

 **3 April 2025**

**SUMMARY OF PRODUCT CHARACTERISTICS**

**for**

**Fampridine "Stada", prolonged-release tablets**

**0. D.SP.NO.**

31753

**1. NAME OF THE MEDICINAL PRODUCT**

Fampridine "Stada"

**2. QUALITATIVE AND QUANTITATIVE COMPOSITION**

**Each prolonged-release tablet contains 10 mg of fampridine.**

**For the full list of excipients, see section 6.1.**

**3. PHARMACEUTICAL FORM**

**Prolonged-release tablets (tablet).**

**A white to off-white coloured, oval shaped film-coated approx. 13 mm × 8 mm tablet, debossed with L10 on one side and plain on the other side.**

**4. CLINICAL PARTICULARS**

**4.1 Therapeutic indications**

**Fampridine "Stada" is indicated for the improvement of walking in adult patients with multiple sclerosis with walking disability (EDSS 4-7).**

**4.2 Posology and method of administration**

**Treatment with Fampridine "Stada" is restricted to prescription and supervision by physicians experienced in the management of MS.**

**Posology**

**The recommended dose is one 10 mg tablet, twice daily, taken 12 hours apart (one tablet in the morning and one tablet in the evening). Fampridine "Stada" should not be administered more frequently or at higher doses than recommended (see section 4.4). The tablets should be taken without food (see section 5.2).**

**Starting and evaluating Fampridine "Stada" treatment**

* **Initial prescription should be limited to two to four weeks of therapy as clinical benefits should generally be identified within two to four weeks after starting Fampridine "Stada".**
* **An assessment of walking ability, e.g. the Timed 25 Foot Walk (T25FW) or Twelve Item Multiple Sclerosis Walking Scale (MSWS-12), is recommended to evaluate improvement within two to four weeks. If no improvement is observed, Fampridine "Stada" should be discontinued.**
* **Fampridine "Stada" should be discontinued if benefit is not reported by patients.**

**Re-evaluating Fampridine "Stada" treatment**

**If decline in walking ability is observed, physicians should consider an interruption to treatment in order to reassess the benefits of Fampridine "Stada" (see above). The re-evaluation should include withdrawal of Fampridine "Stada" and performing an assessment of walking ability. Fampridine "Stada" should be discontinued if patients no longer receive walking benefit.**

**Missed dose**

**The usual dosing regimen should always be followed. A double dose should not be taken if a dose is missed.**

***Special populations***

**Elderly**

**Renal function should be checked in the elderly before starting treatment with Fampridine "Stada". Monitoring renal function to detect any renal impairment is recommended in the elderly (see section 4.4).**

**Renal impairment**

**Fampridine "Stada" is contraindicated in patients with moderate and severe renal impairment (creatinine clearance < 50 ml/min) (see sections 4.3 and 4.4).**

**Hepatic impairment**

**No dose adjustment is required for patients with hepatic impairment.**

***Paediatric population***

**The safety and efficacy of fampridine in children aged 0 to 18 years have not been established. No data are available.**

**Method of administration**

**Fampridine "Stada" is for oral use.**

**The tablet must be swallowed whole. It must not be divided, crushed, dissolved, sucked or chewed.**

**4.3 Contraindications**

* **hypersensitivity to fampridine or to any of the excipients listed in section 6.1**
* **concurrent treatment with other medicinal products containing fampridine (4-amino­pyridine)**
* **patients with prior history or current presentation of seizure**
* **patients with moderate or severe renal impairment (creatinine clearance < 50 ml/min)**
* **concomitant use of fampridine with medicinal products that are inhibitors of Organic Cation Transporter 2 (OCT2) for example, cimetidine**

**4.4 Special warnings and precautions for use**

**Seizure risk**

**Treatment with fampridine increases seizure risk (see section 4.8).**

**Fampridine should be administered with caution in the presence of any factors which may lower seizure threshold.**

**Fampridine should be discontinued in patients who experience a seizure while on treatment.**

**Renal impairment**

**Fampridine is primarily excreted unchanged by the kidneys. Patients with renal impairment have higher plasma concentrations which are associated with increased adverse reactions, in particular neurological effects. Determining renal function before treatment and its regular monitoring during treatment is recommended in all patients (particularly in the elderly in whom renal function might be reduced). Creatinine clearance can be estimated using the Cockroft-Gault formula.**

