For the use of only a Registered Medical Practitioner or a Hospital or a Laboratory

Not to be sold by retail without the prescription of a Registered Medical Practitioner

Prescribing Information

1. Generic Name

Diclofenac Prolonged Release Tablets IP

DICLOTAL®-SR Tablets

2. Qualitative and Quantitative Composition

Each film coated prolonged-release tablet contains:

Diclofenac Sodium IP ……. 100 mg.

Excipients …….. q.s.

Colours: Titanium Dioxide IP and Ferric Oxide USP-NF (Red)

3. Dosage Form and Strength

Dosage Form: Tablets.

Dosage Strength: Diclofenac sodium 100 mg per tablet (in a prolonged release form).

4. Clinical Particulars

4.1 Therapeutic Indication

DICLOTAL-SR Tablets are indicated for symptomatic treatment of pain and inflammation associated with osteoarthritis, rheumatoid arthritis, ankylosing spondylitis, gout, and post-operative conditions including pain following dental surgery.

4.2Posology and Method of Administration

Adults: 1 tablet to be administered orally once daily.

Tablet to be administered whole with liquid, preferably with or after food.

Or, as directed by the physician.

4.3Contraindications

DICLOTAL-SR Tablets re contraindicated in the following:

- In patients with a known hypersensitivity to diclofenac or to any component of the product.
- Active or history of recurrent peptic ulcer/hemorrhage.
- Severe heart failure, hepatic failure and renal failure.
- History of gastrointestinal (GI) bleeding or perforation relating to previous non-steroidal anti-inflammatory drug (NSAID) therapy.
- During the last trimester of pregnancy.

- Patients in whom attacks of asthma, urticaria, or acute rhinitis are precipitated by aspirin or other NSAIDs.
- For the treatment of perioperative pain in the setting of coronary artery bypass graft (CABG) surgery.

4.4Special Warnings and Precautions for Use

Cardiovascular Thrombotic Events: Clinical trials of several COX-2 selective and nonselective NSAIDs of up to three years duration have shown an increased risk of serious cardiovascular (CV) thrombotic events, myocardial infarction, and stroke, which can be fatal. All NSAIDs, both COX-2 selective and nonselective, may have a similar risk. Patients with known CV disease or risk factors for CV disease may be at greater risk. To minimize the potential risk for an adverse CV event in patients treated with an NSAID, the lowest effective dose should be used for the shortest duration possible. Physicians and patients should remain alert for the development of such events, even in the absence of previous CV symptoms. Patients should be informed about the signs and/or symptoms of serious CV events and the steps to take if they occur.

Hypertension: NSAIDs can lead to onset of new hypertension or worsening of preexisting hypertension, either of which may contribute to the increased incidence of CV events. Patients taking thiazides or loop diuretics may have impaired response to these therapies when taking NSAIDs. NSAIDs, including diclofenac sodium, should be used with caution in patients with hypertension. Blood pressure (BP) should be monitored closely during the initiation of NSAID treatment and throughout the course of therapy.

Congestive Heart Failure and Edema: Fluid retention and edema have been observed in some patients taking NSAIDs. Diclofenac sodium should be used with caution in patients with fluid retention or heart failure.

Gastrointestinal (GI) Effects - Risk of GI Ulceration, Bleeding, and Perforation: NSAIDs, including diclofenac sodium, can cause serious GI adverse events including inflammation, bleeding, ulceration, and perforation of the stomach, small intestine, or large intestine, which can be fatal. These serious adverse events can occur at any time, with or without warning symptoms, in patients treated with NSAIDs irrespective of whether the therapy duration is long-/short-term.

NSAIDs should be prescribed with extreme caution in those with a prior history of ulcer disease or GI bleeding. Patients with a prior history of peptic ulcer disease and/or GI bleeding who use NSAIDs have a greater than 10-fold increased risk for developing a GI bleed compared to patients with neither of these risk factors. Other factors that increase the risk for GI bleeding in patients treated with NSAIDs include concomitant use of oral corticosteroids or anticoagulants, longer duration of NSAID therapy, smoking, alcohol, older age, and poor general health status. Most spontaneous reports of fatal GI events are in elderly or debilitated patients and therefore, special care should be taken in treating this population.

