulate matter.

4. CLINICAL PARTICULARS

4.1. Therapeutic indications

- Short stature due to decreased or failed secretion of pituitary growth hormone. Growth hormone deficiency should be verified before the preparation is administered. This requires a thorough investigation of the pituitary function, including proper provocation tests.
- Short stature in gonadal dysgenesis (Turner's Syndrome).
- Growth disturbance in prepubertal children with chronic renal insufficiency.

4.2. Posology and method of administration

Posology:

Short stature due to decreased or failed secretion of pituitary growth hormone:

The dosage is according to individual requirements. Generally a dose of 0,5 – 0,7 IU/kg body weight per week or approximately 14 – 20 IU/m^2 body surface area per week is recommended.

Turner's Syndrome:

Generally a dose of 1,0 IU/kg body weight per week is recommended, or 28 IU/m^2 body surface area per week.

Chronic renal insufficiency:

A dose of 30 IU/m^2 body surface area per week (approximately 1 IU/kg body weight per week) is recommended. Higher doses can be needed if growth velocity is too low. A dose correction can be needed after 6 months of treatment.

Method of administration:

The weekly dose should be divided into six to seven subcutaneous injections. The injection site should be varied to prevent lipoatrophy.

For instructions on handling of the medicine before administration, see section 6.6.

4.3. Contraindications

- Hypersensitivity to somatropin or to any of the excipients of OMNITROPE listed in section 6.1.
- OMNITROPE must not be used when there is any evidence of activity of a tumour. Intracranial tumours must be inactive and anti-tumour therapy must be completed prior to starting growth hormone therapy. Treatment should be discontinued if there is evidence of tumour growth.
- OMNITROPE must not be used for growth promotion in children with closed epiphyses.
- Patients with acute critical illness suffering complications following open-heart surgery, abdominal surgery, multiple accidental trauma, acute respiratory failure or similar

conditions must not be treated with somatropin. Regarding patients undergoing substitution therapy, see section 4.4.

4.4 Special warnings and precautions for use

Diagnosis and therapy with OMNITROPE should be initiated and monitored by physicians who are appropriately qualified and experienced in the diagnosis and management of patients with the therapeutic indication of use.

The maximum recommended daily dose should not be exceeded

(see section 4.2).

Insulin sensitivity:

OMNITROPE may induce a state of insulin resistance. For patients with diabetes mellitus, the insulin dose may require adjustment after OMNITROPE therapy is instituted. Patients with diabetes, glucose intolerance, or additional risk factors for diabetes should be monitored closely during OMNITROPE therapy.

Thyroid function:

Growth hormone increases the peripheral conversion of T4 to T3, which may result in a reduction in serum T4 and an increase in serum T3 concentrations. Whereas the peripheral thyroid hormone levels have remained within the reference ranges for healthy subjects, hypothyroidism theoretically may develop in subjects with subclinical hypothyroidism. Consequently monitoring of thyroid function should therefore be conducted in all patients. In patients with hypopituitarism on standard replacement therapy, the potential effect of growth hormone treatment on thyroid function must be closely monitored.

Hypoadrenalism:

Introduction of somatropin treatment may result in inhibition of 11βHSD-1 and reduced serum cortisol concentrations. In patients treated with somatropin, previously undiagnosed central (secondary) hypoadrenalism may be unmasked and glucocorticoid replacement may be required. In addition, patients treated with glucocorticoid replacement therapy for previously diagnosed hypoadrenalism may require an increase in their maintenance or stress doses, following initiation of somatropin treatment (see section 4.5).

Benign intracranial hypertension:

In case of severe or recurrent headache, visual problems, nausea and/or vomiting, a funduscopy for papilloedema is recommended. If papilloedema is confirmed, a diagnosis of benign intracranial hypertension should be considered and, if appropriate, the growth hormone treatment should be discontinued. At present there is insufficient evidence to give specific advice on the continuation of growth hormone treatment in patients with resolved intracranial hypertension. If growth hormone treatment is restarted, careful monitoring for symptoms of intracranial hypertension is necessary.

