NEW ZEALAND DATA SHEET

ELIDEL®

1. Product Name

Elidel 1% w/w (10 mg/g) topical cream

2. Qualitative and Quantitative Composition

1 g of cream contains 10 mg of pimecrolimus.

For the full list of excipients, see section 6.1.

3. Pharmaceutical Form

Cream for cutaneous use.

The cream is whitish, odourless, non-staining, and easily spreadable.

4. Clinical Particulars

4.1 Therapeutic Indications

Treatment of patients 3 months of age and older with atopic dermatitis (eczema) for the:

- short-term treatment of signs and symptoms; and
- intermittent long-term treatment of emerging and resolving lesions in atopic dermatitis, where topical corticosteroids are ineffective, intolerable or inappropriate.

4.2 Dose and method of administration

Dose

Apply a thin layer of Elidel cream to the affected skin twice daily and rub in gently and completely.

Emollients are considered maintenance therapy for patients with atopic dermatitis (eczema).

In the intermittent long-term management of atopic dermatitis (eczema), Elidel cream treatment should begin at first appearance of signs and symptoms of atopic dermatitis to prevent flares of the disease. Elidel cream should be used twice daily until signs and symptoms resolve.

In general, the duration of treatment with Elidel cream for each eczema episode should not exceed 6 weeks (also see 'Use in paediatric patients'). If signs and symptoms persist beyond 6 weeks, or the condition worsens, Elidel cream should be stopped and patients should be re-examined to confirm the diagnosis of atopic dermatitis, Treatment should be discontinued when there is no longer evidence of the disease apart from dry skin. Treatment can be resumed upon first recurrence of signs and symptoms to prevent flares of the disease.

If the patient is not well controlled on Elidel cream and emollients alone, a short course of a topical mid-potency corticosteroid can be used. Once the flare is under control, the patient can resume using Elidel cream and emollients as outlined below.

Long-term continuous use of Elidel cream is not recommended. Therapy should be intermittent, in conjunction with other therapies.

Method of Administration

Elidel cream may be used on all skin areas, including the head and face, neck and intertriginous areas except on mucous membranes. Elidel cream should not be applied under occlusive dressings.

Emollients can be applied immediately after using Elidel cream. However, after a bath/shower, emollients should be applied before using Elidel cream.

Special Populations

Use in paediatric patients

For infants (3 to 23 months), children (2 to 11 years) and adolescents (12 to 17 years) the posology and method of administration are the same as for adults.

Use in babies under 3 months of age has not been evaluated.

Use in the elderly

Atopic dermatitis (eczema) is rarely observed in patients aged 65 and over. Clinical studies with Elidel cream did not include a sufficient number of patients in this age range to determine whether they respond differently from younger patients.

4.3 Contraindications

Known hypersensitivity to pimecrolimus, other macrolactams or to any of the excipients listed in section 6.1.

4.4 Special warnings and precautions for use

Long-term safety of Elidel cream has not been established.

Pimecrolimus is a calcineurin inhibitor. In transplant patients, prolonged systemic exposure to intense immunosuppression from systemic administration of calcineurin inhibitors has been associated with an increased risk of developing lymphomas and skin malignancies.

However, patients with atopic dermatitis treated with Elidel have not been found to have significant systemic pimecrolimus levels (see section 5.2). In patients treated with topical calcineurin inhibitors including Elidel, although a causal relationship has not been established, rare cases of malignancy (e.g. skin and lymphoma) have been reported.

Elidel cream should not be applied to potentially malignant or pre-malignant skin lesions.

Elidel cream should not be applied to areas affected by cutaneous pre-malignant or potentially malignant changes (e.g. actinic keratoses) as caused, for example, by excessive sun exposure or phototherapy, or to areas where skin cancers have been removed.

The safety of Elidel cream has not been established in patients with Netherton's syndrome and generalised erythroderma. Elidel cream is not recommended in patients with Netherton's syndrome or severely inflamed or damaged skin (e.g. erythroderma) where there is a potential for increased absorption.

