

Motrin®

ibuprofen tablets, USP

PHARMACIA**DESCRIPTION**

MOTRIN Tablets contain the active ingredient ibuprofen, which is the (±) 2-(p-isobutylphenyl) propionic acid. Ibuprofen is a white powder with a melting point of 74-77° C and is very slightly soluble in water (<1 mg/mL) and readily soluble in organic solvents such as ethanol and acetone.

The structural formula is represented below:



MOTRIN, a nonsteroidal anti-inflammatory agent, is available in 400 mg, 600 mg, and 800 mg tablets for oral administration. Inactive ingredients: carnauba wax, colloidal silicon dioxide, croscarmellose sodium, hypromellose, lactose, magnesium stearate, microcrystalline cellulose, propylene glycol, titanium dioxide.

CLINICAL PHARMACOLOGY

MOTRIN Tablets contain ibuprofen which possesses analgesic and antipyretic activities. Its mode of action, like that of other nonsteroidal anti-inflammatory agents, is not completely understood, but may be related to prostaglandin synthetase inhibition.

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In clinical studies in patients with rheumatoid arthritis and osteoarthritis, MOTRIN has been shown to be comparable to aspirin in controlling pain and inflammation and to be associated with a statistically significant reduction in the milder gastrointestinal side effects (see ADVERSE REACTIONS). MOTRIN may be well tolerated in some patients who have had gastrointestinal side effects with aspirin, but these patients when treated with MOTRIN should be carefully followed for signs and symptoms of gastrointestinal ulceration and bleeding. Although it is not definitely known whether MOTRIN causes less peptic ulceration than aspirin, in one study involving 885 patients with rheumatoid arthritis treated for up to one year, there were no reports of gastric ulceration with MOTRIN whereas frank ulceration was reported in 13 patients in the aspirin group (statistically significant $p < .001$).

Gastroscopic studies at varying doses show an increased tendency toward gastric irritation at higher doses. However, at comparable doses, gastric irritation is approximately half that seen with aspirin. Studies using ^{51}Cr -tagged red cells indicate that fecal blood loss associated with MOTRIN Tablets in doses up to 2400 mg daily

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did not exceed the normal range, and was significantly less than that seen in aspirin-treated patients.

In clinical studies in patients with rheumatoid arthritis, MOTRIN has been shown to be comparable to indomethacin in controlling the signs and symptoms of disease activity and to be associated with a statistically significant reduction of the milder gastrointestinal (see ADVERSE REACTIONS) and CNS side effects.

MOTRIN may be used in combination with gold salts and/or corticosteroids.

Controlled studies have demonstrated that MOTRIN is a more effective analgesic than propoxyphene for the relief of episiotomy pain, pain following dental extraction procedures, and for the relief of the symptoms of primary dysmenorrhea.

In patients with primary dysmenorrhea, MOTRIN has been shown to reduce elevated levels of prostaglandin activity in the menstrual fluid and to reduce resting and active intrauterine pressure, as well as the frequency of uterine contractions. The probable mechanism of action is to inhibit prostaglandin synthesis rather than simply to provide analgesia.

The ibuprofen in MOTRIN is rapidly absorbed. Peak serum ibuprofen levels are generally attained one to two hours after administration. With single doses up to 800 mg, a linear relationship exists between amount of drug administered and the integrated area under the serum drug concentration vs time curve. Above 800 mg, however, the area under the curve increases less than proportional to increases in dose. There is no evidence of drug accumulation or enzyme induction.

The administration of MOTRIN Tablets either under fasting conditions or immediately before meals yields quite similar serum ibuprofen concentration-time profiles. When MOTRIN is administered immediately after a meal, there is a reduction in the rate of absorption but no appreciable decrease in the extent of absorption. The bioavailability of the drug is minimally altered by the presence of food.

A bioavailability study has shown that there was no interference with the absorption of ibuprofen when MOTRIN was given in conjunction with an antacid containing both aluminum hydroxide and magnesium hydroxide.

Ibuprofen is rapidly metabolized and eliminated in the urine. The excretion of ibuprofen is virtually complete 24 hours after the last dose. The serum half-life is 1.8 to 2.0 hours.