Malignancy:

In growth hormone deficiency, secondary to treatment of malignant disease, it is recommended to pay attention to signs of relapse of the malignancy. In childhood cancer survivors, an increased risk of a second neoplasm has been reported in patients treated with somatropin after their first neoplasm. Intracranial tumours, in particular meningiomas, in patients treated with radiation to the head for their first neoplasm, were the most common of these second neoplasms.

Slipped capital femoral epiphysis:

In patients with endocrine disorders, including growth hormone deficiency, slipped epiphyses of the hip may occur more frequently than in the general population. Patients limping during treatment with somatropin, should be examined clinically.

Leukaemia:

Leukaemia has been reported in a small number of growth hormone deficiency patients, some of whom have been treated with somatropin. However, there is no evidence that leukaemia incidence is increased in growth hormone recipients without predisposition factors.

Antibodies:

A small percentage of patients may develop antibodies to OMNITROPE. OMNITROPE has given rise to the formation of antibodies in approximately 1 % of patients. The binding capacity of these antibodies is low and there is no effect on growth rate. Testing for antibodies to somatropin should be carried out in any patient with otherwise unexplained lack of response.

Acute critical illness:

The effects of somatropin on recovery were studied in two placebo controlled trials involving 522 critically ill adult patients suffering complications following open heart surgery, abdominal surgery, multiple accidental trauma or acute respiratory failure. Mortality was higher in patients treated with 5,3 or 8 mg somatropin daily compared to patients receiving placebo, 42 % vs. 19 %. Based on this information, these types of patients should not be treated with somatropin. As there is no information available on the safety of growth hormone substitution therapy in acutely critically ill patients, the benefits of continued treatment in this situation should be weighed against the potential risks involved.

In all patients developing other or similar acute critical illness, the possible benefit of treatment with somatropin must be weighed against the potential risk involved.

The maximum recommended daily dose should not be exceeded.

Pancreatitis in children:

Children treated with somatropin have an increased risk of developing pancreatitis compared to adults treated with somatropin. Although rare, pancreatitis should be considered in somatropin-treated children who develop abdominal pain.

Scoliosis:

Scoliosis is known to be more frequent in some of the patient groups treated with somatropin. In addition, rapid growth in any child can cause progression of scoliosis. Somatropin has not been shown to increase the incidence or severity of scoliosis. Signs of scoliosis should be monitored during treatment.

Chronic renal insufficiency:

In chronic renal insufficiency, renal function should be below 50 percent of normal before institution of therapy. To verify growth disturbance, growth should be followed for a year preceding institution of therapy. During this period, conservative treatment for renal insufficiency (which includes control of acidosis, hyperparathyroidism and nutritional status) should have been established and should be maintained during treatment. The treatment should be discontinued at renal transplantation.

To date, no data on final height in patients with chronic renal insufficiency treated with somatropin are available.

Elderly patients:

Experience in patients above 80 years is limited. Elderly patients may be more sensitive to the action of somatropin, and therefore may be more prone to develop adverse reactions.

Lipid metabolism:

Somatropin induces hepatic LDL cholesterol receptors, and affects the profile of serum lipids and lipoproteins. In general, administration of somatropin to growth hormone deficient patients results in reduction in serum LDL and apolipoprotein B. A reduction in serum total cholesterol may also be observed.

Carbohydrate metabolism:

Somatropin increases insulin but fasting blood glucose is commonly unchanged. Children with hypopituitarism may experience fasting hypoglycaemia. This condition is reversed by somatropin.

Water and mineral metabolism:

Growth hormone deficiency is associated with decreased plasma and extracellular volumes. Both are rapidly increased after treatment with somatropin. Somatropin induces the retention of sodium, potassium and phosphorus.

Bone metabolism:

Somatropin stimulates the turnover of skeletal bone. Long-term administration of somatropin to growth hormone deficient patients with osteopenia results in an increase in bone mineral content and density at weight-bearing sites.

Physical capacity:

Muscle strength and physical exercise capacity are improved after long-term treatment with somatropin. Somatropin also increases cardiac output, but the mechanism has yet to be clarified. A decrease in peripheral vascular resistance may contribute to this effect.

