SUMMARY OF PRODUCT CHARACTERISTICS

1. NAME OF THE MEDICINAL PRODUCT

Aktiprol 100mg tablets
Aktiprol 400 mg tablets

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

Aktiprol 100mg tablets:Each tablet contains 100mg of amisulpride
Aktiprol 400 mg tablets: Each tablet contains 400 mg of amisulpride.

Excipient with known effect: Lactose monohydrate.
Each 100mg tablet contains 50.00 mg lactose monohydrate.
Each 400 mg tablet contains 200.00 mg lactose monohydrate.

For the full list of excipients, see section 6.1.

3. PHARMACEUTICAL FORM

Tablet.
Aktiprol 100 mg tablets: White, round, flat, tablets, with diameter 9.5 mm, embossed MC on one side
Aktiprol 400 mg tablets: White, biconvex, capsule shaped tablets, scored on both sides, with dimensions 19 x 10 mm. The score line is only to facilitate breaking for ease of swallowing and not to divide into equal doses.

4. CLINICAL PARTICULARS

4.1 Therapeutic indications

Treatment of acute or chronic schizophrenic disorders, in which positive symptoms (such as delusions, hallucinations, thought disorders) and/or negative symptoms (such as blunted emotions, emotional and social withdrawal) are pronounced, including patients with predominantly negative symptoms.

4.2 Posology and method of administration

Usually:
- if the daily dose is ≤ 400 mg, it is to be administered as a once-daily dose;
- if the daily dose exceeds 400 mg, it is to be administered as two divided doses.

Predominantly negative episodes

Doses between 50 mg/day and 300 mg/day are recommended. Doses should be adjusted individually.
The optimum dosage is about 100 mg/day.

Acute psychotic episodes

It is possible to start via the IM route for a few days, at a maximum dose of 400 mg/day, switching thereafter to oral treatment,
Oral doses between 400mg/day and 800mg/day are recommended. The maximum dose should never exceed 1200mg. Given that there has been no large-scale safety assessment of doses higher than 1200mg/day, these doses should not be used.
The dosage should be maintained or adjusted according to the patient's individual response.

In all cases, the maintenance treatment should be established individually with the minimum effective dose.

Children and adolescents

The efficacy and safety of amisulpride from the age of puberty up to 18 years has not been elucidated:
available data on the use of amisulpride in adolescents with schizophrenia are limited. As a result, amisulpride is not recommended in patients from the age of puberty up to 18 years. Amisulpride is contraindicated for children under 15 years of age.

Elderly subjects
Amisulpride should be used with particular caution in this patient population due to the risk of hypotension and sedation. Dose reduction may also be required in patients with kidney failure.

Renal insufficiency
Amisulpride is eliminated via the renal route. In patients with renal insufficiency, the dose should be reduced by half when creatinine clearance (CrCl) is between 30-60 ml/min and to a third in patients with CrCl between 10-30 ml/min. As no data on patients with serious renal insufficiency (CrCl <10 ml/min) are available, careful monitoring is recommended in this population.

Hepatic insufficiency
Since amisulpride is weakly metabolized, a dosage reduction is not necessary in patients with hepatic insufficiency.

Method of administration
For oral administration.

4.3 Contraindications
- Hypersensitivity to the active ingredient or to any of the other excipients listed in section 6.1
- Serious hypertension events have been reported in patients with pheochromocytoma using antidopaminergiv drugs, including some benzamides. This medicinal product should therefore not be prescribed to known or suspected pheochromocytoma carriers
- Children under 15 years of age
- Known or suspected prolactin-dependent tumors, e.g. pituitary gland prolactinomas and breast cancer (see section 4.4)
- In combination with:
  - Non-antiparkinsonian dopamine agonists (cabergoline, quinagolide)
  - Citalopram, escitalopram, domperidone, hydroxyzine, piperaquine (see section 4.5)

4.4 Special warnings and precautions for use
Potentially fatal neuroleptic malignant syndrome
As with other neuroleptics, Neuroleptic Malignant Syndrome (NMS) may occur. This condition is characterized by high fever, muscle rigidity, autonomic dysfunction, impaired consciousness, rhabdomyolysis, and elevated CPK values, and is potentially fatal. If a patient develops signs and symptoms suggestive of NMS or exhibits unexplained hyperthermia, particularly at high daily doses, all antipsychotic treatments, including amisulpride, should be discontinued.
Rhabdomyolysis has also been observed in patients without neuroleptic malignant syndrome.