The safety and efficacy of Elidel cream in immunocompromised patients have not been studied. The use in immunocompromised patients is therefore not recommended.

The results of the 8 epidemiology studies do not suggest an increased risk of cancer such as lymphoma or skin cancer in association with exposure to topical pimecrolimus, in any population. Furthermore, the ongoing PEER observational registry study has not provided any evidence for an increased systemic malignancy risk (e.g. lymphoma or skin cancer) with pimecrolimus.

In clinical studies, 14/1,544 (0.9%) cases of lymphadenopathy were reported while using Elidel cream. These cases of lymphadenopathy were usually related to infections and noted to resolve upon appropriate antibiotic therapy. Of these 14 cases, the majority had either a clear etiology or were known to resolve. Patients who receive Elidel cream and who develop lymphadenopathy should have the etiology of their lymphadenopathy investigated. In the absence of a clear etiology for the lymphadenopathy, or in the presence of acute infectious mononucleosis, Elidel cream should be discontinued. Patients who develop lymphadenopathy should be monitored to ensure that the lymphadenopathy resolves.

Patients with atopic dermatitis are predisposed to superficial skin infections including eczema herpeticum (Kaposi's varicelliform eruption). Elidel cream should not be applied to areas affected by acute cutaneous viral infections (e.g. herpes simplex, chicken pox).

Treatment with Elidel may be associated with an increased risk of eczema herpeticum, herpes simplex virus infection or skin bacterial infections (impetigo).

In the presence of a dermatological bacterial or fungal infection, the use of an appropriate antimicrobial agent should be instituted. If resolution of the infection does not occur, Elidel cream should be discontinued until the infection has been adequately controlled.

In the presence of viral infection, discontinuation of treatment with Elidel at the site of infection until the viral infection has cleared should be considered.

Use of Elidel cream may cause mild and transient reactions at the site of application, such as a feeling of warmth and/or burning sensation. If the application site reaction is severe, the benefit-risk of treatment should be re-evaluated. In rare cases, application site reactions can be severe. Elidel should not be used on broken skin.

Pimecrolimus per se was neither phototoxic nor photocarcinogenic in animal studies, but the cream base was found to slightly enhance the development of skin tumours induced by UV radiation in hairless mice. Care should be taken to avoid exposure of skin areas treated with Elidel cream to natural or artificial sunlight (see section 4.8 Post-marketing data). Patients should be advised to wear protective clothing, hats and low irritant sunscreens when Elidel is used. Elidel is to be applied first.

Elidel should not be used in patients who are receiving phototherapy.

Care should be taken to avoid contact with eyes and mucous membranes. If accidentally applied to these areas, the cream should be thoroughly wiped off and rinsed off with water.

Occlusive dressings are not recommended as the use of Elidel under occlusion has not been studied in patients.

Elidel cream contains cetyl alcohol and stearyl alcohol which may cause local skin reactions (e.g. contact dermatitis) and benzyl alcohol, which may cause allergic reactions and mild local irritation. Elidel cream also contains propylene glycol, which may cause skin irritation.

4.5 Interaction with other medicines and other forms of interaction

Potential interactions between Elidel cream and other medicinal products have not been systematically evaluated. Pimecrolimus is exclusively metabolised by CYP450 3A4. Based on its minimal extent of absorption, interactions of Elidel cream with systemically administered medicinal products are unlikely to occur (see section 5.2).

The present data indicate that Elidel cream can be used simultaneously with antibiotics, antihistamines and corticosteroids (oral/nasal/inhaled).

