

OSCARTIN 10 (Rosuvastatin 10mg Tablets)

COMPOSITION:

Each film coated tablet contains:
Rosuvastatin 10mg

PHARMACOKINETICS:

Absorption:

Maximum rosuvastatin plasma concentrations are achieved approximately 5 hours after oral administration. The absolute bioavailability is approximately 20%.

Distribution

Rosuvastatin is taken up extensively by the liver which is the primary site of cholesterol synthesis and LDL-C clearance. The volume of distribution of rosuvastatin is approximately 134 L. Approximately 90% of rosuvastatin is bound to plasma proteins, mainly to albumin.

Biotransformation

Rosuvastatin undergoes limited metabolism (approximately 10%). In vitro metabolism studies using human hepatocytes indicate that rosuvastatin is a poor substrate for cytochrome P450-based metabolism. CYP2C9 was the principal isoenzyme involved, with 2C19, 3A4 and 2D6 involved to a lesser extent. The main metabolites identified are the N-desmethyl and lactone metabolites. The N-desmethyl metabolite is approximately 50% less active than rosuvastatin whereas the lactone form is considered clinically inactive. Rosuvastatin accounts for greater than 90% of the circulating HMG-CoA reductase inhibitor activity.

Elimination

Approximately 90% of the rosuvastatin dose is excreted unchanged in the faeces (consisting of absorbed and non-absorbed active substance) and the remaining part is excreted in urine. Approximately 5% is excreted unchanged in urine. The plasma elimination half-life is approximately 19 hours. The elimination half-life does not increase at higher doses. The geometric mean plasma clearance is approximately 50 litres/hour (coefficient of variation 21.7%). As with other HMG-CoA reductase inhibitors, the hepatic uptake of rosuvastatin involves the membrane transporter OATP-C. This transporter is important in the hepatic elimination of rosuvastatin.

PHARMACODYNAMICS:

Pharmacotherapeutic group: HMG-CoA reductase inhibitors

ATC code: C10A A07

Mechanism of action

Rosuvastatin is a selective and competitive inhibitor of HMG-CoA reductase, the rate-limiting enzyme that converts 3-hydroxy-3-methylglutaryl coenzyme A to mevalonate, a precursor for cholesterol. The primary site of action of rosuvastatin is the liver, the target organ for cholesterol lowering.

Rosuvastatin increases the number of hepatic LDL receptors on the cell-surface, enhancing uptake and catabolism of LDL and it inhibits the hepatic synthesis of VLDL, thereby reducing the total number of VLDL and LDL particles.

Pharmacodynamic effects

Rosuvastatin reduces elevated LDL-cholesterol, total cholesterol and triglycerides and increases HDL-cholesterol. It also lowers ApoB, non-HDL-C, VLDL-C, VLDL-TG and increases ApoA-I (see Table3). Rosuvastatin also lowers the LDL-C/HDL-C, total C/HDL-C and nonHDL-C/HDL-C and the ApoB/ApoA-1 ratios.

INDICATIONS:

Treatment of hypercholesterolaemia

Adults, adolescents and children aged 6 years or older with primary hypercholesterolaemia (type IIa including heterozygous familial hypercholesterolaemia) or mixed dyslipidaemia (type IIb) as an adjunct to diet when response to diet and other non-pharmacological treatments (e.g. exercise, weight reduction) is inadequate.

Adults, adolescents and children aged 6 years or older with homozygous familial hypercholesterolaemia as an adjunct to diet and other lipid lowering treatments (e.g. LDL apheresis) or if such treatments are not appropriate.

Prevention of Cardiovascular Events

Prevention of major cardiovascular events in patients who are estimated to have a high risk for a first cardiovascular event , as an adjunct to correction of other risk factors.

CONTRAINDICATIONS:

Rosuvastatin is contraindicated:

- In patients with hypersensitivity to the active substance or to any of the excipients
- In patients with active liver disease including unexplained, persistent elevations of serum transaminases and any serum transaminase elevation exceeding 3 times the upper limit of normal (ULN).
- In patients with severe renal impairment (creatinine clearance <30 ml/min).
- In patients with myopathy.
- In patients receiving concomitant combination of sofosbuvir/velpatasvir/voxilaprevir).
- In patients receiving concomitant ciclosporin.

