SUMMARY OF PRODUCT CHARACTERISTICS

1. NAME OF THE MEDICINAL PRODUCT

TEKFIN 250 mg Tablets

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

Each tablet contains:
Active substance:
Terbinafine hydrochloride equivalent to 250 mg terbinafine
Excipient(s) with known effect:
Sodium starch glycolate_____45 mg
For the full list of excipients, see section 6.1.

3. PHARMACEUTICAL FORM

Tablets.
White colored, slightly convex, round shaped tablets engraved in the middle on one side.

4. CLINICAL PARTICULARS

4.1 Therapeutic indications

- Onychomycosis
- Tinea capitis
- Tinea pedis
- Tinea corporis
- Tinea cruris

4.2 Posology and method of administration

Posology / Frequency and duration of administration

The duration of treatment varies according to the indication and the severity of infection.

Unless otherwise recommended by the doctor;

Children
No data are available in children under 2 years of age (usually <12 kg).
Children weighing 20 to 40 kg: 1/2 tablet of TEKFIN (125 mg) once daily.
Children weighing over 40 kg: 1 tablet of TEKFIN (250 mg) once daily.

Adults
A single dose of TEKFIN 250 mg tablet once daily.

Skin infections
Likely durations of treatment are as follows:
Tinea pedis (interdigital, plantar/moccasin type): 2 to 6 weeks
Tinea corporis and Tinea cruris: 2 to 4 weeks

Complete resolution of the signs and symptoms of infection may not occur until several weeks after mycological cure.

Hair and scalp infections
Likely durations of treatment are as follows:
Tinea capitis: 4 weeks
Tinea capitis is seen especially in children.

Onychomycosis
The duration of treatment for most patients is between 6 to 12 months.

Fingernail onychomycosis
In most cases, 6 weeks of treatment is sufficient for fingernail infections.

Toenail onychomycosis
In most cases, 12 weeks of treatment is sufficient for toenail infections. In some patients with poor nail outgrowth, longer treatment may be required. Optimum clinical efficacy is reached several months after mycological recovery and termination of treatment. This situation is related to the time required for healthy nail outgrowth.

Method of administration
The engraved tablets are taken orally with water. They should preferably be taken at the same time each day and can be taken on an empty stomach or after a meal.

Additional information on special population
Hepatic impairment
TEKFIN is not recommended for use for patients with chronic or active hepatic disease (see section 4.4).

Renal impairment
The use of TEKFIN has not been adequately studied in patients with renal impairment and is therefore not recommended in this population (see sections 4.4 and 5.2)

Pediatric population
The safety of its use in children has not been clearly proven.

Geriatric population
There is no evidence to suggest that elderly patients (aged 65 years or above) require different dosages or experience side-effects different to those of younger patients. When prescribing TEKFIN in this age group, the possibility of pre-existing liver or kidney dysfunction should be considered (see section 4.4).

4.3 Contraindications
In case of hypersensitivity to terbinafine or to any of the excipients in the formulation.

4.4 Special warnings and precautions for use
Liver function
TEKFIN is contraindicated for patients with chronic or active liver disease. Since hepatotoxicity may occur in patients with and without pre-existing liver disease, a liver function test should be performed before prescribing TEKFIN. Periodic monitoring (after 4-6 weeks of treatment) of liver function test is recommended. TEKFIN should be immediately discontinued in case of elevation of liver function test. Very rare cases of serious liver failure (some with a

fatal outcome, or requiring liver transplant) have been reported in patients treated with TEKFIN. In the majority of liver failure cases, the patients had serious underlying systemic conditions and the causal relationship between taking TEKFIN and the development of liver failure is not clear (see section 4.8). TEKFIN treatment should be discontinued and liver functions should be evaluated if the patient develops signs or symptoms such as unexplained persistent nausea, decreased appetite, fatigue, vomiting, abdominal pain in the right upper quadrant, jaundice, dark urine, pale feces, etc.

Dermatological effects
Serious skin reactions (e.g. Stevens-Johnson syndrome, toxic epidermal necrolysis, drug rash with eosinophilia and systemic symptoms) have been very rarely reported in patients taking TEKFIN. If progressive skin rash occurs, treatment with TEKFIN should be discontinued.