**Caution is required when fampridine is prescribed in patients with mild renal impairment or in patients using medicinal products that are substrates of OCT2 for example, carvedilol, propranolol and metformin.**

**Hypersensitivity reactions**

**In post-marketing experience, serious hypersensitivity reactions (including anaphylactic reaction) have been reported, the majority of these cases occurred within the first week of treatment. Particular attention should be given to patients with a previous history of allergic reactions. If an anaphylactic or other serious allergic reaction occurs, fampridine should be discontinued and not restarted.**

**Other warnings and precautions**

**Fampridine should be administered with caution to patients with cardiovascular symptoms of rhythm and sinoatrial or atrioventricular conduction cardiac disorders (these effects are seen in overdose). There is limited safety information in these patients.**

**The increased incidence of dizziness and balance disorder seen with fampridine may result in an increased risk of falls. Therefore, patients should use walking aids as needed.**

**In clinical studies, low white blood cell counts were seen in 2.1 % of fampridine patients versus 1.9 % of patients on placebo. Infections were seen in the clinical studies (see section 4.8) and increased infection rate and impairment of the immune response cannot be excluded.**

**4.5 Interaction with other medicinal products and other forms of interaction**

**Interaction studies have only been performed in adults.**

**Concurrent treatment with other medicinal products containing fampridine (4-amino­pyridine) is contraindicated (see section 4.3).**

**Fampridine is eliminated mainly via the kidneys with active renal secretion accounting for about 60 % (see section 5.2). OCT2 is the transporter responsible for the active secretion of fampridine. Thus, the concomitant use of fampridine with medicinal products that are inhibitors of OCT2 for example, cimetidine are contraindicated (see section 4.3) and concomitant use of fampridine with medicinal products that are substrates of OCT2 for example, carvedilol, propranolol and metformin is cautioned (see section 4.4.)**

**Interferon: Fampridine has been administered concomitantly with interferon-beta and no pharmacokinetic medicinal product interactions were observed.**

**Baclofen: Fampridine has been administered concomitantly with baclofen and no pharmacokinetic medicinal product interactions were observed.**

**4.6 Fertility, pregnancy and lactation**

**Pregnancy**

**There are limited amount of data from the use of fampridine in pregnant women.**

**Animal studies have shown reproductive toxicity (see section 5.3). As a precautionary measure it is preferable to avoid the use of fampridine in pregnancy.**

**Breast-feeding**

**It is unknown whether fampridine is excreted in human or animal milk. Fampridine is not recommended during breast-feeding.**

**Fertility**

**In animal studies no effects on fertility were seen.**

**4.7 Effects on ability to drive and use machines**

**No traffic warning.**

**Fampridine has a moderate influence on the ability to drive and use machines because fampridine can cause dizziness.**

**4.8 Undesirable effects**

**The safety of fampridine has been evaluated in randomised controlled clinical studies, in open label long-term studies and in the post marketing setting.**

**Adverse reactions identified are mostly neurological and include seizure, insomnia, anxiety, balance disorder, dizziness, paraesthesia, tremor, headache and asthenia. This is consistent with fampridine’s pharmacological activity. The highest incidence of adverse reactions identified from placebo-controlled trials in multiple sclerosis patients with fampridine given at the recommended dose, are reported as urinary tract infection (in approximately 12 % of patients).**

**Adverse reactions are presented below by system organ class and absolute frequency. Frequencies are defined as: very common (≥ 1/10); common (≥ 1/100 to < 1/10); uncommon (≥ 1/1,000 to < 1/100); rare (≥ 1/10,000 to < 1/1,000); very rare (< 1/10,000); not known (cannot be estimated from the available data).**