QT interval prolongation
Amisulpride induces a dose-dependent prolongation of the QT interval. This effect, known to potentiate the risk of serious ventricular arrhythmias, particularly of the torsades de pointes, is worsened in patients with bradycardia, hypokalemia, or congenital of acquired prolonged QT internal (use in combination with a drug increasing the QTc interval). (see section 4.8)

Prior to administration and depending on the patients's clinical status, it is necessary to rule out any risk factors for arrhythmias, such as:

- Bradycardia below 55 bpm
- hypokalemia
- Congenital prolongation of the QT interval.
- Ongoing treatment with a medicinal likely to produced pronounced bradycardia (< 55 bpm), hypokalaemia, decreased intracardiac conduction, or prolongation of the QTc interval (see section 4.5).

AN ECG should be performed as part of the initial assessment of patients requiring long-term treatment with a neuroleptic agent.

Stroke
In randomized clinical trials versus placebo performed in a population of elderly patients with dementia and treated with certain atypical antipsychotic drugs, a 3-fold increase of the risk of cerebrovascular events has been observed. The mechanism of such risk increase is not known. An increase in the risk with other antipsychotic drugs, or other populations of patients cannot be excluded. Aktiprol should be used with caution in patients with stroke risk factors.

Elderly patients with dementia:
There is an increased risk of mortality increases in elderly patients with dementia-related psychosis treated with antipsychotic drugs.
Analysis of 17 placebo-controlled trials (mean duration of 10 weeks), largely in patients taking atypical antipsychotic drugs, revealed a risk of mortality in drug-treated patients of between 1.6- to 1.7 times the risk of mortality in placebo-treated patients.
Over the course of a typical 10-week treatment period, the mortality rate in drug-treated patients was approximately 4.5%, compared to approximately 2.6% in the placebo group.
Although the causes of death in the clinical trials with antipsychotics were varied, most of the deaths appeared to be either cardiovascular (e.g. heart failure, sudden death) or infectious (e.g. pneumonia) in nature.
Observational studies suggest that, similar to atypical antipsychotic drugs, treatment with conventional antipsychotic drugs may increase mortality.
It is unclear how much the antipsychotic drug and patient characteristics to contribute to the increase in mortality found in the epidemiological studies.

Venous thromboembolism:
Cases of venous thromboembolism (VTE) have been reported with antipsychotic drugs. Since patients treated with antipsychotics often present with acquired risk factors for VTE, all potential risk factors for VTE must be identified before and during treatment with Aktiprol and preventive measures should be taken if needed (see section 4.8).

Hyperglycaemia/Metabolic syndrome
Cases of hyperglycaemia or glucose intolerance and onset or exacerbation of diabetes have been reported in patients treated with certain atypical antipsychotic drugs, including amisulpride (see section Undesirable effects).
Clinical and laboratory monitoring should be performed in patients receiving treatment with Solian in compliance with current recommendations. Particular caution should be exercised in patients with diabetes mellitus or with risk factors for diabetes.

Seizures
Amisulpride may lower the seizure threshold. Therefore patients with a history of seizures should be closely monitored during Aktiprol therapy.