Acquired immune deficiency syndrome (AIDS):

The safety of use of somatropin in patients affected by HIV has not been established.

Excipients:

Sodium: This medicine contains less than 1 mmol sodium (23 mg) per ml, i.e. Essentially ‘Sodium free’.

OMNITROPE 5 mg/1,5 ml: Because of the presence of benzyl alcohol the medicine must not be given to premature babies or neonates. It may cause toxic reactions and anaphylactoid reactions in infants and children up to 3 years old.

4.5 Interaction with other medicines and other forms of interaction

Concomitant treatment with glucocorticoids inhibits the growth-promoting effects of somatropin containing products. Patients with Adrenocorticotropic hormone (ACTH) deficiency should have their glucocorticoid replacement therapy carefully adjusted to avoid any inhibitory effect on growth. Therefore, patients treated with glucocorticoids should have their growth monitored carefully to assess the potential impact of glucocorticoid treatment on growth.

Growth hormone decreases the conversion of cortisone to cortisol and may unmask previously undiscovered central hypoadrenalism or render low glucocorticoid replacement doses ineffective (see section 4.4).

Data from an interaction study performed in growth hormone deficient adults suggests that somatropin administration may increase the clearance of compounds known to be metabolised by cytochrome P450 isoenzymes. The clearance of compounds metabolised by cytochrome P450 3A4 (e.g. sex steroids, corticosteroids, anticonvulsants and ciclosporin) may be especially increased resulting in lower plasma levels of these compounds. The clinical significance of this is unknown.

Also see section 4.4 for statements regarding diabetes mellitus and thyroid disorder.

4.6 Fertility, pregnancy and lactation

Pregnancy:

OMNITROPE is not recommended during pregnancy and in women of childbearing potential not using contraception.

Lactation:

There have been no clinical studies conducted with somatropin containing products in breastfeeding women. It is not known if somatropin is excreted into breast milk, but absorption of intact protein from the gastrointestinal tract of the infant is extremely unlikely. Therefore, caution should be exercised when OMNITROPE is administered to breastfeeding women.

Fertility:

Fertility studies with OMNITROPE have not been performed.

4.7 Effects on ability to drive and use machines

OMNITROPE has no or negligible influence on the ability to drive and use machines.

4.8 Undesirable effects

Patients with growth hormone deficiency are characterised by extracellular volume deficit. When treatment with OMNITROPE is started, this deficit is rapidly corrected. In adult patients adverse effects related to fluid retention, such as oedema peripheral, face oedema, musculoskeletal stiffness, arthralgia, myalgia and paraesthesia are common. In general these adverse effects are mild to moderate, arise within the first months of treatment and subside spontaneously or with dose-reduction.

The incidence of these adverse effects is related to the administered dose, the age of patients, and possibly inversely related to the age of patients at the onset of growth hormone deficiency. In children such adverse effects are uncommon.

OMNITROPE has given rise to the formation of antibodies in approximately 1 % of the patients. The binding capacity of these antibodies has been low, and no clinical changes have been associated with their formation, see section 4.4.

Tabulated list of adverse reactions

System Organ Class	Adverse Reactions		
	Frequent	**Less frequent**	**Frequency unknown**
Neoplasms Benign, Malignant and Unspecified (including cysts and polyps)		(Children) Leukaemia†	
Immune System Disorders	Formation of antibodies		
Endocrine disorders			Hypothyroidism**
Metabolism and Nutrition Disorders			(Adults and Children) Type II diabetes mellitus
Nervous System Disorders	(Adults) Paraesthesia* (Adults) Carpal Tunnel Syndrome	(Children) Benign intracranial hypertension (Children) Paraesthesia*	(Adults) Benign intracranial hypertension (Children) Headache**
Gastrointestinal Disorders		Pancreatitis	
Skin and Subcutaneous Tissues disorders		(Children) Rash** Urticaria** Pruritus**	(Adults) Rash** Urticaria** Pruritus**