Studies have shown that following ingestion of the drug, 45% to 79% of the dose was recovered in the urine within 24 hours as metabolite A (25%), (+)-2-[p-(2-hydroxymethyl-propyl) phenyl] propionic acid and metabolite B (37%), (+)-2-[p-(2-carboxy-propyl)phenyl] propionic acid; the percentages of free and conjugated ibuprofen were approximately 1% and 14%, respectively.

INDICATIONS AND USAGE

MOTRIN Tablets are indicated for relief of the signs and symptoms of rheumatoid arthritis and osteoarthritis.

MOTRIN is indicated for relief of mild to moderate pain. MOTRIN is also indicated for the treatment of primary dysmenorrhea.

Since there have been no controlled clinical trials to demonstrate whether or not there is any beneficial effect or harmful interaction with the use of MOTRIN in conjunction with aspirin, the combination cannot be recommended (see Drug Interactions).

Controlled clinical trials to establish the safety and effectiveness of MOTRIN in children have not been conducted.

CONTRAINDICATIONS

MOTRIN Tablets should not be used in patients who have previously exhibited hypersensitivity to the drug, or in individuals with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory agents. Anaphylactoid reactions have occurred in such patients.

WARNINGS**Risk of GI Ulceration, Bleeding and Perforation with Nonsteroidal Anti-inflammatory Therapy:**

Serious gastrointestinal toxicity such as bleeding, ulceration, and perforation, can occur at any time, with or without warning symptoms, in patients treated chronically with nonsteroidal anti-inflammatory drugs. Although minor upper gastrointestinal problems, such as dyspepsia, are common, usually developing early in therapy, physicians should remain alert for ulceration and bleeding in patients treated chronically with nonsteroidal anti-inflammatory drugs even in the absence of previous GI tract symptoms. In patients observed in clinical trials of several months to two years duration, symptomatic upper GI ulcers, gross bleeding or perforation appear to occur in approximately 1% of patients treated for 3-6 months, and in about 2-4% of patients treated for one year. Physicians should inform patients about the signs and/or symptoms of serious GI toxicity and what steps to take if they occur.

Studies to date have not identified any subset of patients not at risk of developing peptic ulceration and bleeding. Except for a prior history of serious GI events and other risk factors known to be associated with peptic ulcer disease, such as alcoholism, smoking, etc., no risk factors (eg, age, sex) have been associated with increased risk. Elderly or debilitated patients seem to tolerate ulceration or bleeding less well than other individuals and most spontaneous reports of fatal GI events are in this population. Studies to date are inconclusive concerning the relative risk of various nonsteroidal anti-inflammatory agents in causing such reactions. High doses of any such agents probably carry a greater risk of these reactions, although controlled clinical trials showing this do not exist in most cases. In considering the use of relatively large doses (within the recommended dosage range), sufficient benefit should be anticipated to offset the potential increased risk of GI toxicity.

PRECAUTIONS**General Precautions**

Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If a patient develops such complaints while receiving MOTRIN Tablets, the drug should be discontinued, and the patient should have an ophthalmologic examination which includes central visual fields and color vision testing.

Fluid retention and edema have been reported in association with MOTRIN; therefore, the drug should be used with caution in patients with a history of cardiac decompensation or hypertension.

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MOTRIN like other nonsteroidal anti-inflammatory agents, can inhibit platelet aggregation but the effect is quantitatively less and of shorter duration than that seen with aspirin. MOTRIN has been shown to prolong bleeding time (but within the normal range) in normal subjects. Because this prolonged bleeding effect may be exaggerated in patients with underlying hemostatic defects, MOTRIN should be used with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients on MOTRIN should report to their physicians signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

In order to avoid exacerbation of disease or adrenal insufficiency, patients who have been on prolonged corticosteroid therapy should have their therapy tapered slowly rather than discontinued abruptly when MOTRIN is added to the treatment program.

The antipyretic and anti-inflammatory activity of ibuprofen may reduce fever and inflammation, thus diminishing their utility as diagnostic signs in detecting complications of presumed noninfectious noninflammatory painful conditions.

