

# DATA SHEET

## **LOPRESOR<sup>®</sup>** **SLOW LOPRESOR<sup>®</sup>** **Metoprolol tartrate** **50 mg, 100 mg or 200 mg Tablets**

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### **Qualitative and quantitative composition**

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The active ingredient is Di-[(±)-1-(isopropylamino)-3-[p-(2-methoxyethyl)phenoxy]-2-propanol] L(+)-tartrate (metoprolol tartrate).

Metoprolol is an aryloxypropanolamine derivative.

#### **Lopresor Tablet 50mg**

Pink heart shaped film-coated tablet with slightly convex faces.  
Imprints: CIBA on one side and HM on other side

#### **Lopresor Tablet 100mg**

Light blue, heart shaped, film-coated tablet with slightly convex faces.  
Imprints: CIBA on one side and I/P with score on other side

#### **Slow-Lopresor Tablet 200mg**

Light yellow, capsule shaped, film-coated tablet with convex faces, slightly bevelled edges, and a deep breaking score on both sides.  
Imprints: CG/CG on one side and CDC/CDC on other side.

One tablet contains 50 mg, 100 mg or 200 mg metoprolol tartrate.

For a full list of excipients, see List of excipients.

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### **Pharmaceutical form**

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#### **Lopresor<sup>®</sup>**

Tablets of 50 mg and 100 mg

#### **Slow Lopresor<sup>®</sup>**

Divitabs (fractionable sustained-release tablets) of 200 mg

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### **Clinical particulars**

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#### ***Therapeutic indications***

Disturbances of cardiac rhythm, including supraventricular and ventricular arrhythmias.

Hypertension: as monotherapy or for use in combination with other antihypertensives, for example, a diuretic, peripheral vasodilator or angiotensin converting-enzyme (ACE) inhibitor.

Angina pectoris: For long-term prophylaxis. Nitroglycerin should be used, if necessary, for alleviating acute attacks.

Hyperthyroidism (as adjunctive medication).

Functional heart disorders with palpitation.

Prevention of migraine.

### ***Dosage and method of administration***

For oral treatment, the tablets should be swallowed unchewed.

It is advisable to individualise the dosage. The following dosage recommendations may be taken as a guide:

#### **Disturbances of cardiac rhythm**

Tablets: 100 to 150 mg, given in 2 or 3 divided doses; if necessary, the daily dose can be increased to 300 mg.

#### **Hypertension**

100 to 200 mg daily, given either as a single dose in the morning or as 2 divided doses (morning and evening). If necessary, another antihypertensive can be prescribed in addition (see Therapeutic indications).

Divitabs (fractionable sustained-release tablets): 1 of the Divitabs early in the morning. If necessary, another antihypertensive can be prescribed in addition. In mild hypertension, ½ of one of the Divitabs taken early in the morning may suffice.

#### **Angina pectoris**

100 to 200 mg daily, given in 2 divided doses; if necessary, the daily dose can be increased to 400 mg.

Divitabs: ½ or 1 of the Divitabs early in the morning; if necessary, this dose can be repeated in the evening.

#### **Hyperthyroidism**

150 to 200 mg (may be increased up to 400 mg) daily, given in 3 or 4 divided doses.

#### **Functional heart disorders with palpitation; prevention of migraine**

100 mg daily, given as a single dose in the morning; if necessary, the daily dose can be increased to 200 mg, given in 2 divided doses (morning and evening).

Divitabs: ½ of one of the Divitabs daily, given in the morning; if necessary, the daily dosage can be raised to 1 of the Divitabs, to be taken also as a single dose in the morning.

#### **Children**

The safety and efficacy of Lopresor and Slow Lopresor in children have not been established.

## **Contraindications**

Known hypersensitivity to metoprolol and related derivatives, or to any of the excipients; hypersensitivity to other beta-blockers (cross-sensitivity between beta-blockers can occur).