During pregnancy and lactation and in women of childbearing potential not using appropriate contraceptive measures. The 40 mg dose is contraindicated in patients with pre-disposing factors for myopathy/ rhabdomyolysis. Such factors include:

- Moderate renal impairment (creatinine clearance < 60 ml/min)
- Hypothyroidism
- Personal or family history of hereditary muscular disorders
- Previous history of muscular toxicity with another HMG-CoA reductase inhibitor or fibrate
- Alcohol abuse
- Situations where an increase in plasma levels may occur
- Asian patients
- Concomitant use of fibrates.

POSLOGY & ADMINISTRATIONS:

Posology

Before treatment initiation the patient should be placed on a standard cholesterol-lowering diet that should continue during treatment. The dose should be individualised according to the goal of therapy and patient response, using current consensus guidelines.

Rosuvastatin may be given at any time of day, with or without food.

Treatment of hypercholesterolaemia

The recommended start dose is 5 or 10 mg orally once daily in both statin-naïve or patients switched from another HMG CoA reductase inhibitor. The choice of start dose should take into account the individual patient's cholesterol level and future cardiovascular risk as well as the potential risk for adverse reactions (see below). A dose adjustment to the next dose level can be made after 4 weeks, if necessary . In light of the increased reporting rate of adverse reactions with the 40 mg dose compared to lower doses , a final titration to the maximum dose of 40 mg should only be considered in patients with severe hypercholesterolaemia at high cardiovascular risk (in particular those with familial hypercholesterolaemia), who do not achieve their treatment goal on 20 mg, and in whom routine follow-up will be performed . Specialist supervision is recommended when the 40 mg dose is initiated.

Prevention of cardiovascular events

In the cardiovascular events risk reduction study, the dose used was 20 mg daily .

Paediatric population

Paediatric use should only be carried out by specialists.

Children and adolescents 6 to 17 years of age (Tanner Stage II-V)

Heterozygous familial hypercholesterolaemia

In children and adolescents with heterozygous familial hypercholesterolaemia the usual start dose is 5 mg daily.

- In children 6 to 9 years of age with heterozygous familial hypercholesterolaemia, the usual dose range is 5-10 mg orally once daily. Safety and efficacy of doses greater than 10 mg have not been studied in this population.

- In children 10 to 17 years of age with heterozygous familial hypercholesterolaemia, the usual dose range is 5-20 mg orally once daily. Safety and efficacy of doses greater than 20 mg have not been studied in this population.

Titration should be conducted according to the individual response and tolerability in paediatric patients, as recommended by the paediatric treatment recommendations . Children and adolescents should be placed on standard cholesterol-lowering diet before rosuvastatin treatment initiation; this diet should be continued during rosuvastatin treatment.

Homozygous familial hypercholesterolaemia

In children 6 to 17 years of age with homozygous familial hypercholesterolaemia, the recommended maximum dose is 20 mg once daily. A starting dose of 5 to 10 mg once daily depending on age, weight and prior statin use is advised. Titration to the maximum dose of 20 mg once daily should be conducted according to the individual response and tolerability in paediatric patients, as recommended by the paediatric treatment recommendations . Children and adolescents should be placed on standard cholesterol-lowering diet before rosuvastatin treatment initiation; this diet should be continued during rosuvastatin treatment. There is limited experience with doses other than 20 mg in this population.

The 40 mg tablet is not suitable for use in paediatric patients.

Children younger than 6 years

The safety and efficacy of use in children younger than 6 years has not been studied. Therefore, Rosuvastatin is not recommended for use in children younger than 6 years.

Use in the elderly

A start dose of 5 mg is recommended in patients >70 years No other dose adjustment is necessary in relation to age.

Dosage in patients with renal insufficiency

No dose adjustment is necessary in patients with mild to moderate renal impairment. The recommended start dose is 5 mg in patients with moderate renal impairment (creatinine clearance <60 ml/min). The 40 mg dose is contraindicated in patients with moderate renal impairment. The use of rosuvastatin in patients with severe renal impairment is contraindicated for all doses .

Dosage in patients with hepatic impairment

There was no increase in systemic exposure to rosuvastatin in subjects with Child-Pugh scores of 7 or below. However, increased systemic exposure has been observed in subjects with Child-Pugh scores of 8 and 9 . In these patients an assessment of renal function should be considered . There is no experience in subjects with Child-Pugh scores above 9. Rosuvastatin is contraindicated in patients with active liver disease .

