

Arrow - Alprazolam

Alprazolam 0.25 mg, 0.5 mg, 1 mg and 2 mg tablets

Presentation

Arrow - Alprazolam 0.25

Oval, convex white tablet marked 'A | 25' and 'S'.
Each tablet contains 0.25 mg of alprazolam.

Arrow - Alprazolam 0.5

Oval, convex pink tablet marked 'A | 5' and 'S'.
Each tablet contains 0.5 mg of alprazolam.

Arrow - Alprazolam 1

Oval, convex light blue tablet marked 'A | 1' and 'S'.
Each tablet contains 1 mg of alprazolam.

Arrow - Alprazolam 2

Rectangular white tablet marked '| A | 2 |' and triple scored.
Each tablet contains 2 mg of alprazolam.

Uses

Actions

Alprazolam is an anti-anxiety drug. It is a benzodiazepine derivative, chemically and pharmacologically related to other drugs of this class. Presumably, benzodiazepines exert their effects by binding at stereo-specific receptors at several sites within the central nervous system (CNS). Their exact mechanism of action is unknown.

All benzodiazepines cause a dose-related CNS depressant activity, varying from mild impairment of task performance to hypnosis. Pharmacological properties of alprazolam in animals appear similar to those of other benzodiazepines, that is, it produces significant anxiolytic, muscle relaxant, sleep promoting and anticonvulsant effects in appropriate animal models.

Pharmacodynamics

Clinical studies in healthy volunteers at doses up to 4 mg/day, and in patients with panic disorder at doses up to 10 mg/day, produce only effects that can be considered to be extensions of its pharmacological activities. No clinically significant effects on the cardiovascular or respiratory systems were observed. Alprazolam doses up to 10 mg/day do not clinically affect laboratory parameters or vital signs.

Sleep laboratory studies in man showed that alprazolam decreased sleep latency, increased duration of sleep, and decreased the number of nocturnal awakenings.

Alprazolam produced small decreases in both stages 3 to 4 and rapid eye movement (REM) sleep.

Pharmacokinetics

Absorption

Following oral administration to fasting subjects, alprazolam is rapidly absorbed with nearly complete bioavailability. Peak concentrations in the plasma occur in 0.3 to 3 hours following administration. Plasma levels are proportionate to the dose given. Over the dose range of 0.5 to 3.0 mg, peak levels of 8.0 to 37 mg/mL were observed. Peak plasma levels can show a two- to three-fold variation within individual treatment groups. The plasma half-life of alprazolam after single doses in healthy subjects has ranged from 7 to 22 hours. The mean half-life of individual treatment groups ranged only from 10 to 14 hours. Plasma levels of the drug reach steady-state within 7 days after starting or altering dosage size. The steady-state level is 3 to 4 times that achieved with a single dose. During multiple dose administration of 1.5 to 10 mg/day in divided doses, steady-state plasma levels of 18.3 to 100 ng/mL were observed.

Distribution

In vitro, alprazolam is bound (80%) to human serum protein.

When ¹⁴C alprazolam was administered to pregnant mice, drug related materials appeared uniformly distributed in the foetus with ¹⁴C concentration approximately the same as that in the blood and skeletal muscle of the mother.

Metabolism

About 21 metabolites of alprazolam were detected in humans. The predominant metabolites are α -hydroxyalprazolam and a benzophenone derived from alprazolam. The biological activity of α -hydroxyalprazolam is approximately one-half that of alprazolam. The benzophenone metabolite is essentially inactive. Plasma levels of these metabolites are extremely low, thus precluding precise pharmacokinetic description. However, their half-lives appear to be of the same order of magnitude as that of alprazolam.

Elimination

Alprazolam and its metabolites are excreted primarily in the urine. About 50% of the dose is excreted within 24 hours, and 94% after 72 hours. With chronic dosing, the apparent elimination half-life increases by about 50%, possibly because of compartmentalisation effects. The mean percentage excreted over a two-week period following a single ¹⁴C alprazolam dose was $78.8 \pm 2.1\%$ in urine and $7.02 \pm 0.6\%$ in faeces.

Special patient groups

Changes in the absorption, distribution, metabolism and excretion of benzodiazepines have been reported in a variety of disease states including alcoholism, impaired hepatic function and impaired renal function. Changes have also been demonstrated in elderly patients. It has not yet been determined if similar changes occur in the pharmacokinetics of alprazolam.