**Within each frequency grouping, adverse reactions are presented in the order of decreasing seriousness.**

| **MedDRA SOC** | **Adverse reaction** | **Frequency category** |
| --- | --- | --- |
| **Infections and infestations** | **Urinary tract infection1****Influenza1****Nasopharyngitis1****Viral infection1** | **Very common****Common****Common****Common** |
| **Immune system disorders** | **Anaphylaxis****Angioedema****Hypersensitivity** | **Uncommon****Uncommon****Uncommon** |
| **Psychiatric disorders** | **Insomnia****Anxiety** | **Common****Common** |
| **Nervous system disorders** | **Dizziness****Headache****Balance disorder****Vertigo****Paraesthesia****Tremor****Seizure2****Trigeminal neuralgia3** | **Common****Common****Common****Common****Common****Common****Uncommon****Uncommon** |
| **Cardiac disorders** | **Palpitations****Tachycardia** | **Common****Uncommon** |
| **Vascular disorders** | **Hypotension4** | **Uncommon** |
| **Respiratory, thoracic and mediastinal disorders** | **Dyspnoea****Pharyngolaryngeal pain** | **Common****Common** |
| **Gastrointestinal disorders** | **Nausea****Vomiting****Constipation****Dyspepsia** | **Common****Common****Common****Common** |
| **Skin and subcutaneous tissue disorders** | **Rash****Urticaria** | **Uncommon****Uncommon** |
| **Musculoskeletal and connective tissue disorders** | **Back pain** | **Common** |
| **General disorders and administration site conditions** | **Asthenia****Chest discomfort2** | **Common****Uncommon** |

**1 See section 4.4**

**2 See sections 4.3 and 4.4**

**3 Includes both *de novo* symptoms and exacerbation of existing trigeminal neuralgia.**

**4 These symptoms were observed in the context of hypersensitivity.**

**Description of selected adverse reactions**

***Hypersensitivity***

**In post-marketing experience, there have been reports of hypersensitivity reactions (including anaphylaxis) which have occurred with one or more of the following: dyspnoea, chest discomfort, hypotension, angioedema, rash and urticaria. For further information on hypersensitivity reactions, please refer to sections 4.3 and 4.4.**

Reporting of suspected adverse reactions

Reporting suspected adverse reactions after authorisation of the medicinal product is important. It allows continued monitoring of the benefit/risk balance of the medicinal product. Healthcare professionals are asked to report any suspected adverse reactions via:

Lægemiddelstyrelsen

Axel Heides Gade 1

DK-2300 København S

Website: www.meldenbivirkning.dk

**4.9 Overdose**

**Symptoms**

**Acute symptoms of overdose with fampridine were consistent with central nervous system excitation and included confusion, tremulousness, diaphoresis, seizure, and amnesia.**

**Central nervous system side effects at high doses of 4-aminopyridine include dizziness, confusion, seizures, status epilepticus, involuntary and choreoathetoid movements. Other side effects at high doses include cases of cardiac arrhythmias (for example, supraventricular tachycardia and bradycardia) and ventricular tachycardia as a consequence of potential QT prolongation. Reports of hypertension have also been received.**

**Management**

**Patients who overdose should be provided supportive care. Repeated seizure activity should be treated with benzodiazepine, phenytoin, or other appropriate acute anti-seizure therapy.**

**4.10 Legal status**

NBS (only for hospitals and prescription by specialists in neurology)

**5. PHARMACOLOGICAL PROPERTIES**

**5.0 Therapeutic classification**

**ATC-code: N 07 XX 07. Other nervous system drugs.**

**5.1 Pharmacodynamic properties**

**Pharmacodynamic effects**

**Fampridine is a potassium channel blocker. By blocking potassium channels, fampridine reduces the leakage of ionic current through these channels, thereby prolonging repolarisation and thus enhancing action potential formation in demyelinated axons and neurological function. Presumably, by enhancing action potential formation, more impulses might be conducted in the central nervous system.**

**Clinical efficacy and safety**

**Three phase III, randomised, double-blind, placebo controlled confirmatory studies, (MS-F203 and MS-F204 and 218MS305) have been performed. The proportion of responders was independent of concomitant immunomodulatory therapy (including interferons, glatiramer acetate, fingolimod and natalizumab). The fampridine dose was 10 mg BID.**

**Studies MS-F203 and MS-F204**

**The primary endpoint in studies MS-F203 and MS-F204 was the responder rate in walking speed as measured by the Timed 25-foot Walk (T25FW). A responder was defined as a patient who consistently had a faster walking speed for at least three visits out of a possible four during the double blind period as compared to the maximum value among five off-treatment visits.**

**A significantly greater proportion of fampridine treated patients were responders as compared to placebo (MS-F203: 34.8 % vs. 8.3 %, p < 0.001; MS-F204: 42.9 % vs. 9.3 %, p < 0.001).**