Due to the minimal absorption of Elidel cream, a potential systemic interaction with vaccination is unlikely to occur. In patients with extensive disease, it is recommended that vaccinations should be administered during treatment-free intervals. Application of Elidel cream to vaccination sites, as long

as local reactions persist, was not studied and is therefore not recommended. In a 5-year study in infants 3 months to less than 12 months of age at enrolment with mild to moderate atopic dermatitis, patients with atopic dermatitis who were treated with Elidel cream or topical corticosteroids (TCS) displayed normal immune response maturation and developed effective immunisation against vaccine antigens (see section 5.1)

There is no experience with concomitant use of Elidel cream with immunosuppressive therapies given for atopic eczema such as UVB, UVA, PUVA, azathioprine or ciclosporin A.

Elidel has no photocarcinogenic potential in animals (see section 5.3). However, since the relevance to man is unknown excessive exposure of the skin to ultraviolet light including light from a solarium, or therapy with PUVA, UVA or UVB should be avoided during treatment with Elidel cream.

Rare cases of flushing, rash, burning, itching or swelling have been observed shortly after the intake of alcohol in patients using pimecrolimus cream (see section 4.8).

4.6 Fertility, pregnancy and lactation

Pregnancy

There are insufficient data on the use of Elidel cream in pregnant women. Animal studies using dermal application do not indicate direct or indirect harmful effects with respect to pregnancy, embryonal/foetal development. Studies in animals after oral application have shown reproductive toxicity (see section 5.3).

Based on the minimal extent of pimecrolimus absorption after topical application of Elidel cream (see section 5.2), the potential risk for humans is considered limited. However, Elidel cream should not be used during pregnancy.

Breast-feeding

Animal studies on milk excretion after topical application have not been conducted and the use of Elidel cream in breastfeeding women has not been studied. It is not known whether pimecrolimus is excreted in the milk after topical application. Caution should be exercised when Elidel cream is administered to a breast-feeding woman.

However, based on the minimal extent of pimecrolimus absorption after topical application of Elidel cream, (see section 5.2), the potential risk for humans is considered limited.

Breast-feeding mothers should not apply Elidel cream to the breast in order to avoid unintentional oral uptake by the newborn.

Fertility

There are no clinical data on the effects of pimecrolimus on male or female fertility (see section 5.3 Preclinical safety data).

4.7 Effects on ability to drive and use machines

Elidel cream has no known effect on the ability to drive and use machines.

4.8 Undesirable effects

The most common adverse events were application site reactions which were reported by approximately 19% of the patients treated with Elidel cream and 16% of patients in the control group. These reactions generally occurred early in treatment, were mild/moderate in severity and were of short duration.

Adverse reactions (Table 1) are ranked under heading of frequency, the most frequent first, using the following convention:
very common (≥ 1/10); common (≥ 1/100, < 1/10); uncommon (≥ 1/1,000, < 1/100); rare (≥ 1/10,000,

< 1/1,000); very rare (< 1/10,000); not known (frequency cannot be estimated from the available data).

Organ system	Very common	Common	Uncommon	Rare	Very rare
Infections and infestations			Molluscum contagiosum		
Immune system disorders					Anaphylactic reactions, including severe forms
Metabolism and nutrition disorders				Alcohol intolerance (in most cases, flushing, rash, burning, itching or swelling occurred shortly after the intake of alcohol)	
Skin and subcutaneous tissue disorders		Skin infections (folliculitis)	Furuncle, impetigo, herpes simplex, herpes zoster, herpes simplex dermatitis (eczema herpeticum), skin papilloma, condition aggravated	Allergic reactions (e.g. rash, urticaria, angiooedema), skin discoloration (e.g. hypopigmentation, hyperpigmentation)	
General disorders and administration site conditions	Application site burning	Application site reactions (irritations, pruritus, erythema)	Application site disorders (rash, paraesthesia, desquamation, dryness, pain, oedema)		

Post marketing: Cases of malignancy, including cutaneous (squamous cell carcinoma, basal cell carcinoma) and other types of lymphoma, and skin cancers, have been reported in patients treated with pimecrolimus cream. Cases of lymphadenopathy have been reported in post-marketing use and in clinical trials, however a causal relationship with the Elidel treatment has not been established (see section 4.4).