- Atrioventricular block of second or third degree.
- Decompensated heart failure.
- Clinically relevant sinus bradycardia (heart rate less than 45 to 50 beats/min).
- Sick-sinus syndrome .
- Severe peripheral arterial circulatory disorders.
- Cardiogenic shock.
- Untreated phaeochromocytoma (see Special warnings and precautions for use).
- Hypotension.
- For oral use: severe bronchial asthma or history of severe bronchospasm.

Use of Lopresor is contraindicated in patients with myocardial infarction who have a heart rate of less than 45 to 50 beats/min, P-R interval of greater than 0.24 sec, a systolic blood pressure of less than 100 mmHg, and/or severe heart failure.

## **Special warnings and precautions for use**

In general, patients with bronchospastic diseases should not be given beta-blockers, including Lopresor. However, because of its relative cardioselectivity, oral Lopresor may be administered with caution to patients with mild or moderate bronchospastic diseases who do not respond to, or cannot tolerate, other suitable treatments. Since beta<sub>1</sub>-selectivity is not absolute, a beta<sub>2</sub>-agonist should be administered concomitantly, and the lowest possible dose of Lopresor should be used.

Lopresor should be used with caution in patients with diabetes mellitus, especially those who are receiving insulin or oral hypoglycaemic agents (see Interaction with other medicinal products and other forms of interaction). Diabetic patients should be warned that beta-blockers, including Lopresor, may mask the tachycardia occurring with hypoglycaemia; however, other manifestations of hypoglycaemia such as dizziness and sweating may not be significantly suppressed, and sweating may be increased.

Beta-blockers, including Lopresor, should not be used in patients with untreated congestive heart failure (see Contraindications). This condition should first be stabilised.

Because of their negative effect on atrioventricular conduction, beta-blockers, including Lopresor, should be given only with caution to patients with first degree atrioventricular block (see Contraindications).

If the patient develops increasing bradycardia (heart rate less than 50 to 55 beats/min), the dosage should be gradually reduced, or treatment gradually withdrawn (see Contraindications).

Lopresor should be used with caution in patients with peripheral arterial circulatory disorders (for example, Raynaud's disease or phenomenon, intermittent claudication), because beta-blocker treatment may aggravate such conditions (see Contraindications).

In patients known to have, or suspected of having, a phaeochromocytoma, Lopresor should always be given in combination with an alpha-blocker (see Contraindications).

Metoprolol undergoes substantial hepatic first-pass metabolism, and is mainly eliminated by means of hepatic metabolism (see Pharmacokinetic properties). Therefore, liver cirrhosis may increase the systemic bioavailability of metoprolol and reduce its total clearance, leading to increased plasma concentrations.

Elderly patients should be treated cautiously. An excessive decrease in blood pressure or pulse rate may reduce the blood supply to vital organs to inadequate levels.

The necessity, or desirability, of withdrawing beta-blocking agents, including Lopresor, prior to major surgery is controversial. The impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures. The benefits of continuing a treatment with a beta-blocker, including Lopresor, should be balanced against the risk of withdrawing it in each patient. If a patient being treated with Lopresor needs general anaesthesia, the anaesthetist should be informed that the patient is receiving a beta-blocker. An anaesthetic agent with as little cardiodepressant effect as possible should be used (see Interaction with other medicinal products and other forms of interaction) . If it is thought necessary to withdraw beta-blocker, including Lopresor, therapy before surgery, this should be done gradually and completed about 48 hours before the general anaesthetic.

Lopresor treatment should not be stopped suddenly, especially in patients with ischaemic heart disease. To prevent exacerbation of angina pectoris, the dosage should be gradually reduced over 1 to 3 weeks and, if necessary, replacement therapy should be initiated at the same time.

Anaphylactic reactions precipitated by other agents may be particularly severe in patients taking beta-blockers, and may be resistant to normal doses of adrenaline. Whenever possible, beta-blockers, including Lopresor, should be avoided for patients who are at increased risk of anaphylaxis.