To minimize the potential risk for an adverse GI event in patients treated with an NSAID, the lowest effective dose should be used for the shortest possible duration. Patients and physicians should remain alert for signs and symptoms of GI ulceration and bleeding during NSAID therapy

and promptly initiate additional evaluation and treatment if a serious GI adverse event is suspected. This should include discontinuation of the NSAID until a serious GI adverse event is ruled out. For high risk patients, alternate therapies that do not involve NSAIDs should be considered.

Renal Effects: Long-term administration of NSAIDs has resulted in renal papillary necrosis and other renal injuries. Renal toxicity has also been seen in patients in whom renal prostaglandins have a compensatory role in the maintenance of renal perfusion. In these patients, administration of an NSAID may cause a dose-dependent reduction in prostaglandin formation and, secondarily, in renal blood flow, which may precipitate overt renal decompensation. Patients at greatest risk of this reaction are those with impaired renal function, heart failure, liver dysfunction, those taking diuretics and ACE inhibitors, and the elderly. Discontinuation of NSAID therapy is usually followed by recovery to the pretreatment state. No information is available from controlled clinical studies regarding the use of diclofenac sodium in patients with advanced renal disease. Therefore, treatment with diclofenac sodium is not recommended in these patients with advanced renal disease. If diclofenac sodium therapy must be initiated, close monitoring of the patient's renal function is advisable.

Hepatic Effects: Elevations of one or more liver function tests may occur at any time during therapy with diclofenac sodium. These laboratory abnormalities may progress, may remain unchanged, or may be transient with continued therapy. Post-marketing surveillance has reported cases of severe hepatic reactions, including liver necrosis, jaundice, fulminant hepatitis with and without jaundice, and liver failure. Some of these reported cases resulted in fatalities or liver transplantation.

Physicians should measure transaminases periodically in patients receiving long-term therapy with diclofenac, because severe hepatotoxicity may develop without a prodrome of distinguishing symptoms. The optimum times for making the first and subsequent transaminase measurements are not known. Based on clinical trial data and post-marketing experiences, transaminases should be monitored within 4 to 8 weeks after initiating treatment with diclofenac. However, severe hepatic reactions can occur at any time during treatment with diclofenac. If abnormal liver tests persist or worsen, if clinical signs and/or symptoms consistent with liver disease develop, or if systemic manifestations occur (e.g., eosinophilia, rash, abdominal pain, diarrhea, dark urine, etc.), diclofenac sodium should be discontinued immediately. To minimize the possibility that hepatic injury will become severe between transaminase measurements, physicians should inform patients of the warning signs and symptoms of hepatotoxicity (e.g., nausea, fatigue, lethargy, diarrhea, pruritus, jaundice, right upper quadrant tenderness, and “flu-like” symptoms), and the appropriate action patients should take if these signs and symptoms appear. The lowest effective dose should be used for the shortest duration possible. Caution should be exercised in prescribing diclofenac sodium with concomitant drugs that are known to be potentially hepatotoxic (e.g., antibiotics, anti-epileptics).

Anaphylactic Reactions: As with other NSAIDs, anaphylactic reactions may occur both in patients with the aspirin triad and in patients without known sensitivity to NSAIDs or known prior exposure to diclofenac sodium. Diclofenac sodium should not be given to patients with the aspirin

triad. This symptom complex typically occurs in asthmatic patients who experience rhinitis with or without nasal polyps, or who exhibit severe, potentially fatal bronchospasm after taking aspirin or other NSAIDs. Anaphylaxis-type reactions have been reported with NSAIDs, including diclofenac sodium. Emergency help should be sought in cases where an anaphylactic reaction occurs.

Skin Reactions: NSAIDs, including diclofenac sodium, can cause serious skin adverse events such as exfoliative dermatitis, Stevens-Johnson Syndrome (SJS), and toxic epidermal necrolysis (TEN), which can be fatal. These serious events may occur without warning. Patients should be informed about the signs and symptoms of serious skin manifestations and use of the drug should be discontinued at the first appearance of skin rash or any other sign of hypersensitivity.