Reporting of suspected adverse reactions

Reporting suspected adverse reactions after authorisation of the medicine is important. It allows continued monitoring of the benefit/risk balance of the medicine. Healthcare professionals are asked to report any suspected adverse reactions https://nzphvc.otago.ac.nz/reporting/.

4.9 Overdose

There has been no experience of overdose with Elidel cream.

From the company's experience with developing orally administered pimecrolimus, the maximal systemic exposure in humans was achieved when 30 mg was administered twice daily for 4 weeks. At this dosage level, the medicine was generally well tolerated. By comparison, each gram of Elidel cream contains 10 mg pimecrolimus. The excipients used in Elidel cream are not known to be toxic via the oral route. Hence, the accidental ingestion of Elidel cream is unlikely to be a clinical concern.

For further advice on management of overdose please contact the National Poisons Information Centre (0800 POISON or 0800 764 766).

5. Pharmacological Properties

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: Other dermatological preparations; ATC code: D11AH02

Mechanism of action

Pimecrolimus is a lipophilic anti-inflammatory ascomycin macrolactam derivative and a cell selective inhibitor of the production and release of pro-inflammatory cytokines.

Pimecrolimus binds with high affinity to macrophilin-12 and inhibits the calcium-dependent phosphatase calcineurin. As a consequence, it blocks the synthesis of inflammatory cytokines in T cells.

Pimecrolimus exhibits high anti-inflammatory activity in animal models of skin inflammation after topical and systemic application. In the pig model of allergic contact dermatitis (ACD), topical pimecrolimus is as effective as potent corticosteroids. Unlike corticosteroids, pimecrolimus dose not cause skin atrophy in pigs and does not affect Langerhans´ cells in murine skin.

Pimecrolimus neither impairs the primary immune response nor affects lymph nodes in murine allergic contact dermatitis. Topical pimecrolimus penetrates similarly into, but permeates much less through human skin than corticosteroids, indicating a very low potential of pimecrolimus for systemic absorption. In conclusion, pimecrolimus has a skin-selective pharmacological profile different from corticosteroids.

Clinical efficacy and safety

The efficacy and safety profile of Elidel cream has been evaluated in more than 2000 patients including infants (≥ 3 months), children, adolescents, and adults enrolled in phase 2 and 3 studies. Over 1500 of these patients were treated with Elidel cream and over 500 were treated with control treatment i.e. either Elidel vehicle and/or topical corticosteroids.

Paediatric population

Short-term (acute) treatment in paediatric patients

Children and adolescents: Two 6-week, vehicle-controlled trials were conducted including a total of 403 paediatric patients aged 2 to 17 years. Patients were treated twice daily with Elidel cream. The data of both studies were pooled.

Infants: A similar 6-week study was conducted in 186 patients aged 3 to 23 months.

In these three 6-week studies, the efficacy results at endpoint were as follows:

		Children and adolescents			Infants		
Endpoint	**Criteria**	**Elidel 1% (N=267)**	**Vehicle (N=136)**	**p-value**	**Elidel 1% (N=123)**	**Vehicle (N=63)**	**p-value**
IGA*:	Clear or almost clear[1]	34.8%	18.4%	< 0.001	54.5%	23.8%	< 0.001
IGA*	Improvement[2]	59.9%	33%	Not done	68%	40%	Not done
Pruritus:	Absent or mild	56.6%	33.8%	< 0.001	72.4%	33.3%	< 0.001
EASI°:	Overall (mean % change)[3]	- 43.6	- 0.7	< 0.001	- 61.8	+ 7.35	< 0.001
EASI°:	Head/Neck (mean % change)[3]	- 61.1	+ 0.6	< 0.001	- 74.0	+ 31.48	< 0.001

* *Investigators Global Assessment*

° *Eczema Area Severity Index (EASI): mean % change in clinical signs (erythema, infiltration, excoriation, lichenification) and body surface area involved*

[1] *p-value based on CMH test stratified by centre*

[2] *Improvement = lower IGA than at baseline*

[3] *p-value based on ANCOVA model of EASI at Day 43 endpoint, with centre and treatment as factors and baseline (Day 1) EASI a covariate*

A significant improvement in pruritus was observed within the first week of treatment in 44% of children and adolescents and in 70% of infants.

