GEMTERO 200 mg and GEMTERO 1g (Gemcitabine for Injection 200 mg and 1g)

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2090914

Name of the product
GEMTERO 200 mg (Gemcitabine for Injection 200 mg)
GEMTERO 1g (Gemcitabine for Injection 1g)

Name and strength of Active Ingredient
GEMTERO 200 mg (Gemcitabine for Injection 200 mg):
Each vial contains Gemcitabine hydrochloride equivalent to Gemcitabine 200 mg

GEMTERO 1g (Gemcitabine for Injection 1g):
Each vial contains Gemcitabine hydrochloride equivalent to Gemcitabine 1000 mg

Dosage form
Powder for injection (lyophilised cake)

Product Description
Before Reconstitution: White to off white lyophilized plug contained in a flint glass vial
After Reconstitution: Colorless clear solution free from visible particles

PHARMACODYNAMICS/PHARMACOKINETICS
Pharmacotherapeutic group: Pyrimidine analogues. ATC code: L01BC05

Cytotoxic activity in cell cultures
Gemcitabine shows significant cytotoxic effects against a variety of cultured murine and human tumour cells. Its action is phase-specific such that gemcitabine primarily kills cells that are undergoing DNA synthesis (Sphase) and, under certain circumstances, blocks the progression of cells at the junction of the G_1/S phase boundary. The cytotoxic effect of gemcitabine is dependent on both concentration and time.

Mechanism of action
Cellular metabolism and mechanism of action: Gemcitabine (dFdC), which is a pyrimidine antimetabolite, is metabolised intracellularly by nucleoside kinase to the active diphosphate (dFdCDP) and triphosphate (dFdCTP) nucleosides. The cytotoxic effect of gemcitabine is due to inhibition of DNA synthesis by two mechanisms of action by dFdCDP and dFdCTP. First, dFdCDP inhibits ribonucleotide reductase, which is uniquely responsible for catalysing the reactions that produce deoxynucleoside triphosphates (dCTP) for DNA synthesis. Inhibition of this enzyme by dFdCDP reduces the concentration of deoxynucleosides in general and, in particular, dCTP. Second, dFdCTP competes with dCTP for incorporation into DNA (self-potentiation).

Likewise, a small amount of gemcitabine may also be incorporated into RNA. Thus, the reduced intracellular concentration of dCTP potentiates the incorporation of dFdCTP into DNA. DNA polymerase epsilon lacks the ability to eliminate gemcitabine and to repair the growing DNA strands. After gemcitabine is incorporated into DNA, one additional nucleotide is added to the growing DNA strands. After this addition there is essentially a complete inhibition in further DNA synthesis (masked chain termination). After incorporation into DNA, gemcitabine appears to induce the programmed cell death process known as apoptosis.

PHARMACOKINETICS
The following pharmacokinetic parameters were reported for doses ranging from 500 to 2,592 mg/m^2 that were infused from 0.4 to 1.2 hours.

Peak plasma concentrations (obtained within 5 minutes of the end of the infusion) were 3.2 to 45.5 µg/ml. Plasma concentrations of the parent compound following a dose of 1,000 mg/m^2/30 minutes are greater than 5 µg/ml for approximately 30 minutes after the end of the infusion, and greater than 0.4 µg/ml for an additional hour.

Distribution
The volume of distribution of the central compartment was 12.4 l/m^2 for women and 17.5 l/m^2 for men (inter-individual variability was 91.9%). The volume of distribution of the peripheral compartment was 47.4 l/m^2. The volume of the peripheral compartment was not sensitive to gender. The plasma protein binding was considered to be negligible.

Half-life: This ranged from 42 to 94 minutes depending on age and gender. For the recommended dosing schedule, gemcitabine elimination should be virtually complete within 5 to 11 hours of the start of the infusion. Gemcitabine does not accumulate when administered once weekly.

Metabolism
Gemcitabine is rapidly metabolised by cytidine deaminase in the liver, kidney, blood and other tissues. Intracellular metabolism of gemcitabine produces the gemcitabine mono, di and triphosphates (dFdCMP, dFdCDP and dFdCTP) of which dFdCDP and dFdCTP are considered active. These intracellular metabolites have not been detected in plasma or urine. The primary metabolite, 2'-deoxy-2', 2'-difluorouridine (dFdU), is not active and is found in plasma and urine.