Race

Increased systemic exposure has been seen in Asian subjects. The recommended start dose is 5 mg for patients of Asian ancestry.

Genetic polymorphisms

Specific types of genetic polymorphisms are known that can lead to increased rosuvastatin exposure . For patients who are known to have such specific types of polymorphisms, a lower daily dose of rosuvastatin is recommended.

Dosage in patients with pre-disposing factors to myopathy

The recommended start dose is 5 mg in patients with predisposing factors to myopathy

Concomitant therapy

Rosuvastatin is a substrate of various transporter proteins (e.g. OATP1B1 and BCRP). The risk of myopathy (including rhabdomyolysis) is increased when rosuvastatin is administered concomitantly with certain medicinal products that may increase the plasma concentration of rosuvastatin due to interactions with these transporter proteins (e.g. ciclosporin and certain protease inhibitors including combinations of ritonavir with atazanavir, lopinavir, and/or tipranavir; . Whenever possible, alternative medications should be considered, and, if necessary, consider temporarily discontinuing rosuvastatin therapy. In situations where coadministration of these medicinal products with rosuvastatin is unavoidable, the benefit and the risk of concurrent treatment and rosuvastatin dosing adjustments should be carefully considered

WARNINGS & PRECAUTIONS:

Renal Effects

Proteinuria, detected by dipstick testing and mostly tubular in origin, has been observed in patients treated with higher doses of rosuvastatin, in particular 40 mg, where it was transient or intermittent in most cases. Proteinuria has not been shown to be predictive of acute or progressive renal disease . The reporting rate for serious renal events in post-marketing use is higher at the 40 mg dose. An assessment of renal function should be considered during routine follow-up of patients treated with a dose of 40 mg.

Skeletal Muscle Effects

Effects on skeletal muscle e.g. myalgia, myopathy and, rarely, rhabdomyolysis have been reported in rosuvastatin -treated patients with all doses and in particular with doses > 20 mg. Very rare cases of rhabdomyolysis have been reported with the use of ezetimibe in combination with HMG-CoA reductase inhibitors. A pharmacodynamic interaction cannot be excluded and caution should be exercised with their combined use.

As with other HMG-CoA reductase inhibitors, the reporting rate for rhabdomyolysis associated with rosuvastatin in post-marketing use is higher at the 40 mg dose.

Creatine Kinase Measurement

Creatine Kinase (CK) should not be measured following strenuous exercise or in the presence of a plausible alternative cause of CK increase which may confound interpretation of the result. If CK levels are significantly elevated at baseline (>5xULN) a confirmatory test should be carried out within 5 – 7 days. If the repeat test confirms a baseline CK>5xULN, treatment should not be started.

Before Treatment

Rosuvastatin, as with other HMG-CoA reductase inhibitors, should be prescribed with caution in patients with pre-disposing factors for myopathy/rhabdomyolysis. Such factors include:

- renal impairment
- hypothyroidism
- personal or family history of hereditary muscular disorders
- previous history of muscular toxicity with another HMG-CoA reductase inhibitor or fibrate
- alcohol abuse
- age >70 years
- situations where an increase in plasma levels may occur
- concomitant use of fibrates.

In such patients the risk of treatment should be considered in relation to possible benefit and clinical monitoring is recommended. If CK levels are significantly elevated at baseline (>5xULN) treatment should not be started.

Whilst on Treatment

Patients should be asked to report inexplicable muscle pain, weakness or cramps immediately, particularly if associated with malaise or fever. CK levels should be measured in these patients. Therapy should be discontinued if CK levels are markedly elevated (>5xULN) or if muscular symptoms are severe and cause daily discomfort (even if CK levels are ≤ 5x ULN). If symptoms resolve and CK levels return to normal, then consideration should be given to re-introducing rosuvastatin or an alternative HMG-CoA reductase inhibitor at the lowest dose with close monitoring. Routine monitoring of CK levels in asymptomatic patients is not warranted. There have been very rare reports of an immune-mediated necrotising myopathy (IMNM) during or after

treatment with statins, including rosuvastatin. IMNM is clinically characterised by proximal muscle weakness and elevated serum creatine kinase, which persist despite discontinuation of statin treatment.