Terbinafine should be used with caution in patients with pre-existing psoriasis or lupus erythematosus because predisposition and exacerbation of psoriasis and cutaneous and systemic lupus erythematosus have been reported in a post-marketing setting.

Hematological effects
Very rare cases of blood dyscrasias (neutropenia, agranulocytosis, thrombocytopenia, pancytopenia) have been reported in patients treated with TEKFIN. Etiology of any blood dyscrasias that occur in patients treated with TEKFIN should be evaluated and consideration should be given for a possible change in medication regimen, including discontinuation of treatment with TEKFIN.

Renal function
In patients with renal impairment (creatinine clearance less than 50 mL/min or serum creatinine of more than 300 micromole/L) the use of TEKFIN has not been adequately studied, and therefore, is not recommended (see section 5.2).

Warning for sodium
This medicine contains less than 1 mmol sodium (23 mg) per tablet; no sodium-related side effects are expected at this dose.

Interactions with other drugs
In vitro and *in vivo* studies have shown that terbinafine inhibits the CYP2D6 metabolism. Therefore, patients receiving concomitant treatment with drugs predominantly metabolized by this enzyme, e.g. certain members of the following drug classes, tricyclic antidepressants, beta-blockers, selective serotonin reuptake inhibitors (SSRIs), antiarrhythmics class (including class 1A, 1B and 1C) and monoamine oxidase inhibitors Type B, should be followed, if the co-administered drug has a narrow therapeutic window (see section 4.5).

Other
Treatment should be discontinued in cases of retinal and ocular changes, pancytopenia, neutropenia, Stevens-Johnson syndrome or toxic epidermal necrolysis.

4.5 Interaction with other medicinal products and other forms of interaction
Effect of other medicinal products on terbinafine
The plasma clearance of terbinafine may be accelerated by drugs, which induce metabolism and may be inhibited by drugs, which inhibit cytochrome P450. Where co-administration of

such agents is necessary, the dosage of TEKFIN may need to be adjusted accordingly.

The following medicinal products may increase the effect or plasma concentration of terbinafine:
Cimetidine decreased the clearance of terbinafine by 30%.

Fluconazole increased the C_{max} and AUC of terbinafine by 52% and 69% respectively, due to inhibition of both CYP2C9 and CYP3A4 enzymes. Similar increase in exposure may occur when other drugs which inhibit both CYP2C9 and CYP3A4 such as ketoconazole and amiodarone are concomitantly administered with terbinafine.

The following medicinal products may decrease the effect or plasma concentration of terbinafine:
Rifampicin increased the clearance of terbinafine by 100%.

Effect of terbinafine on other medicinal products
Terbinafine may increase the effect or plasma concentration of the following medicinal products:
Caffeine: Terbinafine decreased the clearance of caffeine administered intravenously by 21%.
Warfarin: Terbinafine may increase the effects of warfarin.

Compounds predominantly metabolized by CYP2D6: *In vitro* and *in vivo* studies have shown that terbinafine inhibits the CYP2D6-mediated metabolism. This finding may be of clinical relevance for compounds predominantly metabolized CYP2D6, e.g. certain members of the following drug classes, tricyclic antidepressants (TCAs), beta-blockers, selective serotonin reuptake inhibitors (SSRIs), antiarrhythmics (including class 1A, 1B and 1C) and monoamine oxidase inhibitors (MAO-Is) Type B, especially if they also have a narrow therapeutic window (see section 4.4).

Terbinafine decreased the clearance of desipramine by 82% (see section 4.4).

In studies in healthy subjects characterized as extensive metabolizers of dextromethorphan (antitussive drug and CYP2D6 probe substrate), terbinafine increased the dextromethorphan/dextrorphan metabolic ratio in urine by 16- to 97-fold on average. Thus, terbinafine may convert extensive CYP2D6 metabolizers to poor metabolizer status.

Information on other drugs concomitantly used with TEKFIN resulting in no or negligible interactions:
According to the results from studies undertaken *in-vitro* and in healthy volunteers, terbinafine shows negligible potential for inhibiting or enhancing the clearance of most drugs that are metabolized via the cytochrome P450 system (e.g. terfenadine, triazolam, tolbutamide or oral contraceptives) with exception of those metabolized through CYP2D6 (see below).

Terbinafine does not interfere with the clearance of antipyrine or digoxin.