Special populations
As amisulpride is eliminated by the renal route, the dose should be decreased in patients with renal failure or another treatment may be considered (see section Posology and method of administration). There are no data concerning patients with serious renal impairment (see section 4.2).
Amisulpride, like all antipsychotics, should be used with particular caution in elderly patients due to the potential risk of sedation and hypotension. A dose reduction may also be required in elderly patients with renal impairment (see section 4.2).
As with other antidopaminergic agents, caution should be exercised when administering amisulpride in patients with Parkinson's disease since it may cause worsening of the disease. Amisulpride should be used only if neuroleptic treatment cannot be avoided.

Withdrawal syndrome
Withdrawal symptoms including nausea, vomiting and insomnia have been described following sudden discontinuation of high doses of antipsychotics. Recurrence of psychotic symptoms may also be observed and involuntary movements disorders (e.g. akathisia, dystonia and dyskinesia) have been reported with amisulpride. Therefore, gradual withdrawal of amisulpride is advisable.

Hyperprolactinemia
Amisulpride may increase prolactin levels (see section Undesirable effects). Patients with a history of hyperprolactinemia or of a potentially prolactin-dependent tumor should be closely monitored during amisulpride treatment (see section 4.3).

Benign pituitary tumour
Amisulpride may increase prolactin levels. Cases of benign pituitary tumours such as prolactinoma have been observed during amisulpride therapy (see section 4.8). In case of very high levels of prolactin or clinical signs of pituitary tumour (such as visual field defect and headache), pituitary imaging should be performed. If the diagnosis of pituitary tumour is confirmed, the treatment with amisulpride must be stopped (see section 4.3).

Parkinson´s disease
As with other antidopaminergic agents, caution should be exercised when prescribing Aktiprol to patients with Parkinson's disease since it may cause worsening of the disease. Aktiprol should be used only if neuroleptic treatment cannot be avoided.

Hepatic toxicity
Severe liver toxicity has been reported with amisulpride use. Patients should be informed that any signs such as asthenia, anorexia, nausea, vomiting, abdominal pain or jaundice must be reported to a doctor immediately. Investigations including a clinical examination and liver function tests must be carried out immediately (see section 4.8).

Other
Leukopenia, neutropenia and agranulocytosis have been reported with antipsychotics, including amisulpride. Unexplained infections or fever may be evidence of blood dyscrasia (see section 4.8), and requires immediate blood tests.
Use of this drug is not recommended in combination with alcohol, dopaminergic antiparkinsonian drugs, antiparasitic likely to induce torsades de pointes, sodium oxybate and hydroxychloroquine (see section 4.5).
Breast cancer

Lactose
This medicinal product contains lactose monohydrate. Its use is not recommended in patients with galactose intolerance, Lapp-lactase deficiency or glucose-galactose malabsorption syndrome (rare hereditaryillnesses).

4.5 Interaction with other medicinal products and other forms of interaction

- *Sedative agents*
  Many drugs or substances can have additive depressant effects on the central nervous system and contribute to a decrease alertness. This must be taken into account for patients using amisulpride. These drugs/substances include morphine derivatives (analgesics, cough suppressants and replacement therapies), neuroleptics, barbiturates, benzodiazepines, anxiolitics other than benzodiazepines (e.g. meprobamate), hypnotics, sedative antidepressants (amitriptyline, doxepin, mianserine, mirtazapine, trimipramine), sedative H1-antihistamines, centrally acting antihypertensives agents, baclofen and thalidomide.

- *Medications likely to induce torsades de pointes*
  This serious cardiac arrhythmia can be caused by a number of antiarrhythmic and non-antiarrhythmic drugs. Hypokalemia (see Potassium-depleting agents) is a promoting factor, as is bradycardia (see Bradycardia-inducing drugs) or pre-existing congenital or acquired QT interval prolongation.
  Medicines likely to cause this adverse effect including class IA and III antiarrhythmic agents and certain neuroleptics. Other agents not belonging to these classes are also involved.
  For dolasteron, erythromycin, spiramycin, and vincamine, only intravenously administered forms are concerned by this interaction. Coadministration of two torsadogenic drugs is generally contraindicated.
  However, some of these torsadogenic drugs are exceptions to this as they are considered essential. In this case, coadministration is simply not recommended. These torsadogenic drugs include methadone, hydroxychloroquine, antiparasitic agents (chloroquine, halofantrine, lumefantrine, pentamidine), neuroleptics.
  However, citalopram, escitalopram, domperidone, hydroxyzine and piperaquine are not among these exceptions, and are therefore contraindicated when coadministered with all torsadogenic drugs.