Hepatic enzymes

The ability of alprazolam to induce human hepatic enzyme systems has not yet been determined. However, this is not a property of benzodiazepines in general. Also, alprazolam did not affect the prothrombin times or plasma warfarin levels in male volunteers administered sodium warfarin orally.

Indications

Arrow - Alprazolam is indicated for the treatments of anxiety and anxiety associated conditions in adults over 18 years old as follows:

1. **Anxiety states (anxiety neuroses)**

Symptoms that occur in such patients include anxiety, tension, fear, insomnia, apprehension, restlessness, concentration difficulties, irritability and/or autonomic hyperactivity resulting in a variety of somatic complaints.

2. **Mixed anxiety-depression**

Symptoms of both anxiety and depression occur concurrently in such patients.

3. **Neurotic or reactive depression**

Such patients primarily exhibit a depressed mood or a pervasive loss of interest or pleasure. Other characteristics include anxiety, appetite disturbances, and changes in weight, cognitive disturbances, decreased energy, feeling of worthlessness or guilt, insomnia, somatic complaints, or thoughts of death or suicide.

4. **Anxiety states, mixed anxiety-depression, or neurotic depression**

Alprazolam is indicated when these conditions are associated with other diseases, such as the chronic phase of alcohol withdrawal and functional or organic disease, particularly certain gastrointestinal, cardiovascular, or dermatological disorders.

The effectiveness of alprazolam in the treatment of anxiety, anxiety associated with depression and/or neurotic (reactive) depression for long-term use (exceeding 6 months) has not been established by systematic clinical trials.

The physician should periodically reassess the usefulness of the drug for each patient.

Dosage and Administration

The optimum dose should be individualised based upon the severity of the symptoms and individual patient's response. The usual dose will meet the needs of most patients. In patients who require higher doses, dosage should be increased cautiously to avoid adverse effects. In general, patients who have not previously received psychotropic medications will require somewhat lower doses than those previously treated with minor tranquilizers, antidepressants or hypnotics, or those with a history of chronic alcoholism.

It is recommended that the general principle of using the lowest effective dose be followed, particularly in elderly or debilitated patients, to preclude the development of ataxia or over-sedation. In patients who experience early morning anxiety and emergence of anxiety symptoms, it is recommended that the same total daily dose be given as more frequent administration.

Conditions	Usual starting dosage *	Usual dosage range
Anxiety	0.25 to 0.5 mg, given three times daily	0.5 to 4.0 mg daily, given in divided doses
Anxiety with depressive symptoms	0.5 mg, given three times daily	1.5 to 4.5 mg daily, given in divided doses
Elderly patients or in the presence of debilitating disease	0.25 mg, given two to three times daily	0.5 to 0.75 mg daily, given in divided doses; to be gradually increased if needed and tolerated

* If side effects occur, the dose should be lowered.

Administration of Arrow - Alprazolam tablets immediately after meals does not affect the extent of absorption compared to administration on an empty stomach. Food does, however, delay the onset of absorption and decrease the rate of absorption of Arrow - Alprazolam tablets. As a direct consequence, side effects such as somnolence are less pronounced.

Duration of treatment

Data is available to support a usage of up to 6 months for anxiety and anxious patients with some symptoms of depression.

Discontinuation therapy

The dosage should be reduced slowly in keeping with good medical practice. It is suggested that the daily dosage of alprazolam be decreased by no more than 0.5 mg every 3 days in order to minimise any possible withdrawal symptoms. Some patients may require an even slower dosage reduction (see Warnings and Precautions).

Contraindications

Hypersensitivity to benzodiazepines or to any component of the product (see **Further Information**); myasthenia gravis; chronic obstructive airways disease with incipient respiratory failure.

Warnings and Precautions

In general, benzodiazepines should be prescribed for short periods only (e.g. 2 to 4 weeks). With the exception of the use of alprazolam for the treatment of panic disorder, continuous long-term use is not recommended. There is evidence that tolerance develops to the sedative effects of benzodiazepines. After as little as one

week therapy with recommended doses, withdrawal symptoms can appear following cessation of treatment, e.g. rebound anxiety following the cessation of an anxiolytic benzodiazepine (see **Withdrawal and dependence** in this section).

Habituation and emotional or physical dependence may occur with benzodiazepines, including alprazolam. As with all benzodiazepines, the risk of dependence increases with higher doses and long-term use and is further increased in patients with a history of alcoholism or drug abuse (see **Withdrawal and dependence**).