Beta-blockers may increase the number and duration of angina attacks in patients with Prinzmetal's angina (variant angina pectoris). Relatively selective beta<sub>1</sub>-receptor blockers, such as Lopresor, can be used in such patients, but only with the utmost care.

Beta-blockers mask some of the clinical signs of thyrotoxicosis. Therefore, where Lopresor is administered to patients having, or suspected of developing, thyrotoxicosis, both thyroid and cardiac function should be monitored closely.

The full oculomucocutaneous syndrome, as described elsewhere with practolol, has not been reported with Lopresor. However, part of this syndrome (dry eyes either alone or, occasionally, with skin rashes) has occurred. In most cases the symptoms cleared when Lopresor treatment was withdrawn. Patients should be observed carefully for potential ocular effects. If such effects occur, discontinuation of Lopresor should be considered.

## ***Interaction with other medicinal products and other forms of interaction***

### **Effect of other medicinal products on metoprolol**

The effects of Lopresor or Slow Lopresor and other antihypertensive drugs on blood pressure are usually additive. Patients receiving concurrent treatment with catecholamine depleting drugs, other beta-blockers (including those in form of eye drops), or monoamine oxidase (MAO) inhibitors, should be carefully monitored.

## **The following medicinal products may increase the effect or plasma concentrations of metoprolol**

### **Calcium channel blockers**

Calcium channel blockers such as verapamil and diltiazem may potentiate the depressant effects of beta-blockers on blood pressure, heart rate, cardiac contractility and atrioventricular conduction. A calcium channel blocker of the verapamil (phenylalkylamine) type should not be given intravenously to patients receiving Lopresor because there is a risk of cardiac arrest in this situation. Patients taking an oral calcium channel blocker of the verapamil type in combination with Lopresor should be closely monitored.

### **Class I anti-arrhythmic drugs and amiodarone**

Amiodarone, propafenone, and other class I anti-arrhythmic agents such as quinidine and disopyramide may potentiate the effects of beta-blockers on heart rate and atrioventricular conduction.

### **Nitroglycerin**

Nitroglycerin may enhance the hypotensive effect of Lopresor.

### **General anaesthetics**

Some inhalation anaesthetics may enhance the cardiodepressant effect of beta-blockers (see Special warnings and precautions for use).

### **CYP2D6 inhibitors**

Potent inhibitors of this enzyme may increase the plasma concentration of metoprolol. Strong inhibition of CYP2D6 would result in the change of phenotype into poor metabolizer (phenocopying, see Pharmacokinetic properties). Caution should therefore be exercised when co-administering potent CYP2D6 inhibitors with metoprolol. Known clinically significant potent inhibitors of CYP2D6 are antidepressants such as fluoxetine, paroxetine or bupropion, antipsychotics such as thioridazine, antiarrhythmics such as quinidine or propafenone, antiretrovirals such as ritonavir, antihistamines such as diphenhydramine, antimalarials such as hydroxychloroquine or quinidine, antifungals such as terbinafine and medications for stomach ulcers such as cimetidine.

## **The following medicinal products may decrease the effect or plasma concentration of metoprolol**

### **Prazosin**

The acute postural hypotension that can follow the first dose of prazosin may be increased in patients already taking a beta-blocker.

### **Digitalis glycosides**

Concurrent use of digitalis glycosides may result in excessive bradycardia and/or increase in atrioventricular conduction time.

### **Sympathomimetics**

Adrenaline or other sympathomimetic agents (for example, in antitussives or nose and eye drops) may provoke hypertensive reactions when used concomitantly with beta-blockers; however, this is less likely with therapeutic doses of beta<sub>1</sub>-selective drugs than with non-selective beta-blockers.

### **Non-steroidal anti-inflammatory drugs**

Concurrent treatment with non-steroidal anti-inflammatory drugs such as indomethacin may decrease the antihypertensive effect of metoprolol.