Long-term treatment in paediatric patients

In two double-blind studies of long-term management of atopic dermatitis in 713 children and adolescents (2 to 17 years) and 251 infants (3 to 23 months), Elidel cream was evaluated as first line foundation therapy.

Elidel cream was used at first signs of itching and redness to prevent progression to flares of atopic dermatitis. Only in case of a flare of severe disease not controlled by Elidel cream, treatment with medium potency topical corticosteroids was initiated. When corticosteroid therapy was initiated for the treatment of flares, Elidel therapy was discontinued. The control group received Elidel vehicle in order to maintain blinding.

Both studies showed a significant reduction in the incidence of flares ($p < 0.001$) in favour of Elidel cream first-line treatment; Elidel cream first-line treatment showed better efficacy in all secondary assessments (Eczema Area Severity Index, IGA, subject assessment); pruritus was controlled within a week with Elidel cream. More patients treated with Elidel cream completed 6 months (children (61% Elidel cream vs 34% control); infants (70% Elidel vs 33% control) and 12 months with no flare (children 51% Elidel vs 28% control); infants (57% Elidel vs 28% control).

Elidel cream had a sparing effect on the use of topical corticosteroids: more patients treated with Elidel cream did not use corticosteroids in 12 months (children: 57% Elidel cream vs 32% control; infants: 64% Elidel cream vs 35% control). The efficacy of Elidel cream was maintained over time.

Petite Study

A 5-year, open-label, randomized, active-controlled study was conducted in 2,418 infants 3 months to less than 12 months of age at enrolment with mild to moderate atopic dermatitis (AD). The primary objective was to compare safety; the secondary objective was to document the long-term efficacy of pimecrolimus cream. Treatment success was defined as an Investigator's Global Assessment score of 0 (clear) or 1 (almost clear). Infants were randomized to Elidel (n = 1,205; with short-term TCSs for disease flares) or low/mid potency topical corticosteroids (TCS; n = 1,213).

Elidel was well tolerated in subjects with mild to moderate atopic dermatitis who were 3 to 12 months of age at the start of the study. The profile and frequency of adverse events was similar in the 2 treatment groups. No impairment of systemic immune assessments was seen, and subjects with atopic dermatitis who were treated with Elidel or topical corticosteroids (TCS) displayed normal immune response maturation and developed effective immunization against vaccine antigens.

Both Elidel and topical corticosteroids had a rapid onset of action with >50% of patients achieving treatment success by week 3. After 5 years, >85% and 95% of patients achieved overall and facial treatment success, in each group respectively. The median total body surface area (TBSA) affected at baseline was approximately 16% in both treatment groups and decreased to less than 5% by week 3. After 1.5 years, the median total body surface area affected by AD decreased to 0% and was maintained at this level until the end of the 5-year study period.

PEER Registry Data

The PEER registry is an ongoing, prospective, parent-reported 10-year observational registry to assess the risk of systemic malignancy in paediatric subjects aged 2-17 years at time of enrollment with atopic dermatitis who have used Elidel cream. Of the 8,015 enrolled subjects (3,740 male, 4,275 female), 3,675 have data out to 60 months (5 years) and 2,490 have data out to 120 months (10 years). Overall, 46,271.0 cumulative person-years have been accrued in the study as of June 2020.

The Data and Safety Monitoring Board has not reported any safety concerns and none of the data indicates that subjects enrolled in this registry study have demonstrated a safety signal with regard to increased cancer risk after having used Elidel cream.

A total of 8 epidemiological studies in UK and US databases including more than 6 million patients with AD evaluated the cancer risk including lymphoma and skin cancer associated with the use of TCIs and found no increased risk of cancer such as lymphoma or skin cancer in association with exposure to topical pimecrolimus, in any population.