Following the prolonged use of alprazolam at therapeutic doses, withdrawal from the medication should be gradual in keeping with good medical practice. An individualised withdrawal timetable needs to be planned for each patient in whom dependence is known or suspected (periods from four weeks to four months have been suggested). It is suggested that the daily dosage of Arrow - Alprazolam be decreased by no more than 0.5 mg every 3 days. Some patients may require an even slower dosage reduction.

Withdrawal symptoms have occurred following rapid decrease or abrupt discontinuance of benzodiazepines including alprazolam. These can range from mild dysphoria and insomnia to a major syndrome, which may include abdominal and muscle cramps, vomiting, sweating, tremor and convulsions. In addition, withdrawal seizures have occurred upon a rapid decrease or abrupt discontinuation of therapy with alprazolam (see **Withdrawal and dependence**).

Depression, psychosis and schizophrenia

The use of alprazolam has not been established in certain types of depression. Thus, it is not recommended as a primary therapy in patients with depression and psychosis. In such conditions, psychiatric assessment and supervision are necessary if benzodiazepines are indicated. Benzodiazepines may increase depression in some patients and may contribute to deterioration in severely disturbed schizophrenics with confusion and withdrawal. Suicidal tendencies may be present or uncovered, and protective measures may be required.

Panic-related disorders have been associated with depression, and an increased frequency of suicide amongst untreated patients has been reported. Therefore, the same precaution must be exercised when using the higher doses of alprazolam in treating patients with panic disorders, as is exercised with the use of any psychotropic drug in treating depressed patients or those in whom there is reason to expect concealed suicidal ideation or plans.

Administration to severely depressed or suicidal patients should be done with appropriate precautions and appropriate size of the prescription.

Withdrawal and dependence

The use of benzodiazepines may lead to dependence as defined by the presence of a withdrawal syndrome on discontinuation of the drug. Tolerance as defined by a need to increase the dose in order to achieve the same therapeutic effect seldom occurs in patients receiving the recommended dose under medical supervision. Tolerance to sedation may occur with benzodiazepines, especially in those with drug-seeking behaviour.

The result of withdrawal symptoms is a direct consequence of physical dependence to alprazolam. Signs and symptoms of withdrawal are similar in character to those noted with barbiturates and alcohol, and are more prominent after a rapid decrease of dosage or abrupt discontinuation. These symptoms range from insomnia, anxiety, dysphoria, palpitations, panic attacks, vertigo, myoclonus, akinesia, hypersensitivity to light, sound and touch, abnormal body sensations (e.g. feelings of motion, metallic taste), depersonalisation, derealisation, delusional beliefs, hyper-reflexia and loss of short-term memory, to a major syndrome that may include convulsions, tremor, abdominal and muscle cramps, confusional state, delirium, hallucinations, hyperthermia, psychosis, vomiting and sweating. Such manifestations of withdrawal, especially the more serious ones, are more common in patients who have received excessive doses over a prolonged period. However, withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines taken continuously at therapeutic levels.

Signs and symptoms of withdrawal are more prominent after a rapid decrease of dosage or abrupt discontinuation of benzodiazepines. Hence, abrupt discontinuation of therapy with alprazolam should be avoided. It is recommended that all patients on alprazolam who require a dosage reduction be gradually tapered under close supervision (see **Dosage and Administration, Discontinuation therapy**) to minimise the incidence or severity of withdrawal problems. It is important to advise patients not to increase the dose of, or abruptly discontinue, their medication without first consulting a physician.

The discontinuation of therapy with alprazolam may not only result in withdrawal symptoms, but also in relapse of the anxiety and panic symptoms of the original disorder and rebound effect. The term relapse refers to the return of symptoms characteristic of the original disorder, at levels approximately equal to those seen at baseline before active treatment was initiated. Rebound phenomenon refers to the return of symptoms characteristic of the original disorder, at levels greater than originally seen at baseline.

In general, rebound phenomenon reflects the re-emergence of pre-existing conditions combined with withdrawal symptoms described earlier. Withdrawal or rebound phenomenon may follow high doses of benzodiazepines for relatively short periods of time.