Contraindicated combinations

- *Non-antiparkinsonian dopamine agonists (cabergoline, quinagolide)*
  There is mutual antagonism between dopamine agonists and neuroleptics.

- *Citalopram, escitalopram, domperidine, hydroxyzine, piperaquine*
  There is an increased risk of ventricular arrhythmias, especially torsades de pointes.

Inadvisable combinations

- *Antiparasitics likely to induce torsades de pointes (chloroquine, halofantrine, lumefantrine, pentamidine)*
  There is an increased risk of ventricular arrhythmias, particularly torsades de pointes.
  If possible, one of the two treatments should be discontinued.
  If coadministration cannot be avoided, a preliminary QT examination should be carried out and ECG monitoring performed.

- *Antiparkinsonian dopamine agonist (amantadine, apolorphine, bromocriptine, entacapone, lisuride, pergolide, piribedil, pramipexole, rasagiline, ropinirole, rotigotine, selegiline, tolcapone)*
  There is mutual antagonism between dopamine agonists and neuroleptics.
  Dopamine agonists can cause or worsen psychotic disorders. If treatment with neuroleptics is required in a patients with Parkinson's disease treated with dopamine agonists, these dopamine agents should be tapered off gradually (sudden discontinuation exposes the patient to a risk of "neuroleptic malignant syndrome").

- *Other medications likely to induce torsades de pointes: class IA antiarrhythmicsagents (quinidine, hydroquinidine, disopyramide) and class III antiarrhythmics (amiodarone, dronedarone, sotalol, dofetilide, ibutilide), and other drugs such as arsenic compounds, diphemanil, dolasetron IV, erythromycin IV, levofloxacin, mequitazine, mizolastine, prucalopride, vincamine IV, moxifloxacin, spiramycin IV, toremifene, vandetanib.*
  There is an increased risk of ventricular arrhythmias, particularly torsades de pointes.

- *Other neuroleptics which could induce torsades de pointes (chlorpromazine, cyamemazine, droperidol, flupenthixol, fluphenazine, haloperidol, levomepromazine, pimozide, pipamperone, pipotiazine, sertindole, sulpiride, sultopride, tiapride, zuclopenthixol).*
  There is an increased risk of ventricular arrhythmias, particularly torsades de pointes.

- *Alcohol (beverage of excipient)*
  Alcohol potentiates the sedative effects induced by this type of drug.
  Impaired alertness may make driving vehicles and using machines dangerous.
  Consumption of alcoholic beverages and medicinal products containing alcohol should be avoided.

- *Levodopa*
  There is mutual antagonism of effects between levodopa and neuroleptics.
  In patients with Parkinson's disease, minimum effective doses of each of these drugs should be used.

- *Methadone*
  There is an increased risk of ventricular arrhythmias, particularly torsades de pointes.

- *Sodium oxybate*
  The central nervous depressant effect is potentiated. Impaired alertness may make driving vehicles and using machines dangerous.

- *Hydroxychloroquine*
  There is an increased risk of ventricular arrhythmias, especially torsades de pointes.

Combinations requiring precautions for use

- *Anagrelide*
  There is an increased risk of ventricular arrhythmias, particularly torsades de pointes.
  When coadministering these agents, clinical and ECG monitoring are required

- *Azithromycin, ciprofloxacin, clarithromycin, levofloxacin, norfloxacin, roxithromycin*

There is an increased risk of ventricular arrhythmia, particularly torsades de pointes.
When co-administering these agents, clinical and ECG monitoring are required.