**Patients who responded to fampridine increased their walking speed on average by 26.3 % vs 5.3 % on placebo (p < 0.001) (MS-F203) and 25.3 % vs 7.8 % (p < 0.001) (MS-F204). The improvement appeared rapidly (within weeks) after starting fampridine.**

**Statistically and clinically meaningful improvements in walking were seen, as measured by the 12- item Multiple Sclerosis Walking Scale.**

***Table 1: Studies MS-F203 and MS-F204***

| **STUDY \*** | **MS-F203** | **MS-F204** |
| --- | --- | --- |
|  | **Placebo** | **Fampridine 10 mg BID** | **Placebo** | **Fampridine 10 mg BID** |
| **n of subjects** | **72** | **224** | **118** | **119** |
| **Consistent improvement** | **8.3 %** | **34.8 %** | **9.3 %** | **42.9 %** |
| **Difference** |  | **26.5 %** |  | **33.5 %** |
| **CI95 %** |  | **17.6 %, 35.4 %** |  | **23.2 %, 43.9 %** |
| **p-value** |  | **< 0.001** |  | **< 0.001** |
| **≥ 20 % improvement** | **11.1 %** | **31.7 %** | **15.3 %** | **34.5 %** |
| **Difference** |  | **20.6 %** |  | **19.2 %** |
| **CI95 %** |  | **11.1 %, 30.1 %** |  | **8.5 %, 29.9 %** |
| **p-value** |  | **< 0.001** |  | **< 0.001** |
| **Walking speed****Feet/sec** | **Ft per sec** | **Ft per sec** | **Ft per sec** | **Ft per sec** |
| **Baseline** | **2.04** | **2.02** | **2.21** | **2.12** |
| **Endpoint** | **2.15** | **2.32** | **2.39** | **2.43** |
| **Change** | **0.11** | **0.30** | **0.18** | **0.31** |
| **Difference** | **0.19** | **0.12** |
| **p-value** | **0.010** | **0.038** |
| **Average % change** | **5.24** | **13.88** | **7.74** | **14.36** |
| **Difference** | **8.65** | **6.62** |
| **p-value** | **< 0.001** | **0.007** |
| **MSWS-12-score****(mean, sem)** |  |  |  |  |
| **Baseline** | **69.27 (2.22)** | **71.06 (1.34)** | **67.03 (1.90)** | **73.81 (1.87)** |
| **Average change** | **-0.01 (1.46)** | **-2.84 (0.878)** | **0.87 (1.22)** | **-2.77 (1.20)** |
| **Difference** | **2.83** | **3.65** |
| **p-value** | **0.084** | **0.021** |
| **LEMMT (mean, sem)****Lower Extremity Manual Muscle Test)** |  |  |  |  |
| **Baseline** | **3.92 (0.070)** | **4.01 (0.042)** | **4.01 (0.054)** | **3.95 (0.053)** |
| **Average change** | **0.05 (0.024)** | **0.13 (0.014)** | **0.05 (0.024)** | **0.10 (0.024)** |
| **Difference** | **0.08** | **0.05** |
| **p-value** | **0.003** | **0.106** |
| **Ashworth Score****(A test for muscle spasticity)** |  |  |  |  |
| **Baseline** | **0.98 (0.078)** | **0.95 (0.047)** | **0.79 (0.058)** | **0.87 (0.057)** |
| **Average change** | **-0.09 (0.037)** | **-0.18 (0.022)** | **-0.07 (0.033)** | **-0.17 (0.032)** |
| **Difference** | **0.10** | **0.10** |
| **p-value** | **0.021** | **0.015** |

***Study 218MS305***

**Study 218MS305 was conducted in 636 subjects with multiple sclerosis and walking disability.**

**Duration of double-blind treatment was 24 weeks with a 2 week post–treatment follow-up. The primary endpoint was improvement in walking ability, measured as the proportion of patients achieving a mean improvement of ≥ 8 points from baseline MSWS-12 score over 24 weeks. In this study there was a statistically significant treatment difference, with a greater proportion of fampridine treated patients demonstrating an improvement in walking ability, compared to placebo-controlled patients (relative risk of 1.38 (95 % CI: [1.06, 1.70]). Improvements generally appeared within 2 to 4 weeks of initiation of treatment, and disappeared within 2 weeks of treatment cessation.**