### **Hepatic enzyme inducers**

Enzyme-inducing drugs may affect plasma concentrations of metoprolol. For example, the plasma concentration of metoprolol is lowered by rifampicin.

## Effect of metoprolol on other medicinal products

### Clonidine

If a patient is treated with clonidine and Lopresor concurrently, and clonidine treatment is to be discontinued, Lopresor should be stopped several days before clonidine is withdrawn. This is because the hypertension that can follow withdrawal of clonidine may be increased in patients receiving concurrent beta-blocker treatment.

### Insulin and oral hypoglycaemic drugs

In diabetic patients who use insulin, beta-blocker treatment may be associated with increased or prolonged hypoglycaemia. Beta-blockers may also antagonise the hypoglycaemic effects of sulfonylureas. The risk of either effect is less with a beta<sub>1</sub>-selective drug such as Lopresor than with a non-selective beta-blocker. However, diabetic patients receiving Lopresor should be monitored to ensure that diabetes control is maintained (see also Special warnings and precautions for use).

### Lidocaine (xylocaine)

Metoprolol may reduce the clearance of lidocaine, leading to increased lidocaine effects.

### Alcohol

Metoprolol may modify the pharmacokinetic parameters of alcohol.

## *Pregnancy and lactation*

### Pregnancy

In general, no drug should be taken during the first 3 months of pregnancy, and the relative benefits and risks of treatment should be carefully considered throughout pregnancy.

Experience with metoprolol in the first trimester of pregnancy is limited, but no fetal malformations attributable to metoprolol have been reported. However, beta-blockers may reduce placental perfusion. The lowest possible dose should be used, and treatment should be discontinued at least 2 to 3 days before delivery to avoid increased uterine contractility and effects of beta-blockade in the newborn baby (for example, bradycardia, hypoglycaemia).

### Lactation

Small quantities of metoprolol are secreted into breast milk: with therapeutic doses, an infant consuming 1 L of breast milk daily would receive a dose of less than 1 mg of metoprolol. Nevertheless, breast-fed infants should be closely observed for signs of beta-blockade.

## *Effects on ability to drive and use machines*

Lopresor may cause dizziness, fatigue or visual disturbances (see Adverse effects), and therefore may adversely affect the patient's ability to drive or use machines.

## *Adverse effects*

Frequency estimates: very common  $\geq 10\%$ ; common  $\geq 1\%$  and  $< 10\%$ ; uncommon  $\geq 0.1\%$  and  $< 1\%$ ; rare  $\geq 0.01\%$  and  $< 0.1\%$ ; very rare  $< 0.01\%$ .

Blood and the lymphatic system disorders	
Very rare	thrombocytopenia

**Psychiatric disorders**

Rare depression, nightmares

Very rare personality disorder, hallucinations

**Nervous system disorders**

Common dizziness, headache

Rare alertness decreased , somnolence or insomnia, paraesthesia

**Eye disorders**

Very rare visual disturbance (e.g. blurred vision), dry eyes and/or eye irritation

**Ear and labyrinth disorders**

Very rare tinnitus, and, in doses exceeding those recommended, hearing disorders (e.g. hypoacusis or deafness)

**Cardiac disorders**

Common bradycardia

Rare heart failure, cardiac arrhythmias, palpitation

Very rare cardiac conduction disorders, precordial pain

**Vascular disorders**

Common orthostatic hypotension (occasionally with syncope)

Rare oedema, Raynaud's phenomenon

Very rare gangrene in patients with pre-existing severe peripheral circulatory disorders

**Respiratory, thoracic and mediastinal disorders**

Common exertional dyspnoea

Rare bronchospasm (which may occur in patients without a history of obstructive lung disease)

Very rare rhinitis

**Gastrointestinal disorders**

Common nausea and vomiting, abdominal pain

Rare diarrhoea or constipation

Very rare dry mouth, retroperitoneal fibrosis (relationship to Lopresor has not been definitely established).