Haematological Effects: Anemia is sometimes seen in patients receiving NSAIDs, including diclofenac sodium. This may be due to fluid retention, occult or gross GI blood loss, or direct effect on erythropoiesis by an unknown mechanism. Patients on long-term treatment with NSAIDs, including diclofenac sodium, should have their hemoglobin or hematocrit checked if they exhibit any signs or symptoms of anemia.

NSAIDs inhibit platelet aggregation and have been shown to prolong bleeding time in some patients. Unlike aspirin, their effect on platelet function is quantitatively less, of shorter duration, and reversible. Patients receiving diclofenac sodium who may be adversely affected by alterations in platelet function, such as those with coagulation disorders or patients receiving anticoagulants, should be carefully monitored.

Preexisting Asthma: Caution is required if administered to patients suffering from, or with, a previous history of bronchial asthma since NSAIDs have been reported to precipitate bronchospasm in such patients. Patients with asthma may have aspirin-sensitive asthma. The use of aspirin in patients with aspirin-sensitive asthma has been associated with severe bronchospasm which can be fatal. Since cross-reactivity, including bronchospasm, between aspirin and other NSAIDs has been reported in such aspirin-sensitive patients, diclofenac sodium should not be administered to patients with this form of aspirin sensitivity and should be used with caution in patients with preexisting asthma.

Hyperkalemia: Increase in serum potassium concentration (hyperkalemia) has been reported with use of NSAIDs, even in some patients without renal impairment. In patients with normal renal function, these effects have been attributed to a hyporeninemic-hypoaldosteronism state.

General: Diclofenac sodium cannot be expected to substitute for corticosteroids or to treat corticosteroid insufficiency.

NOT FOR VETERINARY USE.

4.5Drug Interactions

Drugs That Interfere with Hemostasis: Diclofenac and anticoagulants such as warfarin have a synergistic effect on bleeding. The concomitant use of diclofenac and anticoagulants has an increased risk of serious bleeding compared to the use of either drug alone.

Serotonin release by platelets plays an important role in hemostasis. Case-control and cohort epidemiological studies showed that concomitant use of drugs that interfere with serotonin reuptake and an NSAID may potentiate the risk of bleeding more than an NSAID alone.

Monitor patients with concomitant use of diclofenac with anticoagulants (e.g., warfarin), antiplatelet agents (e.g., aspirin), selective serotonin reuptake inhibitors (SSRIs), and serotonin norepinephrine reuptake inhibitors (SNRIs) for signs of bleeding.

Aspirin: Controlled clinical studies showed that the concomitant use of NSAIDs and analgesic doses of aspirin does not produce greater therapeutic effect than the use of NSAIDs alone. In a clinical study, the concomitant use of an NSAID and aspirin was associated with a significantly increased incidence of GI adverse reactions as compared to use of the NSAID alone. Concomitant use of diclofenac and analgesic doses of aspirin is not generally recommended because of the increased risk of bleeding.

NSAIDs and Salicylates: Concomitant use of diclofenac with other NSAIDs or salicylates (e.g., diflunisal, salsalate) increases the risk of GI toxicity, with little or no increase in efficacy. Thus, concomitant use of diclofenac with other NSAIDs or salicylates is not recommended.

Methotrexate: Concomitant use of NSAIDs and methotrexate may increase the risk for methotrexate toxicity (e.g., neutropenia, thrombocytopenia, renal dysfunction). During concomitant use of diclofenac and methotrexate, monitor patients for methotrexate toxicity.

Cyclosporine: Concomitant use of diclofenac and cyclosporine may increase cyclosporine's nephrotoxicity. During concomitant use of diclofenac and cyclosporine, monitor patients for signs of worsening renal function.

Diuretics: Clinical studies, as well as post-marketing observations, have shown that diclofenac sodium can reduce the natriuretic effect of furosemide and thiazides in some patients. This response has been attributed to inhibition of renal prostaglandin synthesis. During concomitant therapy with NSAIDs, the patient should be observed closely for signs of renal failure, as well as to assure diuretic efficacy.