In clinical trials, there was no evidence of increased skeletal muscle effects in the small number of patients dosed with rosuvastatin and concomitant therapy. However, an increase in the incidence of myositis and myopathy has been seen in patients receiving other HMG-CoA reductase inhibitors together with fibric acid derivatives including gemfibrozil, cicosporin, nicotinic acid, azole antifungals, protease inhibitors and macrolide antibiotics. Gemfibrozil increases the risk of myopathy when given concomitantly with some HMG-CoA reductase inhibitors. Therefore, the combination of Rosuvastatin and gemfibrozil is not recommended. The benefit of further alterations in lipid levels by the combined use of Rosuvastatin with fibrates or niacin should be carefully weighed against the potential risks of such combinations. The 40 mg dose is contraindicated with concomitant use of a fibrate.

Rosuvastatin must not be co-administered with systemic formulations of fusidic acid or within 7 days of stopping fusidic acid treatment. In patients where the use of systemic fusidic acid is considered essential, statin treatment should be discontinued throughout the duration of fusidic acid treatment. There have been reports of rhabdomyolysis (including some fatalities) in patients receiving fusidic acid and statins in combination. Patients should be advised to seek medical advice immediately if they experience any symptoms of muscle weakness, pain or tenderness. Statin therapy may be re-introduced seven days after the last dose of fusidic acid. In exceptional circumstances, where prolonged systemic fusidic acid is needed, e.g. for the treatment of severe infections, the need for co-administration of Rosuvastatin and fusidic acid should only be considered on a case by case basis and under close medical supervision.

Rosuvastatin should not be used in any patient with an acute, serious condition suggestive of myopathy or predisposing to the development of renal failure secondary to rhabdomyolysis (e.g. sepsis, hypotension, major surgery, trauma, severe metabolic, endocrine and electrolyte disorders; or uncontrolled seizures).

Liver Effects

As with other HMG-CoA reductase inhibitors, rosuvastatin should be used with caution in patients who consume excessive quantities of alcohol and/or have a history of liver disease.

It is recommended that liver function tests be carried out prior to, and 3 months following, the initiation of treatment. Rosuvastatin should be discontinued or the dose reduced if the level of serum transaminases is greater than 3 times the upper limit of normal. The reporting rate for serious hepatic events (consisting mainly of increased hepatic transaminases) in post-marketing use is higher at the 40 mg dose.

In patients with secondary hypercholesterolaemia caused by hypothyroidism or nephrotic syndrome, the underlying disease should be treated prior to initiating therapy with rosuvastatin.

Race

Pharmacokinetic studies show an increase in exposure in Asian subjects compared with Caucasians.

Protease inhibitors

Increased systemic exposure to rosuvastatin has been observed in subjects receiving rosuvastatin concomitantly with various protease inhibitors in combination with ritonavir. Consideration should be given both to the benefit of lipid lowering by use of rosuvastatin in HIV patients receiving protease inhibitors and the potential for increased rosuvastatin plasma concentrations when initiating and up titrating rosuvastatin doses in patients treated with protease inhibitors. The concomitant use with certain protease inhibitors is not recommended unless the dose of rosuvastatin is adjusted.

Interstitial lung disease

Exceptional cases of interstitial lung disease have been reported with some statins, especially with long-term therapy. Presenting features can include dyspnoea, non-productive cough and deterioration in general health (fatigue, weight loss and fever). If it is suspected a patient has developed interstitial lung disease, statin therapy should be discontinued.

Diabetes Mellitus

Some evidence suggests that statins as a class raise blood glucose and in some patients, at high risk of future diabetes, may produce a level of hyperglycaemia where formal diabetes care is appropriate. This risk, however, is outweighed by the reduction in vascular risk with statins and therefore should not be a reason for stopping statin treatment. Patients at risk (fasting glucose 5.6 to 6.9 mmol/L, BMI>30 kg/m², raised triglycerides, hypertension) should be monitored both clinically and biochemically according to national guidelines.

In the JUPITER study, the reported overall frequency of diabetes mellitus was 2.8% in rosuvastatin and 2.3% in placebo, mostly in patients with fasting glucose 5.6 to 6.9 mmol/L.