**Fampridine treated patients also demonstrated a statistically significant improvement in the Timed Up and Go (TUG) test, a measure of static and dynamic balance and physical mobility. In this secondary endpoint, a greater proportion of fampridine treated patients achieved ≥ 15 % mean improvement from baseline TUG speed over a 24 week period, compared to placebo. The difference in the Berg Balance Scale (BBS; a measure of static balance), was not statistically significant.**

**In addition, patients treated with fampridine demonstrated a statistically significant mean improvement from baseline compared to placebo in the Multiple Sclerosis Impact Scale (MSIS-29) physical score (LSM difference -3.31, p < 0.001).**

***Table 2: Study 218MS305***

| **Over 24 weeks** | **Placebo****N=318 \*** | **Fampridine 10 mg BID****N=315 \*** | **Difference (95 % CI)*****p*-value** |
| --- | --- | --- | --- |
| **Proportion of patients with mean improvement of ≥ 8 points from baseline MSWS-12 score** | **34 %** | **43 %** | **Risk difference: 10.4 %****(3 %, 17.8 %)****0.006** |
| **MSWS-12 score** **Baseline** **Improvement from baseline** | **65.4****-2.59** | **63.6****-6.73** | **LSM: -4.14****(-6.22; -2.06)****< 0.001** |
| **TUG****Proportion of patients with mean improvement of ≥ 15 % in TUG speed** | **35 %** | **43 %** | **Risk difference: 9.2 %****(0.9 %, 17.5 %)****0.03** |
| **TUG** **Baseline** **Improvement from baseline (sec)** | **27.1****-1.94** | **24.9****-3.3** | **LSM: -1.36****(-2.85; 0.12)****0.07** |
| **MSIS-29 physical score** **Baseline** **Improvement from baseline** | **55.3****-4.68** | **52.4****-8.00** | **LSM: -3.31****(-5.13; -1.50)****< 0.001** |
| **BBS score** **Baseline** **Improvement from baseline** | **40.2****1.34** | **40.6****1.75** | **LSM: 0.41****(-0.13; 0.95)****0.141** |

**\* Intent to treat population = 633; LSM = Least square mean**

**The European Medicines Agency has waived the obligation to submit the results of studies with the reference medicinal product containing fampridine in all subsets of the paediatric population in treatment of multiple sclerosis with walking disability (see section 4.2 for information on paediatric use).**

**5.2 Pharmacokinetic properties**

**Absorption:**

**Orally administered fampridine is rapidly and completely absorbed from the gastrointestinal tract.**

**Fampridine has a narrow therapeutic index. Absolute bioavailability of fampridine prolonged-release tablets has not been assessed, but relative bioavailability (as compared to an aqueous oral solution) is 95 %. The fampridine prolonged-release tablet has a delay in the absorption of fampridine manifested by slower rise to a lower peak concentration, without any effect on the extent of absorption.**

**When fampridine tablets are taken with food, the reduction in the area under the plasma concentration-time curve (AUC0-∞) of fampridine is approximately 2-7 % (10 mg dose). The small reduction in AUC is not expected to cause a reduction in the therapeutic efficacy. However, Cmax increases by 15-23 %.**

**Since there is a clear relationship between Cmax and dose related adverse reactions, it is recommended to take fampridine without food (see section 4.2).**

**Distribution:**

**Fampridine is a lipid-soluble medicinal product which readily crosses the blood-brain barrier.**

**Fampridine is largely unbound to plasma proteins (bound fraction varied between 3-7 % in human plasma). Fampridine has a volume of distribution of approximately 2.6 l/kg.**

**Fampridine is not a substrate for P-glycoprotein.**

**Biotransformation:**

**Fampridine is metabolised in humans by oxidation to 3-hydroxy-4-aminopyridine and further conjugated to the 3-hydroxy-4-aminopyridine sulphate. No pharmacological activity was found for the fampridine metabolites against selected potassium channels *in vitro*.**

**The 3-hydroxylation of fampridine to 3-hydroxy-4-aminopyridine by human liver microsomes appeared to be catalysed by Cytochrome P450 2E1 (CYP2E1).**

**There was evidence of direct inhibition of CYP2E1 by fampridine at 30 μM (approximately 12 % inhibition) which is approximately 100 times the average plasma fampridine concentration measured for the 10 mg tablet.**

**Treatment of cultured human hepatocytes with fampridine had little or no effect on induction of CYP1A2, CYP2B6, CYP2C9, CYP2C19, CYP2E1 or CYP3A4/5 enzyme activities.**