Frequency of application greater than twice daily has not been studied.

Special studies

Tolerability studies demonstrated that Elidel cream does not cause contact sensitising, phototoxicity or photosensitising, nor did they show any cumulative irritation.

The atrophogenic potential of Elidel in humans was tested in comparison to medium and highly potent topical steroids (betamethasone-17-valerate 0.1% cream, triamcinolone acetonide 0.1% cream) and vehicle in sixteen healthy volunteers treated for 4 weeks. Both topical corticosteroids induced a significant reduction in skin thickness measured by echography, as compared to Eidel and vehicle, which did not induce a reduction of skin thickness.

5.2 Pharmacokinetic properties

Absorption

Data in animals

The bioavailability of pimecrolimus in mini-pigs following a single dermal dose (applied for 22 hours under semi-occlusion) was 0.03%. The amount of active substance-related material in the skin at the application site (almost exclusively unchanged pimecrolimus) remained practically constant for 10 days.

Data in humans

Absorption in adults

Systemic exposure to pimecrolimus was investigated in 12 adult patients with atopic dermatitis who were treated with Elidel cream twice daily for 3 weeks. The affected body surface area (BSA) ranged from 15 to 59%. 77.5% of pimecrolimus blood concentrations were below 0.5 ng/ml and 99.8% of the total samples were below 1 ng/ml. The highest blood concentration of pimecrolimus measured in one patient was 1.4 ng/ml.

In 40 adult patients treated for up to 1 year with Elidel, having 14 to 62% of their BSA affected at baseline, 98% of pimecrolimus blood concentrations were below 0.5 ng/ml. A maximum blood concentration of 0.8 ng/ml was measured in only 2 patients in week 6 of treatment. There was no increase in blood concentration over time in any patient during the 12 months of treatment. In 8 adult AD patients, in which AUC levels could be quantified, the $AUC_{(0 - 12\ h)}$ values ranged from 2.5 to 11.4 ng h/ml.

Absorption in children

Systemic exposure to pimecrolimus was investigated in 58 paediatric patients aged 3 months to 14 years. The affected BSA ranged from 10 to 92%. These children were treated with Elidel cream twice daily for 3 weeks and five were treated for up to 1 year on an “as needed” basis.

Pimecrolimus blood concentrations were consistently low regardless of the extent of lesions treated or duration of therapy. They were in a range similar to that measured in adult patients. Around 60% of pimecrolimus blood concentrations were below 0.5 ng/ml and 97% of all samples were below 2 ng/ml. The highest blood concentrations measured in 2 paediatric patients aged 8 months to 14 years of age were 2.0 ng/ml.

In the youngest patients (aged 3 to 23 months), the highest blood concentration measured in one patient was 2.6 ng/ml. In the 5 children treated for 1 year, blood concentrations were consistently low, and the maximum blood concentration measured was 1.94 ng/ml (1 patient). In these five patients, there was no increase in blood concentration over time in any patient during the 12 months of treatment.

In 8 paediatric patients aged 2 - 14 years, $AUC_{(0 - 12\ h)}$ ranged from 5.4 to 18.8 ng x h/ml. AUC ranges observed in patients with < 40% BSA affected at baseline were comparable to those in patients with ≥ 40% BSA.

The maximum body surface area treated was 92% in clinical pharmacology studies and up to 100% in Phase III trials.

Distribution

Consistent with its skin selectivity, after topical application, pimecrolimus blood levels are very low. Therefore, pimecrolimus metabolism could not be determined after topical administration.

In vitro plasma protein binding studies have shown that 99.6% of pimecrolimus in plasma is bound to proteins. The major fraction of pimecrolimus in plasma is bound to different lipoproteins.

Biotransformation

After single oral administration of radiolabeled pimecrolimus in healthy subjects, unchanged pimecrolimus was the major active substance-related component in blood and there were numerous minor metabolites of moderate polarity that appeared to be products of O-demethylations and oxygenation.