Lithium: NSAIDs have produced an elevation of plasma lithium levels and a reduction in renal lithium clearance. The mean minimum lithium concentration increased 15% and the renal clearance was decreased by approximately 20%. These effects have been attributed to inhibition of renal prostaglandin synthesis by the NSAID. Thus, when NSAIDs and lithium are administered concurrently, subjects should be observed carefully for signs of lithium toxicity.

Digoxin: The concomitant use of diclofenac with digoxin has been reported to increase the serum concentration and prolong the half-life of digoxin. Monitoring of serum digoxin level is recommended when diclofenac and digoxin are administered concomitantly.

Antihypertensive Drugs (ACE-Inhibitors, Angiotensin Receptor Blockers, and Beta-Blockers): NSAIDs may diminish the antihypertensive effect of angiotensin converting enzyme (ACE) inhibitors, angiotensin receptor blockers (ARBs), or beta-blockers (including propranolol). During concomitant use of diclofenac and ACE-inhibitors, ARBs, or beta-blockers, monitor blood pressure to ensure that the desired blood pressure is obtained. When these drugs are administered concomitantly in patients who are elderly, volume-depleted, or have impaired renal function,

monitoring of signs for worsening of renal function is recommended. Also, patients should be adequately hydrated and assess renal function at the beginning of the concomitant treatment and periodically thereafter.

Pemetrexed: Concomitant use of diclofenac and pemetrexed may increase the risk of pemetrexed-associated myelosuppression, renal, and GI toxicity.

Tacrolimus: There is a possible increased risk of nephrotoxicity when NSAIDs are given with tacrolimus. This might be mediated through renal antiprostagladin effects of both NSAID and calcineurin inhibitor.

Quinolone Antimicrobials: Convulsions may occur due to an interaction between quinolones and NSAIDs. This may occur in patients with or without a previous history of epilepsy or convulsions. Therefore, caution should be exercised when considering the use of a quinolone in patients who are already receiving an NSAID.

Phenytoin: When using phenytoin concomitantly with diclofenac, monitoring of phenytoin plasma concentrations is recommended due to an expected increase in exposure to phenytoin.

Colestipol and Cholestyramine: These drugs can induce a delay or decrease in absorption of diclofenac. Therefore, it is recommended to administer diclofenac at least one hour before or 4 to 6 hours after administration of colestipol/ cholestyramine.

Cardiac Glycosides: Concomitant use of cardiac glycosides and NSAIDs in patients may exacerbate cardiac failure, reduce GFR, and increase plasma glycoside levels.

Potassium-Sparing Diuretics, Cyclosporine, Tacrolimus, or Trimethoprim: Concomitant treatment of diclofenac with either of these drugs may be associated with increased serum potassium levels (hyperkalemia), which should therefore be monitored frequently.

CYP2C9 Inhibitors or Inducers: Diclofenac is metabolized by cytochrome P450 enzymes, predominantly by CYP2C9. Co-administration of diclofenac with CYP2C9 inhibitors (e.g., voriconazole) may enhance the exposure and toxicity of diclofenac whereas coadministration with CYP2C9 inducers (e.g., rifampin) may lead to compromised efficacy of diclofenac. A dosage adjustment may be warranted when diclofenac is administered with CYP2C9 inhibitors or inducers.

4.6Use in Special Populations

Pregnant Women

Diclofenac is a Pregnancy Category C drug. Use of NSAIDs, including diclofenac, during the third trimester of pregnancy increases the risk of premature closure of the fetal ductus arteriosus. Data from observational studies regarding potential embryofetal risks of NSAID use in women in the first or second trimesters of pregnancy are inconclusive. However, congenital abnormalities have been reported with use of NSAIDs in humans.

DICLOTAL-SR Tablets should not be used during the first two trimesters of pregnancy unless the potential benefit to the patient outweighs the potential risk to fetus. DICLOTAL-SR Tablets are contraindicated in the third trimester (> 30 weeks of gestation) of pregnancy.

There are no studies on the effects of diclofenac during labor or delivery. In animal studies, NSAIDs, including diclofenac, inhibit prostaglandin synthesis, causes delayed parturition, and increase the incidence of stillbirth. Thus, DICLOTAL-SR Tablets are not recommended for use in labor or delivery pain.