There was no effect of terbinafine on the pharmacokinetics of fluconazole. Further there was no clinically relevant interaction between terbinafine and the potential co-medications cotrimoxazole (trimethoprim and sulfamethoxazole), zidovudine or theophylline.

Some cases of menstrual irregularities have been reported in patients taking TEKFIN concomitantly with oral contraceptives, although the incidence of these disorders remains within the background incidence of patients taking oral contraceptives alone.

Terbinafine may decrease the effect or plasma concentration of the following medicinal products:
Terbinafine increased the clearance of ciclosporin by 15%.

Terbinafine may reduce the effects of codeine and tramadol.

Additional information on special populations
No clinical interaction studies have been conducted in special populations.

Pediatric population
No clinical interaction studies have been conducted in the pediatric population. The safety of use in children has not been conclusively proven.

4.6. Pregnancy and lactation
General recommendation
Pregnancy category is B.

Women of child-bearing potential / Birth Control (Contraception)
Some cases of menstrual irregularities have been reported in patients taking TEKFIN concomitantly with oral contraceptives, although the incidence of these disorders remains within the background incidence of patients taking oral contraceptives alone.

There are no data to support special recommendations for women of child-bearing potential.

Pregnancy
For terbinafine, there are limited clinical data on exposure in pregnancy. Animal studies do not indicate direct or indirect harmful effects with respect to pregnancy, embryo/fetal development, parturition or postnatal development. TEKFIN should not be used during pregnancy.

Since documented clinical experience in pregnant women is very limited, TEKFIN should not be used during pregnancy unless the potential benefits outweigh the potential risks.

Lactation
Terbinafine is excreted in breast milk and therefore mothers should not receive TEKFIN treatment whilst breast-feeding.

Reproductive Ability / Fertility
There is no relevant information from human experience. Fertility studies in rats indicated no adverse findings in fertility or reproductive performance.

4.7. Effects on ability to drive and use machines
No studies on the effects of treatment with TEKFIN on the ability to drive and use machines have been performed. Patients who experience dizziness as an undesirable effect should avoid driving vehicles or using machines.

4.8. Undesirable effects

Adverse drug reactions from clinical trials or post-marketing experience are listed by MedDRA system organ class. Within each system organ class, the adverse drug reactions are ranked by frequency, with the most frequent reactions first. Within each frequency grouping, adverse drug reactions are presented in order of decreasing seriousness. In addition, the corresponding frequency category for each adverse drug reaction is based on the following convention (CIOMS III): 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 (frequency cannot be estimated from available data).

Blood and lymphatic system disorders

Uncommon: Anemia
Very rare: Neutropenia, agranulocytosis, thrombocytopenia, lymphocytopenia, pancytopenia

Immune system disorders

Very rare: Anaphylactoid reactions (including angioedema), cutaneous and systemic lupus erythematosus

Psychiatric disorders

Common: Depression
Uncommon: Anxiety

Nervous system disorders

Very common: Headache
Common: Dysgeusia* including ageusia*, dizziness
Uncommon: Paresthesia and hypoesthesia

Eye disorders

Common: Visual impairment

Ear and labyrinth disorders

Uncommon: Tinnitus

Gastrointestinal disorders

Very common: Gastrointestinal symptoms (abdominal distension, decreased appetite, dyspepsia, nausea, mild abdominal pain, diarrhea)

Hepatobiliary disorders

Rare: Hepatic failure, hepatitis, jaundice, cholestasis, hepatic enzyme increased

Skin and subcutaneous tissue disorders

Very common: Rash, urticaria
Uncommon: Photosensitivity reaction
Very rare: Stevens-Johnson syndrome, toxic epidermal necrolysis, acute generalized exanthematous pustulosis, erythema multiforme, toxic skin eruption, dermatitis exfoliative, dermatitis bullous
If progressive skin rash and redness occur, TEKFIN treatment should be discontinued.
Psoriasiform eruptions or exacerbation of psoriasis.

Musculoskeletal, connective tissue and bone disorders
Very common: Musculoskeletal reactions (arthralgia, myalgia)

General disorders and administration site conditions
Uncommon: Pyrexia
Common: Fatigue

Investigations
Uncommon: Weight decreased**

*Hypogeusia, including ageusia, which usually recover within several weeks after discontinuation of the drug. Isolated cases of prolonged hypogeusia have been reported.
**Weight decreased secondary to dysgeusia.