<b>Hepatobiliary disorders</b>	
Very rare	Hepatitis
<b>Skin and subcutaneous tissue disorders</b>	
Rare	skin rash (in the form of urticaria, psoriasiform and dystrophic skin lesions)
Very rare	photosensitivity, hyperhidrosis, alopecia, worsening of psoriasis.
<b>Musculoskeletal, connective tissue disorders</b>	
Rare	muscle cramps
Very rare	arthritis,
<b>Reproductive system and breast disorders</b>	
Very rare	disturbances of libido and potency, Peyronie's disease (relationship to Lopresor has not been definitely established)
<b>General disorders and administration site conditions</b>	
Common	Fatigue
Investigations	
Very rare	Weight increase, liver function test abnormal

## Post Marketing Experience

The following adverse reactions have been reported during post-approval use of Lopresor: Confusional state, an increase in blood triglycerides and a decrease in High Density Lipoprotein (HDL). Because these reports are from a population of uncertain size and are subject to confounding factors, it is not possible to reliably estimate their frequency.

## Overdose

### Signs and symptoms

Poisoning due to an overdose of Lopresor may lead to severe hypotension, sinus bradycardia, atrioventricular block, heart failure, cardiogenic shock, cardiac arrest, bronchospasm, impairment of consciousness (or even coma), convulsions, nausea, vomiting, and cyanosis.

Concomitant ingestion of alcohol, antihypertensives, quinidine, or barbiturates aggravates the signs and symptoms.

The first manifestations of overdose appear 20 minutes to 2 hours after ingestion of Lopresor. The effects of massive overdose may persist for several days, despite declining plasma concentrations.

## Treatment

Patients should be admitted to hospital and, generally, should be managed in an intensive care setting, with continuous monitoring of cardiac function, blood gases, and blood biochemistry. Emergency supportive measures such as artificial ventilation or cardiac pacing should be instituted if appropriate. Even apparently well patients who have taken a small overdose should be closely observed for signs of poisoning for at least 4 hours.

In the event of a potentially life-threatening oral overdose, use induction of vomiting or gastric lavage (if within 4 hours after ingestion of Lopresor) and/or activated charcoal to remove the drug from the gastrointestinal tract. Haemodialysis is unlikely to make a useful contribution to metoprolol elimination.

Atropine may be given intravenously to control significant bradycardia. Intravenous beta-agonists such as prenalterol or isoprenaline should be used to treat bradycardia and hypotension; very high doses may be needed to overcome the beta-blockade. Dopamine, dobutamine or noradrenaline may be given to maintain blood pressure. Glucagon has positive inotropic and chronotropic effects on the heart that are independent of beta-adrenergic receptors, and has proved effective in the treatment of resistant hypotension and heart failure associated with beta-blocker overdose.

Diazepam is the drug of choice for controlling seizures. A beta-agonist or aminophylline can be used to reverse bronchospasm; patients should be monitored for evidence of cardiac arrhythmias during and after administration of the bronchodilator.

The beta-blocker withdrawal phenomenon (see Special warnings and precautions for use) may occur after overdose.

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## Pharmacological properties

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### *Pharmacodynamic properties*

#### **Pharmacotherapeutic group**

Pharmacotherapeutic group: Cardioselective beta-blocker, ATC code: C07A B02

#### **Pharmacodynamic effects and mechanism of action**

Metoprolol is a cardioselective beta-blocker; that is, it blocks beta<sub>1</sub>-adrenergic receptors (which are mainly located in the heart) at lower doses than those needed to block beta<sub>2</sub>-receptors, which are mainly located in the bronchi and peripheral vessels. It has no membrane-stabilising effect nor partial agonist (intrinsic sympathomimetic) activity.

The stimulant effect of catecholamines on the heart is reduced or inhibited by metoprolol. This leads to a decrease in heart rate, cardiac contractility, and cardiac output.