Lactating Women
It is not known whether this drug is excreted in human milk. In limited studies so far available, NSAIDs can appear in breast milk in very low concentrations. Because of the potential for serious adverse reactions in nursing infants from DICLOTAL-SR, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

Paediatric Patients
DICLOTAL-SR Tablets are not recommended for use in children.

Geriatric Patients
As with any NSAIDs, caution should be exercised in treating the elderly patients (65 years and older) with DICLOTAL-SR Tablets. Elderly patients, compared to younger patients, are at greater risk for NSAID-associated serious cardiovascular, gastrointestinal, and/or renal adverse reactions.

Hepatic Impairment Patients
Hepatic metabolism accounts for almost 100% of diclofenac elimination, so patients with hepatic disease may require reduced doses of diclofenac compared to patients with normal hepatic function. DICLOTAL-SR Tablets are contraindicated in patients with severe hepatic impairment.

4.7Effect on Ability to Drive and Use Machines
Undesirable effects such as dizziness, drowsiness, fatigue, and visual disturbances are possible after taking NSAIDs, including diclofenac. If affected, patients should not drive or operate machinery.

4.8Undesirable Effects
The most frequently reported adverse experiences occurring in approximately 1 to 10% of patients are gastrointestinal experiences such as abdominal pain, constipation, diarrhea, dyspepsia, flatulence, gross bleeding/perforation, heartburn, nausea, GI ulcers (gastric/duodenal), and vomiting. Other less frequently reported adverse effects (non-gastrointestinal origin) are abnormal renal function, anemia, dizziness, edema, elevated liver enzymes, headaches, increased bleeding time, pruritus, rashes, and tinnitus.
Additional adverse experiences reported occasionally/rarely include:
Body as a Whole: Fever, infection, sepsis, anaphylactic reactions, appetite changes.

Cardiovascular System: Congestive heart failure, hypertension, tachycardia, syncope, arrhythmia, hypotension, myocardial infarction, palpitations, vasculitis.
Digestive System: Dry mouth, esophagitis, gastric/peptic ulcers, gastritis, gastrointestinal bleeding, glossitis, hematemesis, hepatitis, jaundice, colitis, eructation, fulminant hepatitis with and without jaundice, liver failure, liver necrosis, pancreatitis.
Urogenital System: Cystitis, dysuria, hematuria, interstitial nephritis, oliguria/polyuria, proteinuria, renal failure.
Haematologic and Lymphatic System: Ecchymosis, eosinophilia, leukopenia, melena, purpura, rectal bleeding, stomatitis, thrombocytopenia, agranulocytosis, hemolytic anemia, aplastic anemia, lymphadenopathy, pancytopenia.
Metabolic and Nutritional: Weight changes, hyperglycemia.
Nervous System: Anxiety, asthenia, confusion, depression, dream abnormalities, drowsiness, insomnia, malaise, nervousness, paresthesia, somnolence, tremors, vertigo, convulsions, coma, hallucinations, and meningitis.
Respiratory System: Asthma, dyspnea, respiratory depression, pneumonia.
Skin and Appendages: Alopecia, photosensitivity, increased sweating, angioedema, toxic epidermal necrolysis, erythema multiforme, exfoliative dermatitis, Stevens-Johnson syndrome, urticaria.
Special Senses: Blurred vision, conjunctivitis, hearing impairment.

4.9Overdose

Symptoms: Symptoms following acute NSAID overdose are usually limited to lethargy, drowsiness, nausea, vomiting, and epigastric pain, which are generally reversible with supportive care. Gastrointestinal bleeding can occur. Hypertension, acute renal failure, respiratory depression and coma may occur, but are rare. Anaphylactoid reactions have been reported with therapeutic ingestion of NSAIDs, and may occur following an overdose.
Treatment: Following an NSAID overdose, patients should be managed by symptomatic and supportive care. There are no specific antidotes. Emesis and/or activated charcoal (60 to 100 g in adults, 1 to 2 g/kg in children) and/or osmotic cathartic may be indicated in patients seen within 4 hours of ingestion with symptoms or following a large overdose (5 to 10 times the usual dose). Forced diuresis, alkalinization of urine, hemodialysis, or hemoperfusion may not be useful due to high protein binding.