In two controlled trials of six to eight weeks duration where the ability of patients to discontinue medication was measured, 71% to 93% of alprazolam treated patients tapered completely off therapy compared to 89% to 96% of placebo treated patients. In a controlled clinical trial of 3 to 12 months duration involving 144 patients, in which the ability of patients to discontinue medication was measured, it was found that the majority of alprazolam treated patients (66.9%) were able to taper dose to zero. A minority of patients were unable to successfully stop alprazolam after long-term therapy.

Abuse

Physical and psychological dependence have occurred with recommended doses of benzodiazepines. Caution must therefore be exercised in administering alprazolam to individuals known to be addiction prone, or those whose history suggesting they may increase the dosage on their own initiative. In such patients, it is therefore

desirable to limit repeat prescriptions without adequate medical supervision. Such individuals should be under careful surveillance when receiving benzodiazepines because of their predisposition to habituation and dependence.

Paradoxical reactions

Paradoxical reactions such as acute rage, stimulation or excitement may occur in rare instances. Should such reactions occur, alprazolam should be discontinued.

Elderly or debilitated patients

Such patients may be particularly susceptible to the sedative effects of benzodiazepines and associated giddiness, ataxia and confusion, which may increase the possibility of a fall. Therefore, the dosage should be limited to the smallest effective amount to preclude such effects.

Children

Safety and efficacy of alprazolam in children under 18 years of age have not been established.

Impaired renal or hepatic function

Patients with impaired renal or hepatic function should use benzodiazepine medication with caution and a reduction in dosage, or a decision not to prescribe, may be necessary in such patients. In rare instances, some patients taking benzodiazepines have developed blood dyscrasias, and some have had elevations of liver enzymes. As with other benzodiazepines, periodic blood counts and liver function tests are recommended.

Impaired respiratory function

Caution in the use of alprazolam is recommended in patients with respiratory depression. In patients with chronic obstructive pulmonary disease, benzodiazepines can cause increased arterial carbon dioxide tension and decreased oxygen tension.

Acute narrow-angle glaucoma

Caution should be used in the treatment of patients with acute narrow-angle glaucoma because of atropine-like side effects of alprazolam.

Hypotension

Although hypotension has occurred rarely, benzodiazepines should be administered with care to patients in whom a drop in blood pressure may lead to cardiac or cerebral complications. This is particularly important in elderly patients.

Epilepsy

Abrupt withdrawal of benzodiazepines in persons with convulsive disorders may be associated with a temporary increase in the frequency and/or severity of seizures. Patients with convulsive disorder should not be abruptly withdrawn from alprazolam.

Amnesia

Transient amnesia or memory impairment has been reported in association with the use of benzodiazepines.

Alcohol and other CNS drugs

Patients should be advised that their tolerance for alcohol and other CNS depressants will be diminished and that these drugs should either be eliminated or given in reduced dosage in the presence of Arrow - Alprazolam.

Carcinogenesis, mutagenesis, impairment of fertility

No evidence of carcinogenic potential was observed during the 2-year bioassay studies of alprazolam in rats at doses up to 30 mg/kg/day (150 times the maximum recommended daily human dose) and in mice at doses up to 10 mg/kg/day (50 times the maximum recommended).

Alprazolam was not mutagenic in the rat micronucleus test at doses up to 100 mg/kg, which is 500 times the maximum recommended daily human dose of 10 mg/day. Alprazolam also was not mutagenic *in vitro* in the DNA Damage/Alkaline Elution Assay or the Ames Assay.

Alprazolam produced no impairment of fertility in rats at doses up to 5 mg/kg/day, which is 25 times the maximum recommended daily human dose of 10 mg/day.

Use in pregnancy (Category C)

Benzodiazepines cross the placenta and may cause hypotonia, respiratory depression and hypothermia in the newborn infant. Continuous treatment during pregnancy and administration of high doses in connection with delivery should be avoided.

The data concerning teratogenicity and effects on post-natal development and behaviour following benzodiazepine treatment are inconsistent. There is evidence from some early studies with other members of the benzodiazepine class that *in utero* exposure may be associated with malformations. Later studies with the benzodiazepine class of drugs have provided no clear evidence of any type of defect. Infants exposed to benzodiazepines during late third trimester of pregnancy or during labour have been reported to exhibit either the floppy infant syndrome or neonatal withdrawal symptoms. If alprazolam is used during pregnancy, or if the patient becomes pregnant while taking alprazolam, the patient should be apprised of the potential hazard to the foetus.