Excretion
Systemic clearance ranged from 29.2 l/hr/m^2 to 92.2 l/hr/m^2 depending on gender and age (interindividual variability was 52.2%). Clearance for women is approximately 25% lower than the values for men. Although rapid, clearance for both men and women appears to decrease with age. For the recommended gemcitabine dose of 1,000 mg/m^2 given as a 30 minute infusion, lower clearance values for women and men should not necessitate a decrease in the gemcitabine dose.
Urinary excretion: Less than 10% is excreted as unchanged drug.
Renal clearance was 2 to 7 l/hr/m^2
During the week following administration, 92 to 98% of the dose of gemcitabine administered is recovered, 99% in the urine, mainly in the form of dFdU and 1% of the dose is excreted in faeces.

dFdCTP kinetics
This metabolite can be found in peripheral blood mononuclear cells. Intracellular concentrations increase in proportion to gemcitabine doses of 35-350 mg/m^2/ 30 minutes, which give steady-state concentrations of 0.4-5 µg/ml. At gemcitabine plasma concentrations above 5 µg/ml, dFdCTP levels do not increase, suggesting that the formation is saturable in these cells.
Half-life of terminal elimination: 0.7-12 hours.

dFdU kinetics
Peak plasma concentrations (3-15 minutes after end of 30 minute infusion, 1,000 mg/m^2): 28-52 µg/ml.
Trough concentration following once weekly dosing: 0.07-1.12 µg/ml, with no apparent accumulation.
Triphasic plasma concentration versus time curve, mean half-life of terminal phase - 65 hours (range 33-84 hr).
Formation of dFdU from parent compound: 91%-98%.
Mean volume of distribution of central compartment: 18 l/m^2 (range 11-22 l/m^2).
Mean steady-state volume of distribution (Vss): 150 l/m^2 (range 96-228 l/m^2).
Tissue distribution: Extensive.
Mean apparent clearance: 2.5 l/hr/m^2 (range 1-4 l/hr/m^2).
Urinary excretion: All.

Gemcitabine and paclitaxel combination therapy
Combination therapy did not alter the pharmacokinetics of either gemcitabine or paclitaxel.

Gemcitabine and carboplatin combination therapy
When given in combination with carboplatin the pharmacokinetics of gemcitabine were not altered.

Renal impairment
Mild to moderate renal insufficiency (GFR from 30 ml/min to 80 ml/min) has no consistent, significant effect on gemcitabine pharmacokinetics.

INDICATIONS
- Gemcitabine is indicated for the treatment of locally advanced or metastatic non-small cell-lung cancer
- Gemcitabine is indicated for the treatment of adult patients with locally advanced or metastatic adrenocarcinoma of the pancreas. Gemcitabine is indicated for patients with 5-FU refractory pancreatic cancer
- Gemcitabine is indicated for the treatment of patients suffering from bladder cancer, at the invasive stage
- Gemcitabine, in combination with paclitaxel, is indicated for the treatment of patients with unresectable, locally recurrent or metastatic breast cancer who have relapsed following adjuvant/neoadjuvant chemotherapy. Prior chemotherapy should have included an anthracycline unless clinically contraindicated
- Gemcitabine, in combination with carboplatin, is indicated for the treatment of patients with recurrent epithelial ovarian carcinoma, who have relapse > 6 months, following platinum-base therapy

RECOMMENDED DOSE
Gemcitabine should only be prescribed by a physician qualified in the use of anti-cancer chemotherapy.

Recommended posology:
Bladder cancer
Combination use
The recommended dose for gemcitabine is 1,000 mg/m^2, given by 30minute infusion. The dose should be given on Days 1, 8 and 15 of each 28day cycle in combination with cisplatin. Cisplatin is given at a recommended dose of 70 mg/m^2 on Day 1 following gemcitabine or Day 2 of each 28day cycle. This 4-week cycle is then repeated. Dosage reduction with each cycle or within a cycle may be applied based upon the grade of toxicity experienced by the patient.

Pancreatic cancer
The recommended dose of gemcitabine is 1,000 mg/m^2, given by 30minute intravenous infusion. This should be repeated once weekly for up to 7 weeks followed by a week of rest. Subsequent cycles should consist of injections once weekly for 3 consecutive weeks out of every 4 weeks. Dosage reduction with each cycle or within a cycle may be applied based upon the grade of toxicity experienced by the patient.
Non-small cell lung cancer
Monotherapy
The recommended dose of gemcitabine is 1,000 mg/m^2, given by 30minute intravenous infusion. This should be repeated once weekly for 3 weeks, followed by a 1-week rest period. This 4-week cycle is then repeated. Dosage reduction with each cycle or within a cycle may be applied based upon the grade of toxicity experienced by the patient.