Musculoskeletal, Connective Tissue and Bone Disorders	(Adults and children) Arthralgia* (Adults) Myalgia* Musculoskeletal stiffness*	(Children) Myalgia*	(Children) Musculoskeletal stiffness*
Reproductive system and breast disorders		Gynaecomastia**	
General Disorders and Administration Site Conditions	(Children) Injection site reaction[$] (Adults) Oedema peripheral*	(Children) Oedema peripheral*	(Adults and Children) Face oedema* (Adults) Injection site reaction[$]
Investigations			(Adults and Children) Blood cortisol decreased[‡]

*In general, these adverse effects are mild to moderate, arise within the first months of treatment, and subside spontaneously or with dose-reduction. The incidence of these adverse effects is related to the administered dose, the age of the patients, and possibly inversely related to the age of the patients at the onset of growth hormone deficiency.

**Adverse drug reaction (ADR) identified post-marketing.

$ Transient injection site reactions in children have been reported.

‡ Clinical significance is unknown

† Reported in growth hormone deficient children treated with somatropin, but the incidence appears to be similar to that in children without growth hormone deficiency.

Description of selected adverse reactions:

Reduced serum cortisol levels:

OMNITROPE has been reported to reduce serum cortisol levels, possibly by affecting carrier proteins or by increased hepatic clearance. The clinical relevance of these findings may be limited. Nevertheless, corticosteroid replacement therapy should be optimised before initiation of therapy.

Leukaemia:

Cases of leukaemia (rare or very rare) have been reported in children with a GH deficiency, some of whom were treated with somatropin and included in the post-marketing experience. However, there is no evidence of an increased risk of leukaemia without predisposition factors, such as radiation to the brain or head.

Slipped capital femoral epiphysis and Legg-Calve-Perthes disease:

Slipped capital femoral epiphysis and Legg-Calve-Perthes disease have been reported in children treated with GH. Slipped capital femoral epiphysis occurs more frequently in case of endocrine disorders and Legg-Calve-Perthes is more frequent in case of short stature. But it is unknown if these 2 pathologies are more frequent or not while treated with somatropin. Their diagnosis should be considered in a child with a discomfort or pain in the hip or knee.

Other adverse drug reactions:

Other adverse drug reactions may be considered somatropin class effects, such as possible hyperglycaemia caused by decreased insulin sensitivity, decreased free thyroxin level and benign intra-cranial hypertension.

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 providers are asked to report any suspected adverse reactions to SAHPRA via the Med Safety APP (Medsafety X SAHPRA) and eReporting platform (who-umc.org) found on SAHPRA website. Suspected adverse reactions can also be reported directly to the HCR via the link: https://pvi1j.solutions.iqvia.com or the e-mail address, adverse.event.sac@sandoz.com

4.9 Overdose

Symptoms:

Acute overdose could lead initially to hypoglycaemia and subsequently to hyperglycaemia. Long-term overdose could result in signs and symptoms consistent with the known effects of human growth hormone excess. Treatment is symptomatic and supportive.

5. PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacological Classification: A 21.10 Tropic hormones

Pharmacotherapeutic group: Anterior pituitary lobe hormones and analogues, ATC code: H01A C01.

Somatropin is a recombinant human growth hormone (rhGH) produced by *Escherichia coli* by recombinant DNA technology. It has the same structure and activity as the natural human growth hormone.

Mechanism of action:

Somatropin is a potent metabolic hormone of importance for the metabolism of lipids, carbohydrates and proteins. In children with inadequate endogenous growth hormone, somatropin stimulates linear growth and increases growth rate. In adults, as well as in children, somatropin maintains a normal body composition by increasing nitrogen retention and stimulation of skeletal muscle growth, and by mobilisation of body fat. Visceral adipose tissue is particularly responsive to somatropin. In addition to enhanced lipolysis, somatropin decreases the uptake of triglycerides into body fat stores.

Serum concentrations of IGF-I and IGFBP3 (Insulin-like Growth Factor Binding Protein 3) are increased by somatropin. In addition, the following actions have been demonstrated:

Pharmacodynamic effects:

- Lipid metabolism: Somatropin induces hepatic LDL cholesterol receptors, and affects the profile of serum lipids and lipoproteins. In general, administration of somatropin to growth hormone deficient patients results in reductions in serum LDL and apolipoprotein B. A reduction in serum total cholesterol may also be observed.
- Carbohydrate metabolism: Somatropin increases insulin, but fasting blood glucose is commonly unchanged. Children with hypopituitarism may experience fasting hypoglycaemia. This condition is reversed by somatropin.