- *Beta-blockers in heart failure (bisoprolol, carvedilol, metoprolol, nebivolol)*
  There is an increased risk of ventricular arrhythmias, particularly torsades de pointes. In addition, there is a vasodilator effect and risk of hypotension, particularly postural (additive effect). Clinical and ECG monitoring required.

- *Bradycardia-inducing drugs (in particularly class IA antiarrhythmics, beta-blockers, certain class III antiarrhythmics, certain calcium channel blockers, digitalis glycosides, pilocarpine, anticholinesterases):*
  There is an increased risk of ventricular arrhythmias, particularly torsades de pointes.
  Clinical and ECG monitoring required.

- *Potassium-depleting agents (potassium-depleting diuretics, alone or in combination, stimulant laxatives, glucocorticoids, tetracosactides and amphotericin B IV).*
  There is an increased risk of ventricular arrhythmias, particularly torsades de pointes.
  Any existing hypokalemia should be corrected before administration, and clinical, electrolyte and ECG monitoring implemented.

- *Lithium*
  There is a risk of neuropsychiatric signs suggestive of neuroleptic malignant syndrome or lithium poisoning. Regular clinical and laboratory monitoring are required, particularly at the start of co-administration.

- *Ondansetron*
  There is an increased risk of ventricular arrhythmias, particularly torsades de pointes.
  When coadministering these agents, clinical and ECG monitoring are required.

Combinations to be taken into consideration

- *Other sedative drugs*
  The central nervous depressant effect is potentiated.
  Impaired alertness may make driving vehicles and using machines dangerous.
- *Orlistat*
  There is a risk of treatment failure when the drug is coadministered with orlistat.

4.6 Fertility, pregnancy and lactation

Pregnancy

Studies in animals have shown reproductive toxicity.
There are only limited data available from the use of amisulpride in pregnant women. The safety of amisulpride during human pregnancy has not been established.
Amisulpride crosses the placenta.
Use of the drug is not recommended during pregnancy and in women of childbearing potential not using effective contraception, unless the benefits justify the potential risks.
Neonates exposed to antipsychotic drugs during the third trimester of pregnancy are at risk for extrapyramidal and/or withdrawal symptoms following delivery. There have been reports of agitation, hypertonia, hypotonia, tremor, somnolence, respiratory distress, and feeding disorder in these neonates. These complications have varied in severity; while in some cases symptoms have been self-limited, in other cases neonates have required intensive care unit support and prolonged hospitalisation.
Aktiprol should be used during pregnancy only if the potential benefit justifies the potential risk to the foetus.

Breast-feeding

Amisulpride is excreted into breastmilk in rather large amounts above the accepted value of 10% of the maternal weight-adjusted dosage in some cases, but blood concentrations in breastfed infants have not been evaluated. There is insufficient information on the effects of amisulpride in new-borns/infants. A decision must be made whether to discontinue breast-feeding or to abstain from amisulpride therapy taking into account the benefit of breastfeeding for the child and the benefit of therapy for the woman.

Fertility
A decrease in fertility linked to the pharmacological effects of the drug (prolactin-mediated effect) was observed in treated animals.

4.7 Effects on ability to drive and use machines
Even used as recommended, amisulpride may cause somnolence and blurred vision so that the ability to drive vehicles or operate machinery can be impaired (see section 4.8).

4.8 Undesirable effects
Adverse effects have been ranked under headings of frequency using the following convention:
- 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);
- frequency not known (cannot be estimated from the available data).