Metoprolol lowers elevated blood pressure in the standing and lying position. It also reduces the rise in blood pressure occurring in response to exercise. Treatment results in an initial increase in peripheral vascular resistance, which during long-term administration is normalised or, in some cases, reduced. As with all beta-blockers, the precise mechanism of the antihypertensive effect of metoprolol is not fully understood. However, the long-term reduction blood pressure seen with metoprolol appears to parallel this gradual decrease in total peripheral resistance.

In patients with angina pectoris, metoprolol reduces the frequency and severity of ischaemic episodes and increases physical working capacity. These beneficial effects may be due to

decreased myocardial oxygen demand as a result of the reduced heart rate and myocardial contractility.

In patients with supraventricular tachycardia, atrial fibrillation, or ventricular extrasystoles or other ventricular arrhythmias, metoprolol has a regulating effect on the heart rate. Its anti-arrhythmic action is due primarily to inhibition of the automaticity of pacemaker cells and to prolongation of atrioventricular conduction.

In patients with a suspected or confirmed myocardial infarction, metoprolol lowers mortality. This effect may possibly be attributable to a decrease in the incidence of severe ventricular arrhythmias, as well as to limitation of infarct size. Metoprolol has also been shown to reduce the incidence of non-fatal myocardial reinfarction.

Through its beta-blocking effect, metoprolol is suitable for the treatment of functional heart disorders with palpitation, for the prevention of migraine, and adjunctive treatment of hyperthyroidism.

Long-term treatment with metoprolol may reduce insulin sensitivity. However, metoprolol interferes with insulin release and carbohydrate metabolism less than non-selective beta-blockers.

In short-term studies it has been shown that metoprolol may alter the blood lipid profile. It may cause an increase in triglycerides and a decrease in free fatty acids; in some cases, a small decrease in the high-density lipoprotein (HDL) fraction has been observed, although to a lesser extent than with non-selective beta-blockers. In one long-term study lasting several years, cholesterol levels were found to be reduced.

## ***Pharmacokinetic properties***

### **Absorption**

Metoprolol is absorbed from all parts of the intestine. After dosing with the conventional tablets, absorption is rapid and complete. With Slow Lopresor tablets, absorption is slower, but the availability of metoprolol is similar compared with conventional tablets. Peak plasma concentrations are attained after approximately 1.5 to 2 hours with conventional metoprolol tablets, and after approximately 4 to 5 hours with sustained-release tablets. Plasma concentrations of metoprolol increase approximately in proportion with the dose in the 50-mg to 200-mg dose range. Owing to extensive hepatic first-pass metabolism, approximately 50% of a single oral dose of metoprolol reaches the systemic circulation. The extent of presystemic elimination differs between individuals because of genetic differences in oxidative metabolism. Although the plasma profiles exhibit wide intersubject variability, they are reproducible within an individual. Upon repeated administration, the percentage of the dose systemically available is approximately 40% higher than after a single dose (that is, approximately 70%). This may be due to partial saturation of the first-pass metabolism, or reduced clearance as a result of reduced hepatic blood flow. Ingestion with food may increase the systemic availability of a single oral dose by approximately 20% to 40%.

### **Distribution**

Metoprolol is rapidly distributed, with a reported volume of distribution of 3.2 to 5.6 L/kg. The half-life is not dose-dependent and does not change on repeated dosing. Approximately 10% of metoprolol in plasma is protein bound. Metoprolol crosses the placenta, and is found in breast milk (see Pregnancy and lactation). In patients with hypertension, metoprolol concentrations in cerebrospinal fluid are similar to those in plasma.

### **Biotransformation**

Metoprolol is extensively metabolised by enzymes of the cytochrome P450 system in the liver. The oxidative metabolism of metoprolol is under genetic control with a major contribution

of the polymorphic cytochrome P450 isoform 2D6 (CYP2D6). There are marked ethnic differences in the prevalence of the poor metabolizers (PM) phenotype. Approximately 7% of Caucasians and less than 1% Orientals are PMs.