- Water and mineral metabolism: Growth hormone deficiency is associated with decreased plasma and extracellular volumes. Both are rapidly increased after treatment with somatropin. Somatropin induces the retention of sodium, potassium and phosphorus.
- Bone metabolism: Somatropin stimulates the turnover of skeletal bone. Long-term administration of somatropin to growth hormone deficient patients with osteopenia results in an increase in bone mineral content and density at weight- bearing sites.
- Physical capacity: Muscle strength and physical exercise capacity are improved after long-term treatment with somatropin. Somatropin also increases cardiac output, but the mechanism has yet to be clarified. A decrease in peripheral vascular resistance may contribute to this effect.

5.2 Pharmacokinetic properties

Absorption:

The bioavailability of subcutaneously administered somatropin is approximately 80 %.

A subcutaneous dose of somatropin in healthy adults resulted in the following plasma C_{max} and t_{max} median values:

- 5 mg of 5 mg/1,5 ml: 72 ± 28 µg/l and 4,0 ± 2,0 hours,
- 5 mg of 10 mg/1,5 ml: 74 ± 22 µg/l and 4,0 ± 2,0 hours,
- 5 mg of 15 mg/1,5 ml: 52 ± 19 µg/l and 4,0 ± 2,0 hours, respectively.

Elimination:

The terminal half-life of somatropin after subcutaneous administration was 3 hours.

Special populations:

The absolute bioavailability of somatropin seems to be similar in males and females following subcutaneous administration.

Information about the pharmacokinetics of somatropin in geriatric and paediatric populations, in different races and in patients with renal, hepatic or cardiac insufficiency is either lacking or incomplete.

5.3 Preclinical safety data

In studies regarding general toxicity, local tolerance and reproduction toxicity no clinically relevant effects have been observed.

In *vitro* and in *vivo* genotoxicity studies on gene mutations and induction of chromosome aberrations have been negative.

An increased chromosome fragility has been observed in one in-vitro study on lymphocytes taken from patients after long term treatment with somatropin and following the addition of the radiomimetic drug bleomycin. The clinical significance of this finding is unclear.

In another study, no increase in chromosomal abnormalities was found in the lymphocytes of patients who had received long term somatropin therapy.

6. Pharmaceutical particulars

6.1 List of excipients

OMNITROPE 5 mg/1,5 ml: Benzyl alcohol, disodium hydrogen phosphate heptahydrate, mannitol, poloxamer 188, sodium dihydrogen phosphate dehydrate, water for injection.

Each ml contains 9 mg benzyl alcohol.

OMNITROPE 10 mg/1,5 ml: Disodium hydrogen phosphate heptahydrate, glycine, phenol, poloxamer 188, sodium dihydrogen phosphate dehydrate, water for injection.

OMNITROPE 15 mg/1,5 ml: Disodium hydrogen phosphate heptahydrate, phenol, poloxamer 188, sodium dihydrogen phosphate dihydrate, sodium chloride, water for injection.

OMNITROPE 5 mg/1,5 ml (solution for injection) contains mannitol.

Contains preservatives:

OMNITROPE 5 mg/1,5 ml contains benzyl alcohol 0,9 *% m/v.*

OMNITROPE 10 mg/1,5 ml contains phenol 0,3 *% m/v.*

OMNITROPE 15 mg/1,5 ml contains phenol 0,3 *% m/v.*

6.2 Incompatibilities

In the absence of compatibility studies, this medicine must not be mixed with other medicines.

6.3 Shelf life

Unopened:

OMNITROPE 5 mg/1,5 ml - 24 months

OMNITROPE 10 mg/1,5 ml and OMNITROPE 15 mg/1,5 ml - 18 months

In-use: 28 days

6.4 Special precautions for storage

Unopened cartridge:

Store and transport refrigerated (2 °C – 8 °C). Do not freeze. Store in the original package in order to protect from light.