5. Pharmacological Properties

5.1 Mechanism of Action

Like all other NSAIDs, the mechanism of action of diclofenac is related to inhibition of prostaglandin biosynthesis by inhibition of the cyclooxygenase (COX) enzyme. Diclofenac sodium is a non-selective, reversible, and competitive inhibitor of COX, subsequently blocking the conversion of arachidonic acid into prostaglandin (PG) precursors. This leads to an inhibition of the formation of prostaglandins that are involved in pain, inflammation and fever.

5.2Pharmacodynamic Properties

Diclofenac is a non-steroidal anti-inflammatory drug which exhibits anti-inflammatory, analgesic, and antipyretic effects.

5.3Pharmacokinetic Properties

Absorption: Diclofenac is 100% absorbed after oral administration compared to intravenous administration. However, due to first-pass metabolism, only about 50% of the absorbed dose is systemically available. When DICLOTAL-SR is taken with food, there is a delay of 1 to 2 hours in the Tmax and a two-fold increase in Cmax values. The extent of absorption of diclofenac, however, is not significantly affected by food intake.

Distribution: The apparent volume of distribution of diclofenac sodium is 1.4 L/kg. Diclofenac is more than 99% bound to human serum proteins, primarily to albumin. Serum protein binding is constant over the concentration range (0.15-105 μg/mL) achieved with recommended doses.

Diclofenac diffuses into and out of the synovial fluid. Diffusion into the joint occurs when plasma levels are higher than those in the synovial fluid, after which the process reverses and synovial fluid levels are higher than plasma levels. It is not known whether diffusion into the joint plays a role in the effectiveness of diclofenac.

Metabolism: Five diclofenac metabolites have been identified in human plasma and urine. The metabolites include 4'-hydroxy-, 5-hydroxy-, 3'-hydroxy-, 4',5-dihydroxy- and 3'-hydroxy-4'-methoxydiclofenac. The major diclofenac metabolite, 4'-hydroxy-diclofenac, has very weak pharmacologic activity. The formation of 4'-hydroxy diclofenac is primarily mediated by CYP2C9. CYP3A4 is responsible for the formation of minor metabolites, 5-hydroxy- and 3'-hydroxy-diclofenac. Both diclofenac and its oxidative metabolites undergo glucuronidation or sulfation followed by biliary excretion.

Excretion: Diclofenac is eliminated through metabolism and subsequent urinary and biliary excretion of the glucuronide and the sulfate conjugates of the metabolites. Little or no free unchanged diclofenac is excreted in the urine. Approximately 65% of the dose is excreted in the urine and approximately 35% in the bile as conjugates of unchanged diclofenac plus metabolites. Because renal elimination is not a significant pathway of elimination for unchanged diclofenac, dosing adjustment in patients with mild to moderate renal dysfunction is not necessary. The terminal half-life of unchanged diclofenac is approximately 2 hours.

6. Nonclinical Properties

6.1 Animal Toxicology

Carcinogenesis: Long-term carcinogenicity studies in rats given diclofenac sodium up to 2 mg/kg/day (approximately 0.1 times the maximum recommended human dose (MRHD) of diclofenac 200 mg/day, based on body surface area (BSA) comparison) have revealed no significant increase in tumor incidence. A 2-year carcinogenicity study conducted in mice employing diclofenac sodium at doses up to 0.3 mg/kg/day (approximately 0.007 times the MRHD