Blood and lymphatic system disorders:
Uncommon: Leukopenia, neutropenia (see section 4.4)
Rare: agranulocytosis (see section 4.4)
Immune system disorders:
Uncommon: allergic reaction.
Endocrine disorders:
Common: amisulpride causes an increase in plasma prolactin levels which is reversible after drug discontinuation. This may result in galactorrhoea, amenorrhoea, gynaecomastia, breast pain, and erectile dysfunction.
Rare: benign pituitary tumour such as prolactinoma (see sections 4.3 and 4.4).
Metabolism and nutrition disorders:
Uncommon: hyperglycaemia (see section 4.4), hypertriglyceridemia and hypercholesterolaemia
Rare: hyponatraemia, syndrome of inappropriate antidiuretic hormone secretion (SIADH).
Psychiatric disorders:
Common: insomnia, anxiety, agitation, orgasmic dysfunction
Uncommon: confusion.
Nervous system disorders:
Very common: extrapyramidal symptoms may occur: tremor, rigidity, hypokinesia, hypersalivation, akathisia, dyskinesia. These symptoms are generally mild at optimal dosages and partially reversible without discontinuation of amisulpride upon administration of antiparkinsonian medication. The incidence of extrapyramidal symptoms which is dose related, remains very low in the treatment of patients with predominantly negative symptoms with doses of 50 – 300 mg/day.
Common: somnolence, acute dystonia (spasm torticollis, oculogyric crisis, trismus) may appear. This is reversible without discontinuation of amisulpride upon treatment with an antiparkinsonian agent.
Uncommon: seizures, tardive dyskinesia characterized by rhythmic, involuntary movements primarily of the tongue and/or face have been reported, usually after long term administration. Antiparkinsonian medication is ineffective or may induce aggravation of the symptoms.
Rare: Neuroleptic Malignant Syndrome (see section 4.4), which is a potentially fatal complication.
Not known: restless legs syndrome.
Eye disorders:
Common: blurred vision (see section 4.7).
Cardiac disorders:
Uncommon: bradycardia
Rare: QT interval prolongation, ventricular arrhythmias such as torsade de pointes, ventricular tachycardia, ventricular fibrillation, cardiac arrest, sudden death (see section 4.4).
Vascular disorders:
Common: hypotension
Uncommon: increase in blood pressure
Rare: venous thromboembolism, including pulmonary embolism, sometimes fatal, and deep vein thrombosis (see section 4.4).
Respiratory, thoracic and mediastinal disorders:

Uncommon: nasal congestion, pneumonia aspiration (mainly in association with other antipsychotics and CNS depressants).
Gastrointestinal disorders
Common: constipation, nausea, vomiting, dry mouth.
Hepatobiliary disorders:
Uncommon: hepatocellular injury.
Skin and subcutaneous tissue disorders:
Rare: Angioedema, urticaria
Not known: photosensitivity reaction.
Musculoskeletal and connective tissue disorders:
Uncommon: osteopenia, osteoporosis.
Renal and urinary disorders:
Uncommon: urinary retention.
Pregnancy, puerperium and perinatal conditions:
Not known: Drug withdrawal syndrome neonatal (see section 4.6)
Investigations:
Common: weight gain
Uncommon: elevations of hepatic enzymes, mainly transaminases.

4.9 Overdose
Symptoms
Experience with amisulpride in overdosage is limited. Exaggeration of the known pharmacological effects of the drug has been reported. These include drowsiness and sedation, coma, hypotension and extrapyramidal symptoms. Fatal outcomes have been reported mainly in combination with other psychotropic agents.

Management
In cases of acute overdosage, the possibility of multiple drug intake should be considered.
Since amisulpride is weakly dialysed, hemodialysis is of no use to eliminate the drug.
There is no specific antidote to amisulpride.
Appropriate supportive measures should therefore be instituted: close supervision of vital functions and continuous cardiac monitoring (risk of prolongation of QT interval) until the patient recovers.
If severe extrapyramidal symptoms occur, anticholinergic agents should be administered.
Patients where overdose is suspected should be ECG monitored.