Combination use
The recommended dose for gemcitabine is 1,250 mg/m^2 body surface area given as a 30minute intravenous infusion on Days 1 and 8 of the treatment cycle (21 days). Dosage reduction with each cycle or within a cycle may be applied based upon the grade of toxicity experienced by the patient.
Cisplatin has been used at doses between 75-100mg/m^2 once every 3 weeks.

Breast cancer
Combination use
Gemcitabine, in combination with paclitaxel, is recommended using paclitaxel (175 mg/m^2) administered on Day 1 over approximately 3 hours as an intravenous infusion, followed by gemcitabine (1,250 mg/m^2) as a 30minute intravenous infusion on Days 1 and 8 of each 21-day cycle. Dose reduction with each cycle or within a cycle may be applied based upon the grade of toxicity experienced by the patient. Patients should have an absolute granulocyte count of at least 1,500 (x 10^6/l) prior to initiation of gemcitabine + paclitaxel combination.

Ovarian cancer
Combination use
Gemcitabine, in combination with carboplatin, is recommended using gemcitabine 1,000 mg/m^2 administered on Days 1 and 8 of each 21-day cycle as a 30-minute intravenous infusion. After gemcitabine, carboplatin will be given on Day 1 consistent with a target area under curve (AUC) of 4.0 mg/ml.min. Dosage reduction with each cycle or within a cycle may be applied based upon the grade of toxicity experienced by the patient.

Monitoring for toxicity and dose modification due to toxicity
Dose modification due to non-haematological toxicity
Periodic physical examination and checks of renal and hepatic function should be made to detect non-haematological toxicity. Dosage reduction with each cycle or within a cycle may be applied based upon the grade of toxicity experienced by the patient. In general, for severe (Grade 3 or 4) non-haematological toxicity, except nausea/vomiting, therapy with gemcitabine should be withheld or decreased depending on the judgement of the treating physician. Doses should be withheld until toxicity has resolved, in the opinion of the physician.

For cisplatin, carboplatin, and paclitaxel dosage adjustment in combination therapy.
Dose modification due to haematological toxicity

Initiation of a cycle
For all indications, the patient must be monitored before each dose for platelet and granulocyte counts. Patients should have an absolute granulocyte count of at least 1,500 (x 10^6/l) and platelet count of 100,000 (x 10^2/l) prior to the initiation of a cycle.

Within a cycle

Dose modifications of gemcitabine within a cycle should be performed according to the following tables: Dose modification of gemcitabine within a cycle for bladder cancer, NSCLC and pancreatic cancer, given in monotherapy or in combination with cisplatin		
Absolute granulocyte count (x 10^6 /l)	Platelet count (x 10^6 /l)	Percentage of standard dose of GEMCITABINE (%)
> 1,000 and	> 100,000	100
500-1,000 or	50,000-100,000	75
< 500 or	< 50,000	Omit dose *

*Treatment omitted will not be reinstated within a cycle before the absolute granulocyte count reaches at least 500 (x10^6/l) and the platelet count reaches 50,000 (x10^6/l).

Dose modification of gemcitabine within a cycle for breast cancer, given in combination with paclitaxel		
Absolute granulocyte count (x 10^6 /l)	Platelet count (x 10^6 /l)	Percentage of standard dose of GEMCITABINE (%)
1,200 and	> 75,000	100
1,000- < 1,200 or	50,000-75,000	75
700- < 1,000 and	50,000	50
< 700 or	< 50,000	Omit dose*

*Treatment omitted will not be reinstated within a cycle. Treatment will start on Day 1 of the next cycle once the absolute granulocyte count reaches at least 1,500 (x10^6/l) and the platelet count reaches 100,000 (x10^6/l).

Dose modification of gemcitabine within a cycle for ovarian cancer, given in combination with carboplatin		
Absolute granulocyte count (x 10^6 /l)	Platelet count (x 10^6 /l)	Percentage of standard dose of GEMCITABINE (%)
> 1,500 and	100,000	100
1,000-1,500 or	75,000-100,000	50
< 1,000 or	< 75,000	Omit dose*

*Treatment omitted will not be reinstated within a cycle. Treatment will start on Day 1 of the next cycle once the absolute granulocyte count reaches at least 1,500 (x10^6/l) and the platelet count reaches 100,000 (x10^6/l).