Severe cutaneous adverse reactions

Severe cutaneous adverse reactions including Stevens-Johnson syndrome (SJS) and drug reaction with eosinophilia and systemic symptoms (DRESS), which could be life-threatening or fatal, have been reported with rosuvastatin. At the time of prescription, patients should be advised of the signs and symptoms of severe skin reactions and be closely monitored. If signs and symptoms suggestive of this reaction appears, Rosuvastatin should be discontinued immediately and an alternative treatment should be considered.

If the patient has developed a serious reaction such as SJS or DRESS with the use of Rosuvastatin, treatment with Rosuvastatin must not be restarted in this patient at any time.

Paediatric population

The evaluation of linear growth (height), weight, BMI (body mass index), and secondary characteristics of sexual maturation by Tanner staging in paediatric patients 6 to 17 years of age taking rosuvastatin is limited to a two-year period. After two years of study treatment, no effect on growth, weight, BMI or sexual maturation was detected.

In a clinical trial of children and adolescents receiving rosuvastatin for 52 weeks, CK elevations>10xULN and muscle symptoms following exercise or increased physical activity were observed more frequently compared to observations in clinical trials in adults.

Lactose: This product contains lactose. Patients with rare hereditary problems of galactose intolerance, total lactase deficiency or glucose-galactose malabsorption should not take this medicine.

DRUG INTERACTIONS:

Effect of coadministered medicinal products on rosuvastatin

Transporter protein inhibitors: Rosuvastatin is a substrate for certain transporter proteins including the hepatic uptake transporter OATP1B1 and efflux transporter BCRP. Concomitant administration of rosuvastatin with medicinal products that are inhibitors of these transporter proteins may result in increased rosuvastatin plasma concentrations and an increased risk of myopathy.

Ciclosporin: During concomitant treatment with rosuvastatin and ciclosporin, rosuvastatin AUC values were on average 7 times higher than those observed in healthy volunteers. Rosuvastatin is contraindicated in patients receiving concomitant ciclosporin. Concomitant administration did not affect plasma concentrations of ciclosporin.

Protease inhibitors: Although the exact mechanism of interaction is unknown, concomitant protease inhibitor use may strongly increase rosuvastatin exposure. For instance, in a pharmacokinetic study, co-administration of 10 mg rosuvastatin and a combination product of two protease inhibitors (300 mg atazanavir / 100 mg ritonavir) in healthy volunteers was associated with an approximately three-fold and seven-fold increase in rosuvastatin AUC() and C_{max} respectively. The concomitant use of rosuvastatin and some protease inhibitor combinations may be considered after careful consideration of rosuvastatin dose adjustments based on the expected increase in rosuvastatin exposure.

Gemfibrozil and other lipid-lowering products: Concomitant use of rosuvastatin and gemfibrozil resulted in a 2-fold increase in rosuvastatin C_{max} and AUC.

Based on data from specific interaction studies no pharmacokinetic relevant interaction with fenofibrate is expected, however a pharmacodynamic interaction may occur. Gemfibrozil, fenofibrate, other fibrates and lipid lowering doses (> or equal to 1 g/day) of niacin (nicotinic acid) increase the risk of myopathy when given concomitantly with HMG-CoA reductase inhibitors, probably because they can produce myopathy when given alone. The 40 mg dose is contraindicated with concomitant use of a fibrate. These patients should also start with the 5 mg dose.

Ezetimibe: Concomitant use of 10 mg rosuvastatin and 10 mg ezetimibe resulted in a 1.2-fold increase in AUC of rosuvastatin in hypercholesterolaemic subjects (Table 1). A pharmacodynamic interaction, in terms of adverse effects, between rosuvastatin and ezetimibe cannot be ruled out.

Antacid: The simultaneous dosing of rosuvastatin with an antacid suspension containing aluminium and magnesium hydroxide resulted in a decrease in rosuvastatin plasma concentration of approximately 50%. This effect was mitigated when the antacid was dosed 2 hours after rosuvastatin. The clinical relevance of this interaction has not been studied.

Erythromycin: Concomitant use of rosuvastatin and erythromycin resulted in a 20% decrease in AUC and a 30% decrease in C_{max} of rosuvastatin. This interaction may be caused by the increase in gut motility caused by erythromycin.

Cytochrome P450 enzymes: Results from in vitro and in vivo studies show that rosuvastatin is neither an inhibitor nor an inducer of cytochrome P450 isoenzymes. Therefore, drug interactions resulting from cytochrome P450 mediated metabolism are not expected. In addition, rosuvastatin is a poor substrate for these isoenzymes. No clinically relevant interactions have been observed between rosuvastatin and either fluconazole (an inhibitor of CYP2C9 and CYP3A4) or ketoconazole (an inhibitor of CYP2A6 and CYP3A4).