5. PHARMACOLOGICAL PROPERTIES
5.1 Pharmacodynamic properties
Pharmacotherapeutic group: Psycholeptics, antipsychotics, benzamides
ATC code N05A L05
Amisulpride binds selectively with a high affinity to human dopaminergic D_2/D_3 receptor subtypes whereas it is devoid of affinity for D_1, D_4 and D_5 receptor subtypes.
Unlike classical and atypical neuroleptics, amisulpride has no affinity for serotonin, -adrenergic, histamine H1 and cholinergic receptors. In addition, amisulpride does not bind to sigma sites.
In animal studies, at high doses, amisulpride blocks post-synaptic D_2 receptors located in the limbic structures in preference to those in the striatum. Unlike classical neuroleptics it does not induce catalepsy and hypersensitivity of D_2 dopamine receptors does not develop after repeated treatment. At low doses it preferentially blocks pre-synaptic D_2/D_3 receptors, producing dopamine release responsible for its disinhibitory effects.

5.2 Pharmacokinetic properties
In man, amisulpride shows two absorption peaks: one which is attained rapidly, one hour post-dose and a second between 3 and 4 hours after administration. Corresponding plasma concentrations are 39 ± 3 and 54 ± 4 ng/ml after a 50 mg dose.
The volume of distribution is 5.8 l/kg, plasma protein binding is low (16%) and no drug interactions are suspected.
Absolute bioavailability is 48%.
Amisulpiride is weakly metabolised: two inactive metabolites, accounting for approximately 4% of the dose, have been identified. There is no accumulation of amisulpride and its pharmacokinetics remain unchanged after the administration of repeated doses. The elimination half-life of amisulpride is approximately 12 hours after an oral dose.

Amisulpride is eliminated unchanged in the urine. Fifty percent of an intravenous dose is excreted via the urine, of which 90% is eliminated in the first 24 hours. Renal clearance is in the order of 20 l/h or 330 ml/min.
A carbohydrate rich meal (containing 68% fluids) significantly decreases the AUCs, Tmax and Cmax of amisulpride but no changes were seen after a high fat meal. However, the significance of these findings in routine clinical use is not known.

Hepatic insufficiency:
Since the drug is weakly metabolised a dosage reduction should not be necessary in patients with hepatic insufficiency.

Renal insufficiency:
The elimination half-life is unchanged in patients with renal insufficiency while systemic clearance is reduced by a factor of 2.5 to 3. The AUC of amisulpride in mild renal failure increased two fold and almost tenfold in moderate renal failure (see section 4.2). Experience is however limited and there is no data with doses greater than 50 mg.
Amisulpride is very weakly dialysed.

Elderly patients:
Limited pharmacokinetic data in elderly subjects (> 65 years) show that a 10-30 % rise occurs in C_{max}, $T_{½}$ and AUC after a single oral dose of 50 mg. No data are available after repeat dosing.

6. PHARMACEUTICAL PARTICULARS
6.1 List of excipients
Lactose monohydrate 230 mesh, Sodium starch glycolate type A, Hypromellose 2910 E5, Microcrystalline cellulose 101, Magnesium stearate

6.2 Incompatibilities
Not applicable.

6.3 Shelf life
36 months

6.4 Special precautions for storage
Store below 30°C in the original package

6.5 Nature and contents of container
Amisulpride tablets are packed in PVC/PVDC-Alu blisters containing 30, 60 or 100 tablets per box.
100mg: Each blister contains 10 tablets.
400mg: Each blister contains 5 tablets.
The respective number of blisters are included in the outer box depending on the pack size.

7. MANUFACTURER
MEDOCHEMIE LTD. (Central Factory), Konstantinoupoleos 1-10, Limassol, 3011, Cyprus.

8. PRODUCT REGISTRATION HOLDER
KOMEDIC SDN BHD, 4 Jalan PJS 11/14, Bandar Sunway, 46150 Petaling Jaya, Selangor

9. DATE OF REVISION OF THE TEXT
06/2025

Font size :7, Times New Roman