Dose modifications due to haematological toxicity in subsequent cycles, for all indications
The gemcitabine dose should be reduced to 75% of the original cycle initiation dose, in the case of the following haematological toxicities:
- Absolute granulocyte count < 500 x 1.00^6/l for more than 5 days
- Absolute granulocyte count < 100 x 10^6/l for more than 3 days
- Febrile neutropenia
- Platelets < 25,000 x 10^6/l
- Cycle delay of more than 1 week due to toxicity

Special populations

Patients with renal or hepatic impairment
Gemcitabine should be used with caution in patients with hepatic or renal insufficiency.

Elderly population (> 65 years)
Gemcitabine has been well tolerated in patients over the age of 65. There is no evidence to suggest that dose adjustments, other than those already recommended for all patients, are necessary in the elderly.

Paediatric population (< 18 years)
Gemcitabine is not recommended for use in children under 18 years of age due to insufficient data on safety and efficacy.

Method of administration
Gemcitabine is tolerated well during infusion and may be administered ambulant. If extravasation occurs, generally the infusion must be stopped immediately and started again in another blood vessel. The patient should be monitored carefully after the administration.

Instructions for reconstitution (and further dilution, if performed to injection)
The only approved diluent for reconstitution of gemcitabine sterile powder is sodium chloride 9 g/ml (0.9%) solution for injection (without preservative). Due to solubility considerations, the maximum concentration for gemcitabine upon reconstitution is 40 mg/ml. Reconstitution at concentrations greater than 40 mg/ml may result in incomplete dissolution and should be avoided.

1. Use aseptic technique during the reconstitution and any further dilution of gemcitabine for intravenous infusion administration.
2. To reconstitute, add 5 ml of sterile sodium chloride 9 mg/ml (0.9 %) solution for injection, without preservative, to the 200 mg vial or 25 ml sterile sodium chloride 9 mg/ml (0.9 %) solution for injection, without preservative, to the 1,000 mg vial. The total volume after reconstitution is 5.26 ml (200 mg vial) or 26.3 ml (1,000 mg vial) respectively. This yields a gemcitabine concentration of 38 mg/ml, which includes accounting for the displacement volume of the lyophilised powder. Shake to dissolve. Further dilution with sterile sodium chloride 9 mg/ml (0.9 %) solution for injection,without preservative,

Size: 210 x 360 mm
Pharma Code No: 0914, Leaflet folding size: 35 x 50 mm
Spec.: Printed on 40 GSM Bible paper, front & back side printing
Note: Pharma code position and Orientation are tentative, will be changed according to printers requirment to suit pharmacode position at center after folding.
Color (01): Black

can be done. Reconstituted solution is a colorless clear solution free from visible particles.

3. Parenteral medicinal products should be inspected visually for particulate matter and discolouration prior to administration. If particulate matter is observed, do not administer.

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

Route of administration
Intravenous

Contraindications
- Hypersensitivity to the active substance or to any of the excipients
- Breast-feeding
- Concomitant administration of gemcitabine and radiotherapy, due to the risk of radiosensitization and of onset of severe pulmonary and esophageal fibrosis.
- Cisplatin/Gemcitabine in patient with severe renal failure.

Warnings and precautions
General
Prolongation of the infusion time and increased dosing frequency have been shown to increase toxicity.

Haematological toxicity
Gemcitabine can suppress bone marrow function as manifested by leucopenia, thrombocytopenia and anaemia.

Patients receiving gemcitabine should be monitored prior to each dose for platelet, leucocyte and granulocyte counts. Suspension or modification of therapy should be considered when drug-induced bone marrow depression is detected. However, myelosuppression is short-lived and usually does not result in dose reduction and rarely in discontinuation.

Peripheral blood counts may continue to deteriorate after gemcitabine administration has been stopped. In patients with impaired bone marrow function, the treatment should be started with caution. As with other cytotoxic treatments, the risk of cumulative bone-marrow suppression must be considered when gemcitabine treatment is given together with other chemotherapy.

Concomitant radiotherapy
Concomitant radiotherapy (given together or less than 7 days apart): Toxicity has been reported.

Live vaccinations
Yellow fever vaccine and other live attenuated vaccines are not recommended in patients treated with gemcitabine.

Cardiovascular
Due to the risk of cardiac and/or vascular disorders with gemcitabine, particular caution must be exercised with patients presenting a history of cardiovascular events.