Liver Effects: As with other nonsteroidal anti-inflammatory drugs, borderline elevations of one or more liver tests may occur in up to 15% of patients. These abnormalities may progress, may remain essentially unchanged, or may be transient with continued therapy. The SGPT (ALT) test is probably the most sensitive indicator of liver dysfunction. Meaningful (3 times the upper limit of normal) elevations of SGPT or SGOT (AST) occurred in controlled clinical trials in less than 1% of patients. A patient with symptoms and/or signs suggesting liver dysfunction, or in whom an abnormal liver test has occurred, should be evaluated for evidence of the development of more severe hepatic reaction while on therapy with MOTRIN. Severe hepatic reactions, including jaundice and cases of fatal hepatitis, have been reported with ibuprofen as with other nonsteroidal anti-inflammatory drugs. Although such reactions are rare, if abnormal liver tests persist or worsen, if clinical signs and symptoms consistent with liver disease develop, or if systemic manifestations occur (eg eosinophilia, rash, etc.), MOTRIN should be discontinued.

Hemoglobin Levels: In cross-study comparisons with doses ranging from 1200 mg to 3200 mg daily for several weeks, a slight dose-response decrease in hemoglobin/hematocrit was noted. This has been observed with other nonsteroidal anti-inflammatory drugs; the mechanism is unknown. With daily doses of 3200 mg, the total decrease in hemoglobin may exceed 1 gram; if there are no signs of bleeding, it is probably not clinically important.

In two postmarketing clinical studies the incidence of a decreased hemoglobin level was greater than previously reported. Decrease in hemoglobin of 1 gram or more was observed in 17.1% of 193 patients on 1600 mg ibuprofen daily (osteoarthritis), and in 22.8% of 189 patients taking 2400 mg of ibuprofen daily (rheumatoid arthritis). Positive stool occult blood tests and elevated serum creatinine levels were also observed in these studies.

Septic Meningitis: Septic meningitis with fever and coma has been observed on rare occasions in patients on ibuprofen therapy. Although it is probably more likely to occur in patients with systemic lupus erythematosus and related connective tissue diseases, it has been reported in patients who do not have an underlying chronic disease. If signs or symptoms of meningitis develop in a patient on MOTRIN, the possibility of its being related to MOTRIN should be considered.

Renal Effects: As with other nonsteroidal anti-inflammatory drugs, long term administration of ibuprofen to animals has resulted in renal papillary necrosis and other abnormal renal pathology. In humans, there have been reports of acute interstitial nephritis with hematuria, proteinuria, and occasionally nephrotic syndrome.

A second form of renal toxicity has been seen in patients with prerenal conditions leading to a reduction in renal blood flow or blood volume, where the renal prostaglandins have a supportive role in the maintenance of renal perfusion. In these patients administration of a nonsteroidal anti-inflammatory drug may cause a dose dependent reduction in prostaglandin formation and 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 the elderly. Discontinuation of nonsteroidal anti-inflammatory drug therapy is typically followed by recovery to the pretreatment state. Those patients at high risk who chronically take MOTRIN should have renal function monitored if they have signs or symptoms which may be consistent with mild azotemia, such as malaise, fatigue, loss of appetite, etc. Occasional patients may develop some elevation of serum creatinine and BUN levels without signs or symptoms.

Since ibuprofen is eliminated primarily by the kidneys, patients with significantly impaired renal function should be closely monitored; and a reduction in dosage should be anticipated to avoid drug accumulation. Prospective studies on the safety of ibuprofen in patients with chronic renal failure have not been conducted.

Information for Patients

MOTRIN, like other drugs of its class, is not free of side effects. The side effects of these drugs can cause discomfort and, rarely, there are more serious side effects, such as gastrointestinal bleeding, which may result in hospitalization and even fatal outcomes.

Nonsteroidal anti-inflammatory drugs are often essential agents in the management of arthritis and have a major role in the treatment of pain, but they also may be commonly employed for conditions which are less serious.

Physicians may wish to discuss with their patients the potential risks (see WARNINGS, PRECAUTIONS, and ADVERSE REACTIONS) and likely benefits of nonsteroidal anti-inflammatory drug treatment, particularly when the drugs are used for less serious conditions where treatment without such agents may represent an acceptable alternative to both the patient and physician.