Use in lactation

Benzodiazepines, including alprazolam, are known to be excreted in human milk. Although the levels in breast milk are low, benzodiazepines generally show increased toxicity in neonates, and may cause drowsiness, lethargy, weight loss, hypotonia and/or feeding difficulties in the infant. Therefore, unless there are compelling circumstances to the contrary, alprazolam is not recommended for use while breast feeding.

Effects on ability to drive or use machinery

Patients receiving alprazolam should be warned not to operate dangerous machinery or motor vehicles until it is known that they do not become drowsy or dizzy while taking alprazolam. Abilities may be impaired on the day following use.

Adverse Effects

Adverse events, if they occur, are generally observed at the beginning of therapy and usually disappear upon continuing medication or decreased dosage. The most common adverse reactions to alprazolam are sedation or drowsiness, and light-headedness or dizziness. Less common adverse reactions are blurred vision, headache, depression, insomnia, nervousness or anxiety, tremor, change in weight, memory impairment or amnesia, ataxia or coordination disorders, various gastrointestinal symptoms, dermatitis, and autonomic manifestations.

In addition, the following adverse events have been reported in association with the use of alprazolam: dystonia, irritability, anorexia, fatigue, slurred speech, musculoskeletal weakness, sexual dysfunction or changes in libido, menstrual irregularities, incontinence, urinary retention, abnormal liver function, and hyperprolactinaemia. Increased intraocular pressure has been rarely reported.

As with other benzodiazepines, adverse events such as concentration difficulties, confusion, hallucinations, stimulation, and adverse behavioural effects such as irritability, agitation, rage and aggressive or hostile behaviour have been reported rarely. In many of the spontaneous case reports of adverse behavioural effects, these patients were taking other CNS drugs concomitantly and/or were described as having underlying psychiatric conditions. Patients who have borderline personality disorder, a prior history of violent or aggressive behaviour, or alcohol or substance abuse may be at risk for such events. Instances of irritability, hostility and intrusive thoughts have been reported upon discontinuance of alprazolam in patients with post-traumatic stress disorder.

Rarely, jaundice or abnormal liver function tests occur during alprazolam therapy. The hepatic functions recover after ceasing the drug.

Episodes of hypomania, mania and other adverse behavioural effects may occur in rare instances with the use of alprazolam, and may necessitate the discontinuation of therapy. Such discontinuation should follow the recommended daily dosage reduction regimen (see **Dosage and Administration**).

Interactions

Benzodiazepines, including alprazolam, produce additive CNS depressant effects when co-administered with drugs such as barbiturates, alcohol, sedatives, tricyclic antidepressants, non-selective monoamine oxidase inhibitors and other antipsychotics, skeletal muscle relaxants, antihistamines, narcotic analgesics and anaesthetics.

Pharmacokinetic interactions can occur when alprazolam is administered along with drugs that interfere with its metabolism. Compounds that inhibit certain hepatic enzymes (particularly cytochrome P4503A4) may increase the concentration of alprazolam and enhance its activity. Data from clinical studies with alprazolam, *in vitro* studies with alprazolam, and clinical studies with drugs metabolised similarly to alprazolam provide evidence for varying degrees of interaction and possible

interaction with alprazolam for a number of drugs. Based on the degree of interaction and the type of data available, the following recommendations are made:

- Co-administration of alprazolam with ketoconazole, itraconazole, or other azole-type antifungals is not recommended.
- Caution and consideration of dose reduction is recommended when alprazolam is co-administered with nefazodone, fluvoxamine, cimetidine or disulfiram.
- Caution is recommended when alprazolam is co-administered with fluoxetine, propoxyphene, oral contraceptives, sertraline, diltiazem, erythromycin or other macrolide antibiotics. Increased levels of alprazolam have been observed with co-administration of erythromycin.
- Interactions involving HIV protease inhibitors (e.g. ritonavir) and alprazolam are complex and time dependent. Low doses of ritonavir resulted in a large impairment of alprazolam clearance, prolonged its elimination half-life and enhanced clinical effects. However, upon extended exposure to ritonavir, CYP3A induction offsets this inhibition. This interaction will require a dose-adjustment or discontinuation of alprazolam.
- The anticholinergic effects of other drugs, including atropine and similar drugs, antihistamines and antidepressants, may be potentiated when taken in conjunction with benzodiazepines.
- Interactions have been reported between some benzodiazepines and anticonvulsants, with changes in the serum concentration of the benzodiazepine or the anticonvulsant. It is recommended that patients be observed for altered responses when benzodiazepines and anticonvulsants are prescribed together, and that serum level monitoring of the anticonvulsant be performed more frequently.
- Minor EEG changes, usually low voltage fast activity, of no known clinical significance, have been reported with benzodiazepine administration.
- The steady-state plasma concentrations of imipramine and desipramine have been reported to increase by an average of 31 and 20%, respectively, when alprazolam was given in doses up to 4 mg/day concomitantly. The clinical significance of these changes is unknown.
- Alprazolam causes a small decrease (7%) in lithium clearance. Caution should be exercised with close monitoring of lithium concentrations to avoid toxicity.
- Oral contraceptives may increase the elimination half-life of alprazolam. A 20% increase in the alprazolam steady-state plasma concentration may be expected in women taking alprazolam and oral contraceptives concurrently.
- Pharmacokinetic interactions of benzodiazepines with other drugs have been reported. Clearance of alprazolam and certain other benzodiazepines can be delayed by the co-administration of cimetidine or macrolide antibiotics. The clinical significance of this is unclear.

Overdosage

Symptoms

Symptoms of overdosage with alprazolam are extensions of its pharmacological actions including central nervous system depression ranging from drowsiness to coma. In mild cases, symptoms include drowsiness, mental confusion, slurred speech and lethargy. In more serious cases, symptoms may include ataxia,

hypotonia, hypotension, respiratory depression, coma and, very rarely, death. Serious sequelae occur when alprazolam is taken with other drugs and/or ethanol is concomitantly ingested.

Treatment

In management of overdose, it should be borne in mind that multiple agents may have been taken. Following overdose with alprazolam, activated charcoal should be given to reduce absorption. Hypotension and respiratory depression should be managed according to general supportive procedures.

Haemoperfusion, forced diuresis and haemodialysis are generally not useful in benzodiazepine intoxication. The benzodiazepine antagonist flumazenil may be useful in hospitalised patients for the reversal of acute benzodiazepine effects on the respiratory and cardiovascular systems. Consult the flumazenil data sheet prior to use.

Experiments in animals have indicated that cardiopulmonary collapse can occur following massive intravenous doses of alprazolam (over 195 mg/kg; 975 times the maximum recommended daily dose of 10 mg/day). Animals could be resuscitated with positive mechanical ventilation and the intravenous infusion of noradrenaline.

Pharmaceutical Precautions

Storage

Blisters: store below 25°C in a cool dry place and protect from light

Bottles: store below 30°C in a cool dry place and protect from light

Shelf-life

Blisters: 3 years for 0.25 mg, 0.5 mg and 1 mg tablets

Bottles: 18 months for 0.25 mg, 0.5 mg and 1 mg tablets; 3 years for 2 mg tablets

Medicine Classification

Controlled Drug C5

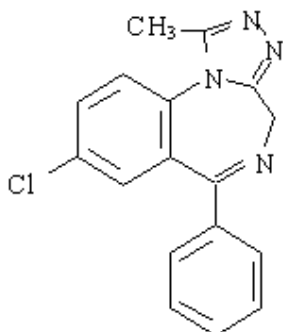
Package Quantities

Arrow - Alprazolam 0.25 mg, 0.5 mg and 1 mg tablets are available in both blister packs and bottles of 50 tablets.

Arrow - Alprazolam 2 mg tablets are available in bottles of 50 tablets.

Further Information

Arrow - Alprazolam contains alprazolam, which is a white crystalline powder soluble in methanol or ethanol, but has no appreciable solubility in water. The chemical name for alprazolam is 8-chloro-1-methyl-6-phenyl-4*H*-s-triazolo (4,3- α)(1,4)-benzodiazepine. Its structural formula is:



$C_{17}H_{13}ClN_4$

Molecular weight: 308.76

CAS: 28981-97-7

The excipients in Arrow - Alprazolam tablets are lactose, microcrystalline cellulose, maize starch, sodium benzoate, docusate sodium, povidone, colloidal anhydrous silica, sodium starch glycollate and magnesium stearate. Arrow - Alprazolam 0.5 mg tablets also contain Pigment Blend Purple PB20026 and Arrow - Alprazolam 1 mg tablets also contain Indigo Carmine CI73015. The tablets are gluten free.

Name and Address

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