SUMMARY OF PRODUCT CHARACTERISTICS

1. NAME OF THE MEDICINAL PRODUCT

Bladex 1 mg tablets
Bladex 5 mg tablets

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

Each tablet contains folic acid hydrate equivalent to 1 mg folic acid.
Excipient with known effect: Each tablet contains 76 mg lactose monohydrate and 8.3 mg sucrose.

Each tablet contains folic acid hydrate equivalent to 5 mg folic acid.
Excipient with known effect: Each tablet contains 72 mg lactose monohydrate and 8.3 mg sucrose.

For the full list of excipients, see section 6.1.

3. PHARMACEUTICAL FORM

Tablet

1 mg:
Light yellow or light yellow orange speckled, round and biconvex tablet with breaking line on one side with a diameter of about 7.0 mm and thickness of about 2.75 mm

5 mg:
Yellow or yellow orange speckled, round and biconvex tablet with breaking line on one side with a diameter of about 7.0 mm and thickness of about 2.75 mm

The tablet can be divided into equal doses.

4. CLINICAL PARTICULARS

4.1 Therapeutic indications

- Treatment of folate deficiency states confirmed by blood test including B_{12} status (see section 4.4).
- During treatment with drugs that inhibit folate absorption or folate metabolism such as methotrexate.
- For the prevention of neural tube defects in the foetus for women planning a pregnancy and where the risk for neural tube defects in the foetus is elevated.

Consideration should be given to national, official guidelines on the appropriate use of folic acid.

4.2 Posology and method of administration

Posology
The exact dosing has to be adapted to the patient’s demand, according to the clinical status and considering the diet, the possibly influencing concomitant medication, and other factors affecting the serum folate level.

Adults

- Treatment of folate deficiency states confirmed by blood test including vitamin B_{12} status: 1–5 mg daily. Higher doses might be necessary in individual cases. For doses of 5 mg or more, the 5 mg tablets should be used.
- In drug induced folate deficiency (e.g. patients receiving methotrexate): The appropriate dosing regimen is dependent on the disease. The exact dose should be determined individually. However, a commonly recommended dosing regimen in patients with rheumatoid arthritis is 1 mg daily or 5 mg once weekly. Folic acid should be taken 24 hours after methotrexate therapy.
- Prevention of neural tube defects in the foetus for women planning a pregnancy and where the risk for neural tube defects in the foetus is elevated: 5 mg daily at least 4 weeks before conception and at least 12 weeks thereafter.

Paediatric population
[Invented name] 1 mg tablets can be used in children and adolescents aged 1–18 years.
[Invented name] 5 mg tablets can be used in children and adolescents aged 6–18 years.

The exact dose should be determined individually according to the patient´s clinical status and the type of deficiency.

In folate deficient megaloblastic anaemia
The usual dose for children and adolescents is 0.5–1 mg daily.

However, the dose should be determined individually, and higher doses might be needed.
The treatment effect should be monitored.

Special populations
Dosage adjustments are not needed in the elderly.
Dosage adjustments are not needed in patients with renal or hepatic impairment.

Method of administration
Oral use.
The tablets can be taken independent of meals with a glass of liquid.
For patients who are unable to swallow tablets, the tablet may be crushed and mixed with food or dissolved in water immediately before administration.

Duration of administration
The duration of therapy depends on the cause of the folic acid deficiency and on the therapeutic success.

4.3 Contraindications

- Hypersensitivity to the active substance or to any of the excipients listed in section 6.1.

4.4 Special warnings and precautions for use

Patients with vitamin B_{12} deficiency should not be treated with folic acid unless administered with adequate amounts of hydroxocobalamin, as it can mask the condition, or the development of such, at risk of serious neurological damage. This can be detected by analysis of methylmalonic acid in plasma.

Since folate may stimulate cell partition, caution should be shown when treating patients with folate dependent tumour disease. Folic acid supplements may increase growth of already existing malignity.

Plasmodium parasites can utilize exogenous folate for their DNA synthesis. Supplementation of folic acid can therefore reduce the effect of folic acid antagonists used for preventing and treating malaria (see section 4.5).

This medicinal product contains lactose and sucrose
Patients with rare hereditary problems of fructose intolerance, galactose intolerance, galactosaemia, sucrase-isomaltase insufficiency or glucose-galactose malabsorption should not take this medicine.

4.5 Interaction with other medicinal products and other forms of interaction

Drugs influenced by concomitant administration of folic acid
Serum levels of anticonvulsant drugs (phenytoin, phenobarbital, primidone and possibly carbamazepine) may be reduced by administration of folate and therefore patients should be carefully monitored by the physician and the anticonvulsant drug dose adjusted as necessary.

Fluorouracil and fluorouracil prodrugs toxicity may occur in patients taking folic acid and therefore this combination should be avoided.

Folic acid possibly enhances the toxicity of capecitabine.

High doses of folic acid (daily doses of 5 mg or higher) have shown to counteract the effect of sulfadoxine-pyrimethamine. Folate supplements can also influence the effect of other anti-folate anti-malaria medicinal products (see section 4.4).