Laboratory Tests

Because serious GI tract ulcerations and bleeding can occur without warning symptoms, physicians should follow chronically treated patients for the signs and symptoms of ulcerations and bleeding and should inform them of the importance of this follow-up (see Risk of GI Ulceration, Bleeding and Perforation with Nonsteroidal Anti-inflammatory therapy).

Drug Interactions: *Coumarin-type anticoagulants.* Several short-

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term controlled studies failed to show that MOTRIN significantly affected prothrombin times or a variety of other clotting factors when administered to individuals on coumarin-type anticoagulants. However, because bleeding has been reported when MOTRIN and other nonsteroidal anti-inflammatory agents have been administered to patients on coumarin-type anticoagulants, the physician should be cautious when administering MOTRIN to patients on anticoagulants.

Aspirin: Animal studies show that aspirin given with nonsteroidal anti-inflammatory agents, including MOTRIN, yields a net decrease in anti-inflammatory activity with lowered blood levels of the non-aspirin drug. Single dose bioavailability studies in normal volunteers have failed to show an effect of aspirin on ibuprofen blood levels. Correlative clinical studies have not been done.

Methotrexate: Ibuprofen, as well as other nonsteroidal anti-inflammatory drugs, probably reduces the tubular secretion of methotrexate based on *in-vitro* studies in rabbit kidney slices. This may indicate that ibuprofen could enhance the toxicity of methotrexate. Caution should be used if MOTRIN is administered concomitantly with methotrexate.

H-2 Antagonists: In studies with human volunteers, co-administration of cimetidine or ranitidine with ibuprofen had no substantive effect on ibuprofen serum concentrations.

Furosemide: Clinical studies, as well as random observations, have shown that ibuprofen 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 ibuprofen, the patient should be observed closely for signs of renal failure (see PRECAUTIONS, Renal Effects), as well as to assure diuretic efficacy.

Lithium: Ibuprofen produced an elevation of plasma lithium levels and a reduction in renal lithium clearance in a study of eleven normal volunteers. The mean minimum lithium concentration increased 15% and the renal clearance of lithium was decreased by 19% during this period of concomitant drug administration.

This effect has been attributed to inhibition of renal prostaglandin synthesis by ibuprofen. Thus, when ibuprofen and lithium are administered concurrently, subjects should be observed carefully for signs of lithium toxicity. (Read circulars for lithium preparation before use of such concurrent therapy.)

Pregnancy: Reproductive studies conducted in rats and rabbits at doses somewhat less than the maximal clinical dose did not demonstrate evidence of developmental abnormalities. However, animal reproduction studies are not always predictive of human response. As there are no adequate and well-controlled studies in pregnant women, this drug should be used during pregnancy only if clearly needed. Because of the known effects of nonsteroidal anti-inflammatory drugs on the fetal cardiovascular system (closure of ductus arteriosus), use during late pregnancy should be avoided. As with other drugs known to inhibit prostaglandin synthesis, an increased incidence of dystocia and delayed parturition occurred in rats. Administration of MOTRIN is not recommended during pregnancy.

Nursing Mothers: In limited studies, an assay capable of detecting 1 mcg/mL did not demonstrate ibuprofen in the milk of lactating mothers. However, because of the limited nature of the studies, and the possible adverse effects of prostaglandin-inhibiting drugs on neonates, MOTRIN is not recommended for use in nursing mothers.

ADVERSE REACTIONS

The most frequent type of adverse reaction occurring with MOTRIN Tablets is gastrointestinal. In controlled clinical trials the percentage of patients reporting one or more gastrointestinal complaints ranged from 4% to 16%.

In controlled studies when MOTRIN was compared to aspirin and indomethacin in equally effective doses, the overall incidence of gastrointestinal complaints was about half that seen in either the aspirin- or indomethacin-treated patients.

Adverse reactions observed during controlled clinical trials at an incidence greater than 1% are listed in the table. Those reactions listed in Column one encompass observations in approximately 3,000 patients. More than 500 of these patients were treated for periods of at least 54 weeks.