Pulmonary
Pulmonary effects, sometimes severe (such as pulmonary oedema, interstitial pneumonitis or adult respiratory distress syndrome (ARDS)) have been reported in association with gemcitabine therapy. The aetiology of these effects is unknown. If such effects develop, consideration should be made to discontinuing gemcitabine therapy. Early use of supportive care measure may help ameliorate the condition.

Sodium
Gemcitabine 200 mg contains 3.5 mg (<1 mmol) sodium per vial. This should be taken into consideration by patients on a controlled sodium diet.

Gemcitabine 1000 mg contains 17.5 mg (<1 mmol) sodium per vial. This should be taken into consideration by patients on a controlled sodium diet.

Hepatic Impairment
Administration of gemcitabine in patients with concurrent liver metastases or a pre-existing medical history of hepatitis, alcoholism or liver cirrhosis may lead to exacerbation of the underlying hepatic insufficiency. Laboratory evaluation of hepatic function (including virological tests) should be performed periodically. Gemcitabine should be used with caution in patients with hepatic insufficiency.

Renal Impairment
Haemolytic uraemic syndrome (HUS) was rarely reported in patients receiving gemcitabine. Gemcitabine should be discontinued at the first signs of any evidence of microangiopathic haemolytic anaemia, such as rapidly falling haemoglobin with concomitant thrombocytopenia, elevation of serum bilirubin, serum creatinine, blood urea nitrogen, or LDH. Renal failure may not be reversible with discontinuation of therapy and dialysis may be required.

Special precautions for disposal and other handling
Handling
The normal safety precautions for cytostatic agents must be observed when preparing and disposing of the infusion solution. Handling of the solution for infusion should be done in a safety box and protective coats and gloves should be used. If no safety box is available, the equipment should be supplemented with a mask and protective glasses.

If the preparation comes into contact with the eyes, this may cause serious irritation. The eyes should be rinsed immediately and thoroughly with water. If there is lasting irritation, a doctor should be consulted. If the solution is spilled on the skin, rinse thoroughly with water.

Interaction with other Medicaments
No specific interaction studies have been performed.

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Radiotherapy
Concurrent (given together or less than 7 days apart) - Toxicity associated with this multimodality therapy is dependent on many different factors, including dose of gemcitabine, frequency of gemcitabine administration, dose of radiation, radiotherapy planning technique, the target tissue, and target volume.

Radiation injury has been reported on targeted tissues (e.g., oesophagitis, colitis, and pneumonitis) in association with both concurrent and non-concurrent use of gemcitabine.

Others
Yellow fever and other live attenuated vaccines are not recommended due to the risk of systemic, possibly fatal, disease, particularly in immunosuppressed patients.

Incompatibility
This medicinal product must not be mixed with other medicinal products.

Pregnancy and lactation
Pregnancy
Category D
There are no adequate data from the use of gemcitabine in pregnant women. This substance should not be used during pregnancy unless clearly necessary. Women should be advised not to become pregnant during treatment with gemcitabine and to warn their attending physician immediately, should this occur after all.

Lactation
It is not known whether gemcitabine is excreted in human milk, and adverse effects on the suckling child cannot be excluded. Breast-feeding must be discontinued during gemcitabine therapy.

Side effects
The most commonly reported adverse drug reactions associated with Gemcitabine treatment include: nausea with or without vomiting, raised liver transaminases (AST/ALT) and alkaline phosphatase; proteinuria and haematuria; dyspnoea (highest incidence in lung cancer patients); allergic skin rashes occur and are associated with itching.

The frequency and severity of the adverse reactions are affected by the dose, infusion rate and intervals between doses. Dose-limiting adverse reactions are reductions in thrombocyte, leucocyte and granulocyte counts.

The following table of undesirable effects are presented:

System Organ Class	Adverse Effects
Blood and lymphatic system disorders	Leucopenia (Neutropenia Grade 3 = 19.3 %; Grade 4 = 6 %), Bone-marrow suppression is usually mild to moderate and mostly affects the granulocyte count, Thrombocytopenia, Anaemia, Febrile neutropenia, Thrombocytosis
Immune system disorders	Anaphylactoid reaction
Metabolism and nutrition disorders	Anorexia
Nervous system disorders	Headache, Insomnia, Somnolence, Cerebrovascular accident
Cardiac disorders	Myocardial infarct, Arrythmias, predominantly supraventricular in nature, Heart failure
Vascular disorders	Hypotension, signs of peripheral vasculitis and gangrene
Respiratory, thoracic and mediastinal disorders	Dyspnoea, Cough, Rhinitis, Interstitial pneumonitis, Bronchospasm – usually mild and transient but may require parenteral treatment, Pulmonary oedema, Adult respiratory distress syndrome
Gastro-intestinal disorders	Vomiting, Nausea, Diarrhoea, Stomatitis and ulceration of the mouth, Constipation, Ischaemic colitis
Hepato-biliary disorders	Elevation of liver transaminases (AST and ALT) and alkaline phosphatase, Increased bilirubin, Increased gamma-glutamyl transferase (GGT), Serious hepatotoxicity, including liver failure and death
Skin and subcutaneous tissue disorders	Allergic skin rash frequently associated with pruritus, Alopecia, Itching, Sweating, Ulceration, Vesicle and sore formation, Scaling, Severe skin reactions, including desquamation and bullous skin eruptions, Lyell's syndrome, Stevens-Johnson syndrome
Musculoskeletal and connective tissue disorders	Back pain, Myalgia
Renal and urinary disorders	Haematuria, Mild proteinuria, Renal failure, Haemolytic uraemic syndrome
General disorders and administration site conditions	Influenza-like symptoms - the most common symptoms are fever, headache, chills, myalgia, asthenia and anorexia. Cough, rhinitis, malaise, perspiration and sleeping difficulties have also been reported, Oedema/peripheral oedema - including facial oedema. Oedema is usually reversible after stopping treatment, Fever, Asthenia, Chills, Injection site reactions - mainly mild in nature
Injury, poisoning, and procedural complications	Radiation toxicity, Radiation recall

Combination use in breast cancer
The frequency of Grade 3 and 4 haematological toxicities, particularly neutropenia, increases when gemcitabine is used in combination with paclitaxel. However, the increase in these adverse reactions is not associated with an increased incidence of infections or haemorrhagic events. Fatigue and febrile neutropenia occur more frequently when gemcitabine is used in combination with paclitaxel. Fatigue, which is not associated with anaemia, usually resolves after the first cycle.

Grade 3 and 4 Adverse Events: Paclitaxel versus Gemcitabine plus paclitaxel
Laboratory: Anaemia, Thrombocytopenia, Neutropenia
Non-laboratory: Febrile neutropenia, Fatigue, Diarrhoea, Motor neuropathy, Sensory neuropathy

*Grade 4 neutropenia lasting for more than 7 days occurred in 12.6% of patients in the combination arm and 5.0% of patients in the paclitaxel arm.

Combination use in bladder cancer

Grade 3 and 4 Adverse Events: MVAC versus Gemcitabine plus cisplatin
Laboratory: Anaemia, Thrombocytopenia
Non-laboratory: Nausea and vomiting, Diarrhoea, Infection, Stomatitis

Combination use in ovarian cancer

Grade 3 and 4 Adverse Events: Carboplatin versus Gemcitabine plus carboplatin
Laboratory: Anaemia, Neutropenia, Thrombocytopenia, Leucopenia
Non-laboratory: Haemorrhage, Febrile neutropenia, Infection without neutropenia

Sensory neuropathy was also more frequent in the combination arm than with single-agent carboplatin

Symptoms and treatment of overdose
There is no known antidote for overdose of gemcitabine. Doses as high as 5,700 mg/m^2 have been administered by intravenous infusion over 30 minutes every 2 weeks with clinically acceptable toxicity. In the event of suspected overdose, the patient should be monitored with appropriate blood counts and receive supportive therapy, as necessary.

Storage condition
Before reconstitution:
Store below 30^{0}C and protect from moisture.
After reconstitution:
Store below 25°C and use within 24 hours.

Do not refrigerate after reconstitution

Shelf life
2 Years

Dosage forms and packaging available
GEMTERO 200 mg (Gemcitabine for Injection 200 mg)
1 vial per box

GEMTERO 1g (Gemcitabine for Injection 1g)
1 vial per box

Product Registration Holder:
Camber Laboratories Sdn Bhd
Unit E-13A-02, Menara SUEZCAP 2, No.2, KL Gateway,
Jalan Kerinchi, Gerbang Kerinchi Lestari,
59200 Kuala Lumpur, Malaysia.

Manufactured by:
HETERO LABS LIMITED
Unit VI, Sy. No 410 & 411,
TSIIC Formulation SEZ,
Polepally Village, Jadcherla Mandal,
Mahaboobnagar Dist. Telangana, India.

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