**Elimination:**

**The major route of elimination for fampridine is renal excretion, with approximately 90 % of the dose recovered in urine as parent medicinal product within 24 hours. Renal clearance (CLR 370 ml/min) is substantially greater than glomerular filtration rate due to combined glomerular filtration and active excretion by the renal OCT2 transporter. Faecal excretion accounts for less than 1 % of the administered dose.**

**Fampridine is characterised by linear (dose-proportional) pharmacokinetics with a terminal elimination half-life of approximately 6 hours. The maximum plasma concentration (Cmax) and, to a smaller extent, area under the plasma concentration-time curve (AUC) increase proportionately with dose.**

**There is no evidence of clinically relevant accumulation of fampridine taken at the recommended dose in patients with full renal function. In patients with renal impairment, accumulation occurs relative to the degree of impairment.**

**Special populations**

**Elderly**

**Fampridine is primarily excreted unchanged by the kidneys, and with creatinine clearance known to decrease with age, monitoring of renal function in elderly patients is recommended (see section 4.2).**

**Paediatric population**

**No data are available.**

**Renal impairment**

**Fampridine is eliminated primarily by the kidneys as unchanged medicinal product and therefore renal function should be checked in patients where renal function might be compromised. Patients with mild renal impairment can be expected to have approximately 1.7 to 1.9 times the fampridine concentrations achieved by patients with normal renal function. Fampridine must not be administered to patients with moderate and severe renal impairment (see sections 4.3 and 4.4).**

**5.3 Preclinical safety data**

**Fampridine was studied in oral repeat dose toxicity studies in several animal species.**

**Adverse responses to orally administered fampridine were rapid in onset, most often occurring within the first 2 hours post-dose. Clinical signs evident after large single doses or repeated lower doses were similar in all species studied and included tremors, convulsions, ataxia, dyspnoea, dilated pupils, prostration, abnormal vocalisation, increased respiration, and excess salivation. Gait abnormalities and hyper-excitability were also observed. These clinical signs were not unexpected and represent exaggerated pharmacology of fampridine. In addition, single cases of fatal urinary tract obstructions were observed in rats. The clinical relevance of these findings remains to be elucidated, but a causal relationship with fampridine treatment cannot be excluded.**

**In reproduction toxicity studies in rats and rabbits, decreased weight and viability of foetuses and offspring were observed at maternally toxic doses. However, no increased risk for malformations or adverse effects on fertility was noted.**

**In a battery of *in vitro* and *in vivo* studies fampridine did not show any potential to be mutagenic, clastogenic or carcinogenic.**

**6. PHARMACEUTICAL PARTICULARS**

**6.1 List of excipients**

**Tablet core**

**Hypromellose, microcrystalline**

**cellulose, colloid anhydrous silica**

**magnesium stearate**

**Film-coat**

**Hypromellose**

**titanium dioxide**

**macrogol**

**6.2 Incompatibilities**

**Not applicable.**

**6.3 Shelf-life**

**2 years.**

**6.4 Special precautions for storage**

**Store below 25 °C. Store in the original package in order to protect from moisture.**

**6.5 Nature and contents of container**

**Aluminium with desiccant/aluminium non-peelable blister in cartons of**

**14 x 1 (unit-dose blister) prolonged-release tablets**

**28 x 1 (unit-dose blister) prolonged-release tablets**

**56 x 1 (unit-dose blister) prolonged-release tablets**

**196 x 1 (unit-dose blister) prolonged-release tablets**

**Not all pack sizes may be marketed.**

**6.6 Special precautions for disposal and other handling**

**No special requirements.**

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

**Instructions on how to open the blister**

**1. Remove one blister by tearing down perforations.**

**2. Starting at one corner, carefully peel back the foil to reveal the tablet:**

**Note: The tablet cannot be pushed through the foil!**



**7. MARKETING AUTHORISATION HOLDER**

Stada Arzneimittel AG

Stadastrasse 2-18

61118 Bad Vilbel

Tyskland

**Representative**

Stada Nordic ApS

Marielundvej 46 A

2730 Herlev

**8. MARKETING AUTHORISATION NUMBER(S)**

63180

**9. DATE OF FIRST AUTHORISATION**

3 May 2022

**10. DATE OF REVISION OF THE TEXT**

3 April 2025