Still other reactions occurring less frequently than 1 in 100 were reported in controlled clinical trials and from marketing experience. These reactions have been divided into two categories: Column two of the table lists reactions with therapy with MOTRIN where the probability of a causal relationship exists; for the reactions in Column three, a causal relationship with MOTRIN has not been established.

Reported side effects were higher at doses of 3200 mg/day than at doses of 2400 mg or less per day in clinical trials of patients with rheumatoid arthritis. The increases in incidence were slight and still within the ranges reported in the table.

OVERDOSAGE

Approximately 1 1/2 hours after the reported ingestion of from 7 to 10 MOTRIN Tablets (400 mg), a 19-month old child weighing 12 kg was seen in the hospital emergency room, apneic and cyanotic, responding only to painful stimuli. This type of stimulus, however, was sufficient to induce respiration. Oxygen and parenteral fluids were given; a greenish-yellow fluid was aspirated from the stomach with no evidence to indicate the presence of ibuprofen. Two hours after ingestion the child's condition seemed stable; she still responded only to painful stimuli and continued to have periods of apnea lasting from 5 to 10 seconds. She was admitted to intensive care and sodium bicarbonate was administered as well as infusions of dextrose and normal saline. By four hours post-ingestion she could be aroused easily, sit by herself and respond to spoken commands. Blood level of ibuprofen was 102.9 µg/mL approximately 8 1/2 hours after accidental ingestion. At 12 hours she appeared to be completely recovered.

In two other reported cases where children (each weighing approximately 10 kg) accidentally, acutely ingested approximately 120 mg/kg, there were no signs of acute intoxication or late sequelae. Blood level in one child 90 minutes after ingestion was 700 µg/mL — about 10 times the peak levels seen in absorption-excretion studies.

A 19-year old male who had taken 8,000 mg of ibuprofen over a period of a few hours complained of dizziness, and nystagmus was noted. After hospitalization, parenteral hydration and three days bed

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rest, he recovered with no reported sequelae.

In cases of acute overdosage, the stomach should be emptied by vomiting or lavage, though little drug will likely be recovered if more than an hour has elapsed since ingestion. Because the drug is acidic and is excreted in the urine, it is theoretically beneficial to administer alkali and induce diuresis. In addition to supportive measures, the use of oral activated charcoal may help to reduce the absorption and reabsorption of MOTRIN.

DOSAGE AND ADMINISTRATION

Do not exceed 3200 mg total daily dose. If gastrointestinal complaints occur, administer MOTRIN Tablets with meals or milk.

Rheumatoid arthritis and osteoarthritis, including flare-ups of chronic disease:

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HOW SUPPLIED

MOTRIN Tablets are available in the following strengths, colors and sizes:

400 mg (white, round, imprinted with MOTRIN 400)	
Bottles of 100	NDC 0009-7385-01
Bottles of 500	NDC 0009-7385-02
Unit dose blister of 100	NDC 0009-7385-04
600 mg (white, elliptical, imprinted with MOTRIN 600)	
Bottles of 90	NDC 0009-7386-05
Bottles of 100	NDC 0009-7386-01
Bottles of 270	NDC 0009-7386-09
Bottles of 500	NDC 0009-7386-02
Unit dose blister of 100	NDC 0009-7386-04