Interactions requiring rosuvastatin dose adjustments: When it is necessary to co-administer rosuvastatin with other medicinal products known to increase exposure to rosuvastatin, doses of rosuvastatin should be adjusted. Start with a 5 mg once daily dose of rosuvastatin if the expected increase in exposure (AUC) is approximately 2-fold or higher. The maximum daily dose of rosuvastatin should be adjusted so that the expected rosuvastatin exposure would not likely exceed that of a 40 mg daily dose of rosuvastatin taken without interacting medicinal products, for example a 20 mg dose of rosuvastatin with gemfibrozil (1.9-fold increase), and a 10 mg dose of rosuvastatin with combination atazanavir/ritonavir (3.1fold increase).

Effect of rosuvastatin on co-administered medicinal products

Vitamin K antagonists: As with other HMG-CoA reductase inhibitors, the initiation of treatment or dosage up-titration of rosuvastatin in patients treated concomitantly with vitamin K antagonists (e.g. warfarin or another coumarin anticoagulant) may result in an increase in International Normalised Ratio (INR). Discontinuation or down-titration of rosuvastatin may result in a decrease in INR. In such situations, appropriate monitoring of INR is desirable.

Oral contraceptive/hormone replacement therapy (HRT): Concomitant use of rosuvastatin and an oral contraceptive resulted in an increase in ethinylestradiol and norgestrel AUC of 26% and 34%, respectively. These increased plasma levels should be considered when selecting oral contraceptive doses. There are no pharmacokinetic data available in subjects taking concomitant rosuvastatin and HRT; therefore, a similar effect cannot be excluded. However, the combination has been extensively used in women in clinical trials and was well tolerated.

Other medicinal products:

Digoxin: Based on data from specific interaction studies no clinically relevant interaction with digoxin is expected.

Fusidic Acid: Interaction studies with rosuvastatin and fusidic acid have not been conducted. The risk of myopathy, including rhabdomyolysis may be increased by the concomitant administration of systemic fusidic acid with statins. The mechanism of this interaction (whether it is pharmacodynamic or pharmacokinetic, or both) is yet unknown. There have been reports of rhabdomyolysis (including some fatalities) in patients receiving this combination.

If treatment with systemic fusidic acid is necessary, Rosuvastatin treatment should be discontinued throughout the duration of the fusidic acid treatment. Ticagrelor can cause renal insufficiency and may affect renal excretion of rosuvastatin, increasing the risk for rosuvastatin accumulation. In some cases, co-administered ticagrelor and rosuvastatin led to renal function decrease, increased CPK level and rhabdomyolysis. Renal function and CPK control is recommended while using ticagrelor and rosuvastatin concomitantly.

ADVERSE REACTIONS

During treatment initiation, the most common adverse reactions are nausea, vomiting, diarrhoea, abdominal pain and loss of appetite which resolve spontaneously in most cases. To prevent them, it is recommended to take in 2 or 3 daily doses and to increase slowly the doses. At the start of treatment, transient visual disturbances may occur due to a decrease in glycaemia levels.

PREGNANCY & LACTATION:

Rosuvastatin is contraindicated in pregnancy and lactation.

Women of child bearing potential should use appropriate contraceptive measures.

Since cholesterol and other products of cholesterol biosynthesis are essential for the development of the foetus, the potential risk from inhibition of HMG-CoA reductase outweighs the advantage of treatment during pregnancy. Animal studies provide limited evidence of reproductive toxicity. If a patient becomes pregnant during use of this product, treatment should be discontinued immediately.

Rosuvastatin is excreted in the milk of rats. There are no data with respect to excretion in milk in humans.

OVERDOSE:

There is no specific treatment in the event of overdose. In the event of overdose, the patient should be treated symptomatically and supportive measures instituted as required. Liver function and CK levels should be monitored. Haemodialysis is unlikely to be of benefit.

STORAGE: Store below 30°C. Protect from light and moisture.

SHELF LIFE: 36 months

PRESENTATION:

OSCARTIN 10 : ALU-ALU Pack of 10×10 tablets.

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