No metabolism of pimecrolimus was observed in human skin *in vitro*.

Elimination

Active substance-related radioactivity was excreted principally via the faeces (78.4%) and only a small fraction (2.5%) was recovered in urine. Total mean recovery of radioactivity was 80.9%. Parent compound was not detected in urine and less than 1% of radioactivity in faeces was accounted for by unchanged pimecrolimus.

5.3 Preclinical safety data

Conventional studies of repeated dose toxicity, reproductive toxicity, and carcinogenicity, using oral administration produced effects at exposures sufficiently in excess of those in man to be of negligible clinical significance. Pimecrolimus had no genotoxic, antigenic, phototoxic, photoallergenic or photocarcinogenic potential. Dermal application in embryo/fetal developmental studies in rats and rabbits and in carcinogenicity studies in mice and rats were negative.

Effects on reproductive organs and altered sex hormone functions were seen in male and female rats in repeated dose toxicity studies after oral administration of 10 or 40 mg/kg/day (= 20 to 60 times the maximum human exposure after dermal application). This is reflected by the findings from the fertility study. The No Observed Adverse Effect Level (NOAEL) for female fertility was 10 mg/kg/day (=20 times the maximum human exposure after dermal application). In the oral embryotoxicity study in rabbits, a higher resorption rate associated with maternal toxicity was observed at 20 mg/kg/day (=7 times the maximum human exposure after dermal application); the mean number of live fetuses was not affected.

Dose-dependent increases in the incidence of lymphomas were observed at all doses in a 39 week monkey oral toxicity study. Signs of recovery and/or at least partial reversibility of the effects were noted upon cessation of dosages in a few animals. Failure to derive a NOAEL precludes an assessment of the margin of safety between a non-carcinogenic concentration in the monkey and exposures in patients. The systemic exposure at the LOAEL of 15mg/kg/day was 31 times the highest maximum exposure observed in a human (paediatric patient). The risk for humans cannot

be completely ruled out as the potential for local immunosuppression with the long-term use of pimecrolimus cream is unknown.

6. Pharmaceutical Particulars

6.1 List of excipients

Elidel cream also contains

- Triglycerides
- Oleyl alcohol
- Propylene glycol
- Stearyl alcohol
- Cetyl alcohol
- Mono-and diglycerides
- Sodium cetostearyl sulphate
- Benzyl alcohol
- Citric acid
- Sodium hydroxide
- Purified water.

6.2 Incompatibilities

In the absence of compatibility studies, this medicinal product must not be mixed with other topical medicinal products.

6.3 Shelf life

Unopened: 2 years.
After first opening the tube: 12 weeks.

6.4 Special precautions for storage

Do not store above 25°C. Do not freeze.

6.5 Nature and contents of container

Aluminium tube with an epoxy protective inner lacquer and polypropylene screw cap.

Pack sizes of 5, 15 or 30 grams.

Not all pack sizes may be marketed.

6.6 Special precautions for disposal and other handling

Emollients can be applied together with Elidel cream (see section 4.2).

Any unused medicine or waste material should be disposed of in accordance with local requirements.

7. Medicines Schedule

Prescription Medicine

8. Sponsor Details

Viatris Ltd
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AUCKLAND
www.viatris.co.nz
Telephone 0800 168 169

9. Date of First Approval

6 June 2002

10. Date of Revision of the Text

17 March 2022

Summary table of changes

Section changed	Summary of new information
4.2	Updated information to reflect paediatric study results.
4.4	Added results from epidemiology studies and observational registry study on cancer risk. Added information on excipients and skin reactions.
4.5	Added more information on vaccination.
4.6	Adverse reactions updated into tabulated list
5.1	Summarised pharmacodynamic information. Added paediatric study and special studies.
5.2	Summarised pharmacokinetic information.
5.3	Updated preclinical safety data with company core data sheet.