Incidence Greater than 1% (but less than 3%) Probable Causal Relationship	Precise Incidence Unknown (but less than 1%) Probable Causal Relationship**	Precise Incidence Unknown (but less than 1%) Causal Relationship Unknown**
GASTROINTESTINAL		
Nausea*, epigastric pain*, heartburn*, diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of GI tract (bloating and flatulence)	Gastric or duodenal ulcer with bleeding and/or perforation, gastrointestinal hemorrhage, melena, gastritis, hepatitis, jaundice, abnormal liver function tests; pancreatitis	
CENTRAL NERVOUS SYSTEM		
Dizziness*, headache, nervousness	Depression, insomnia, confusion, emotional lability, somnolence, aseptic meningitis with fever and coma (See PRECAUTIONS)	Paresthesias, hallucinations, dream abnormalities, pseudotumor cerebri
DERMATOLOGIC		
Rash* (including maculopapular type), pruritus	Vesiculobullous eruptions, urticaria, erythema multiforme, Stevens-Johnson syndrome, alopecia	Toxic epidermal necrolysis, photoallergic skin reactions
SPECIAL SENSES		
Tinnitus	Hearing loss, amblyopia (blurred and/or diminished vision, scotomata and/or changes in color vision) (see PRECAUTIONS)	Conjunctivitis, diplopia, optic neuritis, cataracts
HEMATOLOGIC		
	Neutropenia, agranulocytosis, aplastic anemia, hemolytic anemia (sometimes Coombs positive), thrombocytopenia with or without purpura, eosinophilia, decreases in hemoglobin and hematocrit (see PRECAUTIONS)	Bleeding episodes (eg epistaxis, menorrhagia)
METABOLIC/ENDOCRINE		
Decreased appetite		Gynecomastia, hypoglycemic reaction, acidosis
CARDIOVASCULAR		
Edema, fluid retention (generally responds promptly to drug discontinuation) (see PRECAUTIONS)	Congestive heart failure in patients with marginal cardiac function, elevated blood pressure, palpitations	Arrhythmias (sinus tachycardia, sinus bradycardia)
ALLERGIC		
	Syndrome of abdominal pain, fever, chills, nausea and vomiting; anaphylaxis; bronchospasm (see CONTRAINDICATIONS)	Serum sickness, lupus erythematosus syndrome, Henoch-Schonlein vasculitis, angioedema
RENAL		
	Acute renal failure (see PRECAUTIONS), decreased creatinine clearance, polyuria, azotemia, cystitis, hematuria	Renal papillary necrosis
MISCELLANEOUS		
	Dry eyes and mouth, gingival ulcer, rhinitis	

* Reactions occurring in 3% to 9% of patients treated with MOTRIN. (Those reactions occurring in less than 3% of the patients are unmarked.)
 ** Reactions are classified under "Probable Causal Relationship (PCR)" if there has been one positive rechallenge or if three or more cases occur which might be causally related. Reactions are classified under "Causal Relationship Unknown" if seven or more events have been reported but the criteria for PCR have not been met.

Suggested Dosage: 1200 mg-3200 mg daily (300 mg qid; 400 mg, 600 mg or 800 mg tid or qid). Individual patients may show a better response to 3200 mg daily, as compared with 2400 mg, although in well-controlled clinical trials patients on 3200 mg did not show a better mean response in terms of efficacy. Therefore, when treating patients with 3200 mg/day, the physician should observe sufficient increased clinical benefits to offset potential increased risk.

The dose should be tailored to each patient, and may be lowered or raised depending on the severity of symptoms either at time of initiating drug therapy or as the patient responds or fails to respond. In general, patients with rheumatoid arthritis seem to require higher doses of MOTRIN than do patients with osteoarthritis.

The smallest dose of MOTRIN that yields acceptable control should be employed. A linear blood level dose-response relationship exists with single doses up to 800 mg (See CLINICAL PHARMACOLOGY for effects of food on rate of absorption).

The availability of four tablet strengths facilitates dosage adjustment.

In chronic conditions, a therapeutic response to therapy with MOTRIN is sometimes seen in a few days to a week but most often is observed by two weeks. After a satisfactory response has been achieved, the patient's dose should be reviewed and adjusted as required.

Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for relief of pain.

In controlled analgesic clinical trials, doses of MOTRIN greater than 400 mg were no more effective than the 400 mg dose.

Dysmenorrhea: For the treatment of dysmenorrhea, beginning with the earliest onset of such pain, MOTRIN should be given in a dose of 400 mg every 4 hours as necessary for the relief of pain.

800 mg (white, elliptical, imprinted with MOTRIN 800)	
Bottles of 100	NDC 0009-7387-01
Bottles of 270	NDC 0009-7387-08
Bottles of 500	NDC 0009-7387-02
Unit dose blister of 100	NDC 0009-7387-04

Store at controlled room temperature 20° to 25°C (68° to 77°F) [see USP].

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Distributed by:
 Pharmacia & Upjohn Company
 A subsidiary of Pharmacia Corporation
 Kalamazoo, Michigan 49001, USA

Revised July 2003

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