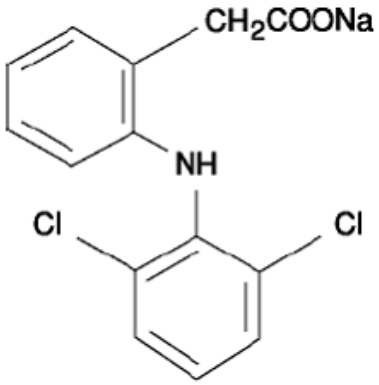
based on BSA comparison) in males and 1 mg/kg/day (approximately 0.02 times the MRHD based on BSA comparison) in females did not reveal any oncogenic potential.
Mutagenesis: Diclofenac sodium did not show mutagenic activity in *in vitro* point mutation assays in mammalian (mouse lymphoma) and microbial (yeast, Ames) test systems and was non-mutagenic in several mammalian *in vitro* and *in vivo* tests, including dominant lethal and male germinal epithelial chromosomal studies in mice, and nucleus anomaly and chromosomal aberration studies in Chinese hamsters.
Impairment of Fertility: Diclofenac sodium administered to male and female rats at 4 mg/kg/day (approximately 0.2 times the MRHD based on BSA comparison) did not affect fertility.
Teratogenicity: Reproductive and developmental studies in animals demonstrated that diclofenac sodium administration during organogenesis did not produce teratogenicity despite the induction of maternal toxicity and fetal toxicity in mice at oral doses up to 20 mg/kg/day (approximately 0.5 times the MRHD on BSA comparison), and in rats and rabbits at oral doses up to 10 mg/kg/day (approximately 0.5 and 1 times, respectively, the MRHD based on BSA comparison). In a study in which pregnant rats were orally administered 2 or 4 mg/kg diclofenac (0.1 and 0.2 times the MRHD based on BSA) from Gestation Day 15 through Lactation Day 21, significant maternal toxicity (peritonitis, mortality) was noted. These maternally toxic doses were associated with dystocia, prolonged gestation, reduced fetal weights and growth, and reduced fetal survival. Diclofenac has been shown to cross the placental barrier in mice and rats.

7. Description

DICLOTAL-SR Tablets are buff coloured, circular, biconvex, film coated tablets plain on both sides.

DICLOTAL-SR Tablets contain 100 mg of diclofenac sodium in a prolonged release form for oral administration in adults for the treatment of various painful inflammatory conditions.

Diclofenac Sodium
Diclofenac Sodium is the sodium salt form of diclofenac, a benzene acetic acid derivate and non-steroidal anti-inflammatory drug (NSAID) with analgesic, antipyretic and anti-inflammatory activity.
Diclofenac sodium is an odorless, white to off-white crystalline, and slightly hygroscopic powder.
Molecular Weight: 318.14 g/mol.
Chemical Name: 2-[(2,6-dichlorophenyl)amino] benzeneacetic acid, monosodium salt.
Molecular Formula: C14H10Cl2NNaO2.
Structural Formula:



Inactive ingredients (excipients) of DICLOTAL-SR Tablets contain Hydroxypropyl Methyl Cellulose, Lactose, Polyvinylpyrrolidone, K-30, Isopropyl Alcohol, Colloidal Silicon Dioxide, Magnesium Stearate, and Talc.

8. Pharmaceutical Particulars

8.1 Incompatibilities

None known.

8.2Shelf-life

24 Months.

8.3Packaging Information

Strip of 15 tablets.

8.4Storage and Handling Instructions

Store protected from light and moisture at a temperature not exceeding 30°C.
Keep out of reach of children.

9. Patient Counseling Information

- NSAID medicines should be used exactly as prescribed, at the lowest dose possible, and for the shortest time needed.
- NSAID medicines may increase the chance of a heart attack or stroke. This chance increases with longer use of NSAID medicines and in people who have heart disease.
- Do not take NSAID medicines for pain right before or after a heart bypass surgery.
- NSAID medicines can cause ulcers and bleeding in the stomach and intestines at any time during treatment. Ulcers and bleeding can happen without warning symptoms.

- Do not take an NSAID medicine if you had an asthma attack, urticaria/itching, or other allergic reaction with aspirin or any other NSAID medicine.
- Pregnant women should avoid use of NSAID medicines especially in the last 3 months of pregnancy. Breastfeeding mothers should be advised to consult their doctor before use of this medicine.

10. Details of Manufacturer

Blue Cross Laboratories Pvt Ltd.
A-12, MIDC Ambad, Nashik - 422 010.

11. Details of Permission or License Number with Date

Mfg. Lic. No.: BD/25.
Date of FDA Product Permission: 30/09/2020.

12. Date of Revision

March 2021.

MADE IN INDIA BY
BLUE CROSS LABORATORIES PVT LTD.
A-12, M.I.D.C., NASHIK-422 010.
Regd. Off.: Peninsula Chambers, G. K. Marg, Mumbai-400 013.