Adverse drug reactions from spontaneous reports and literature cases (frequency not known):

The following adverse drug reactions are from post-marketing experience with TEKFIN via spontaneous case reports and literature cases. As these reactions are reported voluntarily from a population of uncertain size, it is not possible to reliably estimate their frequency, which is therefore categorized as 'not known'. Adverse drug reactions are listed according to MedDRA system organ class. Within each system organ class, ADRs are presented in order of decreasing seriousness.

Adverse drug reactions from spontaneous reports and literature (frequency not known):

Immune system disorders
Anaphylactic reaction, serum sickness-like reaction

Nervous system disorders
Anosmia including permanent anosmia, hyposmia

Eye disorders
Vision blurred, visual acuity reduced

Ear and labyrinth disorders
Hypoacusis, impaired hearing

Vascular disorders
Vasculitis

Gastrointestinal disorders
Pancreatitis

Skin and subcutaneous tissue disorders
Drug rash with eosinophilia and systemic symptoms

Musculoskeletal, connective tissue and bone disorders
Rhabdomyolysis

General disorders and administration site conditions
Influenza-like illness

Investigations
Blood creatine phosphokinase increased

Reporting of suspected adverse reactions
Reporting suspected adverse reactions after authorization 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 the national reporting system.

4.9 Overdose
A few cases of overdose (up to 5 g) have been reported, giving rise to headache, nausea, epigastric pain and dizziness. The recommended treatment of overdosage consists in eliminating the drug, primarily by the administration of activated charcoal, and giving symptomatic supportive therapy if needed.

5. PHARMACOLOGICAL PROPERTIES
5.1 Pharmacodynamic properties
Pharmacotherapeutic group: Antifungals for systemic use
ATC code: D01BA02

Terbinafine is an allylamine which has a broad spectrum of activity against fungal pathogens of hair and nails such as Trichophyton (e.g. T. rubrum, T. mentagrophytes, T. verrucosum, T. tonsurans, T. violaceum), Microsporum (e.g. M. canis), Epidermophyton floccosum and Candida genus yeast (e.g. C. albicans) and Pityrosporum. At low concentrations terbinafine is fungicidal against dermatophytes, molds and certain dimorphic fungi. The activity versus yeasts is fungicidal or fungistatic depending on the species.

Terbinafine interferes specifically with fungal sterol biosynthesis at an early step. This leads to a deficiency in ergosterol and to an intracellular accumulation of squalene, resulting in fungal cell death. Terbinafine acts by inhibition of squalene epoxidase in the fungal cell membrane. The enzyme squalene epoxidase is not linked to the cytochrome P450 system.

When given orally, the drug concentrates in skin, hair and nails at levels associated with fungicidal activity.

Clinical trials
Onychomycosis
The efficacy of terbinafine in the treatment of onychomycosis is illustrated based on placebo-controlled clinical trials conducted among patients with toenail and/or fingernail infections.
Results of the toenail onychomycosis study, as assessed after 12 weeks of treatment with 36 weeks follow-up after completion of therapy, demonstrated mycological cure, defined as simultaneous occurrence of negative KOH plus negative culture, in 70% of patients. Fifty-nine percent (59%) of patients experienced effective treatment (mycological cure plus 0% nail involvement or >5mm of new unaffected nail growth); 38% of patients demonstrated mycological cure plus clinical cure (0% nail involvement).

Results of the fingernail onychomycosis study, as assessed after 6 weeks of treatment with 18 weeks follow-up after completion of therapy, demonstrated mycological cure in 79% of patients, effective treatment in 75% of the patients, and mycological cure plus clinical cure in 59% of the patients.
The mean time to treatment success for onychomycosis was approximately 10 months for the toenail study and 4 months for the fingernail study. In the toenail study, for patients evaluated at least six months after achieving clinical cure and at least one year after completing terbinafine therapy, the clinical relapse rate was approximately 15%.