CYP2D6 poor metabolisers exhibit several-fold higher plasma concentrations of metoprolol than extensive metabolisers with normal CYP2D6 activity. However, the cytochrome P450 2D6 dependent metabolism of metoprolol seems to have little or no effect on safety or tolerability of the drug. None of the metabolites of metoprolol contribute significantly to its beta-blocking effect.

## **Elimination**

The average elimination half-life of metoprolol is 3 to 4 hours; in poor metabolisers the half-life may be 7 to 9 hours. Approximately 95% of the dose can be recovered in urine. In most subjects (extensive metabolisers), less than 5% of an oral dose, and less than 10% of an intravenous dose, is excreted as unchanged drug. In poor metabolisers, up to 30% or 40% of oral or intravenous doses, respectively, may be excreted unchanged.

## **Characteristics in patients**

Elderly subjects show no significant changes in the plasma concentrations of metoprolol as compared with young persons.

Impaired renal function has no influence on the bioavailability of metoprolol or on its elimination. The excretion of metabolites, however, is reduced. Significant accumulation of metabolites will occur only in patients with a creatinine clearance of approximately 5 mL/min or less, and this accumulation would not influence the beta-blocking properties of metoprolol.

Liver cirrhosis may increase the bioavailability of unchanged metoprolol and reduce its total clearance.

Inflammatory disease has no effect on the pharmacokinetics of metoprolol. Hyperthyroidism may increase the presystemic clearance of metoprolol.

## ***Preclinical safety data***

### **Reproductive toxicity**

Reproduction toxicity studies in mice, rats and rabbits did not indicate teratogenic potential for metoprolol tartrate. High doses were associated with some maternal toxicity, and growth delay of the offspring both in utero and after birth. There was no evidence of impaired fertility in rats at oral doses up to 500 mg/kg.

### **Mutagenicity**

Metoprolol tartrate was devoid of mutagenic/genotoxic potential in the bacterial cell system (Ames) test and in vivo assays involving mammalian somatic cells or germinal cells of male mice.

### **Carcinogenicity**

Metoprolol tartrate was not carcinogenic in mice and rats after oral administration of doses up to 800 mg/kg for 21 to 24 months.

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## Pharmaceutical particulars

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### **List of excipients**

#### **Lopresor**

*Tablets of 50 mg:* Silica aerogel, cellulose, lactose, magnesium stearate, polyvinylpyrrolidone, sodium carboxymethyl starch, hydroxypropyl methylcellulose, red iron oxide (E 172), polysorbate 80, talc, titanium dioxide (E 171).

*Tablets of 100 mg:* Silica aerogel, cellulose, magnesium stearate, sodium carboxymethyl starch, hydroxypropyl methylcellulose, glyceryl polyethylene glycol oxystearate, talc, titanium dioxide (E 171).

#### **Slow Lopresor**

Divitabs (divisible sustained-release tablets) of 200 mg: Silica aerogel, cellulose, dibasic calcium phosphate, copolymer based on polyacrylic/methacrylic esters, magnesium stearate, hydroxypropyl methylcellulose, glycol palmitostearate, yellow iron oxide (E 172), polysorbate 80, talc, titanium dioxide (E 171).

### **Incompatibilities**

Not applicable

### **Shelf life**

#### **Lopresor**

Tablets of 50 mg and 100 mg: 5 years

#### **Slow Lopresor**

Divitabs of 200 mg: 5 years

### **Special precautions for storage**

#### **Lopresor**

Tablets of 50 mg: Protect from moisture and heat (store below 30°C).

Tablets of 100 mg: Protect from moisture (store below 30°C).

### **Nature and contents of container**

Lopresor 50mg:	bottles containing 100 tablets
Lopresor 100mg:	bottles containing 60 tablets
Slow Lopresor 200mg:	blisters containing 28 tablets

### **Instructions for use and handling**

Lopresor and Slow Lopresor should be kept out of the reach and sight of children.

***Medicine classification***

Prescription Medicine

***Name and address***

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