Shelf life after first use:

After first use, the cartridge should remain in the pen and has to be kept in a refrigerator (2 °C – 8 °C) for a maximum of 28 days. Store and transport refrigerated (2 °C – 8 °C). Do not freeze. Store in the original pen in order to protect from light.

6.5 Nature and contents of container

OMNITROPE 5 mg/1,5 ml: 1,5 ml of solution in a cartridge (colourless type I glass) with a grey plunger on one side (siliconised bromobutyl), a grey disc (bromobutyl) and a gold cap (aluminium) on the other side. The glass cartridge is irreversibly integrated in a transparent container and assembled to a plastic mechanism with a threaded rod at one extremity.

OMNITROPE 10 mg/1,5 ml: 1,5 ml of solution in a cartridge (colourless type I glass) with a grey plunger on one side (siliconised bromobutyl), a grey disc (bromobutyl) and a silver cap (aluminium) on the other side. The glass cartridge is irreversibly integrated in a transparent container and assembled to a plastic mechanism with a threaded rod at one extremity.

OMNITROPE 15 mg/1,5 ml: 1,5 ml of solution in a cartridge (colourless type I glass) with a grey plunger and a blue ring on one side (siliconised bromobutyl), a grey disc (bromobutyl) and a silver cap (aluminium) on the other side. The glass cartridge is irreversibly integrated in a transparent container and assembled to a plastic mechanism with a threaded rod at one extremity.

Pack sizes of 1, 5’s and 10’s.

OMNITROPE is packed into an outer cardboard carton.

Not all pack sizes may be marketed.

6.6 Special precautions for disposal and other handling

Directions for use:

OMNITROPE 5 mg/1,5 ml solution for injection is a sterile, ready-to-use solution for subcutaneous injection filled in a glass cartridge. This presentation is intended for multiple use. It should only be administered with SurePal 5, an injection device specifically developed for use with OMNITROPE 5 mg/1,5 ml solution for injection.

OMNITROPE 10 mg/1,5 ml solution for injection is a sterile, ready-to-use solution for subcutaneous injection filled in a glass cartridge. This presentation is intended for multiple use. It should only be administered with SurePal 10, an injection device specifically developed for use with OMNITROPE 10 mg/1,5 ml solution for injection.

OMNITROPE 15 mg/1,5 ml solution for injection is a sterile, ready-to-use solution for subcutaneous injection filled in a glass cartridge. This presentation is intended for multiple use. It should only be administered with SurePal 15, an injection device specifically developed for use with OMNITROPE 15 mg/1,5 ml solution for injection.

The injection should be given subcutaneously, and the site varied to prevent lipoatrophy.

Administration needs to be carried out using sterile, disposable pen needles. Patients and caregivers have to receive appropriate training and instruction on the proper use of the OMNITROPE cartridges and the pen from the physician or other suitable qualified health professionals.

The following is a general description of the administration process. The manufacturer's instructions with each pen must be followed for loading the cartridge, attaching the injection needle and for the administration.

1. Hands should be washed.
2. If the solution is cloudy or contains particulate matter, it should not be used. The content must be clear and colourless.
3. Disinfect the rubber membrane of the cartridge with a cleansing swab.
4. Insert the cartridge into SurePal following the instructions for use provided with the pen.
5. Clean the site of injection with an alcohol swab.
6. Administer the appropriate dose by subcutaneous injection using a sterile pen needle. Remove the pen needle and dispose of it in accordance with local requirements.

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

7. HOLDER OF CERTIFICATE OF REGISTRATION

Sandoz SA (Pty) Ltd[1]

Magwa Crescent West

Waterfall City

Jukskei View

Midrand

2090

8. REGISTRATION NUMBER(S)

OMNITROPE 5 mg/1,5 ml: 49/21.10/0735.732

OMNITROPE 10 mg/1,5 ml: 49/21.10/0736.733

OMNITROPE 15 mg/1,5 ml: 49/21.10/0737.734

9. DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUHORISATION

17 March 2020/

27 October 2025

10. DATE OF REVISION OF THE TEXT

21 May 2026

[1]Company Reg. No.: 1990/001979/07