Tinea capitis (hair fungus):
In the three comparative efficacy studies, oral terbinafine (62.5 – 250 mg once daily) was given to a total of 117 patients, of whom over 97% were children. Single daily doses of terbinafine for 4 weeks or griseofulvin for 8 weeks were given after the evening meal. Efficacy, demonstrated by negative mycology tests and a reduction in symptomatology, was evaluated at 8 weeks and at the follow-up examination (Week 12 for the first two studies, Week 24 for the third study). Negative mycology test results at follow-up were achieved by 85%, 88% and 72% of patients given terbinafine in the three studies – the corresponding figures for griseofulvin were 73%, 89% and 69%. The effective treatment (negative mycology plus no, or only mild, symptoms and signs) was achieved in 82%, 78% and 69% of terbinafine-treated patients, compared with 66%, 74% and 59% in patients given griseofulvin; the difference was statistically significant in favor of terbinafine in the first study.

A 12-week randomized, double-blind, parallel group study was conducted in children with Tinea capitis infection due to Trichophyton species. Both 2- and 4-week treatment duration provided good efficacy with terbinafine tablets. A 16-week, randomized, active-controlled (open-label griseofulvin), parallel-group, multicenter study was conducted in patients with Tinea capitis (>4 years) due to Microsporum species, and terbinafine tablets were administered double-blindly once daily for 6, 8, 10 and 12 weeks, based on body weight as follows: <20 kg: 62.5 mg; 20-40 kg: 125 mg; >40 kg: 250 mg. There was no significant difference in complete cure rates between the different treatment duration groups and 6-week treatment showed high complete cure rate (62%) with good tolerability and compliance. Terbinafine was very well tolerated in both the Trichophyton and Microsporum studies. These results show that terbinafine reduced treatment duration from 6-8 weeks to only 2-4 weeks in T. capitis caused by Trichophyton species compared to standard therapy with griseofulvin.

In phase II clinical studies conducted in Tinea capitis, adverse events reported from the 588 children enrolled were, in general, mild, relatively infrequent and often had an uncertain relationship to treatment. There were 11 reports of elevated SGPT levels and one of taste loss. Other events included mild gastrointestinal or skin symptoms, and laboratory findings indicative of incurrent infections.

Fungal infections of the skin (Tinea corporis, Tinea cruris, Tinea pedis) and yeast infections of the skin caused by the genus Candida (e.g. Candida albicans) where oral therapy is generally considered appropriate owing to the site, severity or extent of the infection:
In three studies, two 4-week placebo-controlled and one 6-week active-controlled (griseofulvin 250 mg), terbinafine 125 mg twice daily showed statistically superior efficacy (negative mycology tests and a reduction in clinical symptomatology) compared to placebo and griseofulvin in the treatment of Tinea corporis/cruris.

In a double-blind, placebo-controlled 4 weeks study, terbinafine 125 mg twice-daily was compared to placebo in patients with cutaneous candidiasis. Twenty-nine percent (29%) of patients in the treatment arm and 17% of patients on placebo demonstrated mycological cure at the end of treatment and 67% of terbinafine-treated patients had negative mycological results at the end of follow-up. Given the above response rates, 2 weeks therapy of terbinafine should be the minimum duration of treatment period and approximately half of the patients would require 3-4 weeks of treatment to achieve cure.

The efficacy of terbinafine 125 mg twice-daily in the treatment of Tinea pedis was evaluated in two double-blind studies, one placebo-controlled and the other active-controlled (griseofulvin 250 mg twice daily). Sixty-five percent (65%) of patients on terbinafine reported mycological cure at follow-up whereas none of the placebo-treated patients responded.

In the other study, terbinafine was shown to be highly effective at follow-up after 6 weeks therapy compared to patients on griseofulvin (with 45% and 38% of cure, respectively). These patients when observed after 10 months reported 94% cure rate, compared to 30% efficacy of griseofulvin.

5.2. Pharmacokinetic properties

Absorption

Following oral administration, terbinafine is well absorbed (>70%). A single oral dose of 250 mg terbinafine resulted in a mean peak plasma concentration of 1.3 microgram/mL within 1.5 hours of administration. At steady-state (70% steady state is achieved in approximately 28 days), in comparison to a single dose, peak concentration of terbinafine was on average 25% higher and plasma AUC increased by a factor of 2.3.

The bioavailability of terbinafine is moderately affected by food (increase in the AUC of less than 20%), but not sufficiently to require dose adjustments.

Distribution

Terbinafine binds strongly to plasma proteins (99%). It rapidly diffuses through the dermis and concentrates in the lipophilic stratum corneum. Terbinafine is also secreted in sebum, thus achieving high concentrations in hair follicles, hair and sebum rich skins. There is also evidence that terbinafine is distributed into the nail plate within the first few weeks of commencing therapy.

Biotransformation

Terbinafine is metabolized rapidly and extensively by at least seven CYP isoenzymes with major contributions from CYP2C9, CYP1A2, CYP3A4, CYP2C8 and CYP2C19.

Elimination

From the increase in plasma AUC, an effective half-life of ~30 hours can be calculated. Multiple dose administration followed by extended blood sampling revealed a triphasic elimination with a terminal half-life of approximately 16.5 days.

Bioavailability

The absolute bioavailability of terbinafine from tablets as a result of first-pass metabolism is approximately 50 %.

Characteristics of patients

Geriatrics

No age-dependent changes in pharmacokinetics have been observed in steady-state plasma concentrations of terbinafine.

Pediatrics

The safety of use in children has not been definitively established. Terbinafine has been observed to be well-tolerated in children over 2 years of age.

Renal / Hepatic impairment

The elimination rate may be reduced in patients with renal or hepatic impairment, resulting in higher blood levels of terbinafine.

Single dose pharmacokinetic studies in patients with renal impairment (creatinine clearance <50 mL/min) or with pre-existing liver disease have shown that the clearance of terbinafine may be reduced by about 50%.

5.3. Preclinical safety data

In long-term studies (up to 1 year) in rats and dogs, no marked toxic effects were seen in either species up to oral doses of about 100 mg/kg a day. At high oral doses, the liver and possibly also the kidney were identified as potential target organs.

In a two-year carcinogenicity study in mice, no neoplastic or other abnormal findings attributable to treatment were made up to doses of 130 (males) and 156 (females) mg/kg a day. In a two-year carcinogenicity study in rats, an increased incidence of liver tumors was observed in males at the highest dose level of 69 mg/kg a day. The changes which may be associated with peroxisome proliferation have been shown to be species-specific since they were not seen in the carcinogenicity study in mice or other studies in mice, dogs or monkeys.

During high dose studies in monkeys, refractile irregularities were observed in the retina at the higher doses (non-toxic levels 50 mg/kg). These irregularities were associated with the presence of a terbinafine metabolite in the ocular tissue and disappeared after drug discontinuation.

An 8-week oral study in juvenile rats provided a no-toxic-effect level (NTEL) of close to 100 mg/kg/day, with the only finding being slightly increased liver weights, while in maturing dogs at ≥100 mg/kg/day (AUC values about 13x [male] and 6x [female] times those in children), signs of central nervous system (CNS) disturbance including convulsion attacks in individual animals were observed. Similar findings have been observed at high exposure upon intravenous administration of terbinafine to adult rats or monkeys.

A standard battery of *in vitro* and *in vivo* genotoxicity tests revealed no evidence of mutagenic or clastogenic potential.

No adverse effects on fertility or other reproduction parameters were observed in studies in rats or rabbits.

6. PHARMACEUTICAL PARTICULARS

6.1. List of excipients

Sodium starch glycolate
Hydroxypropyl methyl cellulose
Microcrystalline cellulose PH101
Microcrystalline cellulose PH102
Colloidal silicon dioxide
Magnesium stearate

6.2. Incompatibilities

There is no known incompatibility.

6.3. Shelf life

36 months.

6.4. Special precautions for storage

Keep at room temperature below 25°C. Protect from moisture and light.

6.5. Nature and contents of container

Supplied in blister packs, consisting of transparent PVC/PVDC on one side and printed aluminum foil on the other side, containing 14 or 28 tablets, available in cardboard boxes.

6.6. Special precautions for disposal and other handling

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

7. MARKETING AUTHORIZATION HOLDER

DEVA Holding A.Ş.
Halkalı Merkez Mah. Basın Ekspres Cad. No:1
34303 Küçükçekmece – İSTANBUL / TÜRKİYE

8. MARKETING AUTHORIZATION NUMBER

205/34

9. DATE OF FIRST AUTHORIZATION/RENEWAL OF THE AUTHORIZATION

Date of first authorization : 17.02.2005
Date of latest renewal :

10. DATE OF REVISION OF THE TEXT