Drugs influencing levels of folic acid
Folate deficiency states may be produced by oral contraceptives, antituberculous drugs, alcohol, glucarpidase, and folic acid antagonists such as methotrexate, pyrimethamine, triamterene, trimethoprim, and sulfonamides.

Absorption of folic acid may be reduced by sulfasalazine.

4.6 Fertility, pregnancy and lactation

Pregnancy
Based on the human experience there are no known hazards to the use of folic acid in pregnancy. Harmful effects in the human foetus, mother or the pregnancy have not been reported following ingestion of folic acid.

Breast-feeding
Folic acid is actively excreted into breast milk (see section 5.2).
No adverse effects have been seen in breast-fed infants whose mothers were receiving folic acid, therefore it is usually compatible with breast-feeding.

Fertility
Animal studies to evaluate the effect on fertility have not been conducted.

4.7 Effects on ability to drive and use machines

Folic acid has no influence on the ability to drive and use machines.

4.8 Undesirable effects

The following adverse events have been reported.
The frequencies are defined as follows: very common (≥1/10), common (≥1/100 to <1/10), uncommon (≥1/1,000 to <1/100) rare (≥1/10,000 to <1/1,000), very rare (<1/10,000) and not known (cannot be estimated from available data).

System organ class	Frequency	Adverse event
Immune system disorders	Rare	Hypersensitivity
	Not known	Anaphylactic reactions
Gastrointestinal disorders	Rare	Nausea, vomiting, diarrhoea, flatulence
Skin and subcutaneous tissue disorders	Rare	Rash, pruritus, erythema, urticaria, facial angioedema

Reporting of suspected adverse reactions
Reporting suspected adverse reactions after authorisation of the medicinal product is important. It allows continued monitoring of the benefit/risk balance of the medicinal product. Healthcare professionals are asked to report any suspected adverse reactions via the national reporting system.

4.9 Overdose

Overdose generally produces no symptoms and symptomatic treatment of overdose should only be required in exceptional cases.

5. PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: Folic acid and derivatives ATC code: B03BB01

Folic acid is a component of coenzymes involved in certain transmethylation processes, such as deoxyribonucleic acid and ribonucleic acid synthesis. Folic acid is one of the B vitamins and is necessary for the normal production and maturation of red blood cells. Folic acid deficiency is one of the causes megaloblastic anaemia.

5.2 Pharmacokinetic properties

Absorption
Folic acid is rapidly absorbed from the gastrointestinal tract, mainly from the proximal part of the small intestine. Dietary folates are stated to have about half the bioavailability of crystalline folic acid. The naturally occurring folate polyglutamates are largely deconjugated and reduced by dihydrofolate reductase in the intestine to from 5-methyltetrahydrofolate (5MTHF). Folic acid given therapeutically enters the portal circulation largely unchanged, since it is a poor substrate for reduction by dihydrofolate reductases. Bioavailability of the folic acid is around 85%when administered with food and around 100% when taken on empty stomach.

Distribution
Absorbed folic acid is transported to the liver, which contains about half the body pool of folate and retains 10 to 20% of absorbed folate due to the first-pass effect, while the rest is transported via the systemic circulation to body tissues.
Folic acid crosses the blood brain barrier. Folic acid is excreted into breast milk.
Folic acid crosses the placenta. The mechanism of folate transport across the placenta is established within the first trimester of pregnancy to satisfy the high requirements for folate during foetal development (see section 4.6). As a result of the high folate concentration in the intervillous blood, folate in foetal blood is two to four times higher than in maternal blood.

Biotransformation
Folate, dihydrofolate and tetrahydrofolate are actively reduced and methylated to methyltetrafolate in

the liver, which is then transported to the bile and secreted in order then then be reabsorbed via the intestines (enterohepatic cycle). Folates which are not bound to specific and non-specific binding proteins are subjected to catabolism by oxidative cleavage, generating p-aminobenzoylglutamates which in turn are acetylated in the liver before excretion.

Elimination
Folic acid metabolites are eliminated in the urine and folate in excess of body requirements is excreted unchanged in the urine.

Folic acid is removed by haemodialysis.

Folate is secreted via breast milk. Folic acid supplementation in well-nourished lactating women does not affect breast milk folate concentration, whereas, in women with severe folate deficiency, supplementation increases the folate concentration of breast milk even before any improvement in maternal folate status is seen (see section 4.6).

5.3 Preclinical safety data

Effects in non-clinical studies were observed only at exposures considered sufficiently in excess of the maximum human exposure indicating little relevance to clinical use. Non-clinical studies on reproduction and development have not been performed.

6. PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Lactose monohydrate
Starch, pregelatinised
Macrogol
Stearic acid (E 570)
Sucrose
Magnesium stearate (E 470b)

6.2 Incompatibilities

Not applicable.

6.3 Shelf life

1 mg:
3 years

5 mg:
2 years

6.4 Special precautions for storage

Store in the original package in order to protect from light. This medicinal product does not require any special temperature storage conditions.

6.5 Nature and contents of container

PVC/PVdC/PVC-Aluminium blister packs with 12, 20, 28, 30, 40, 50, 60 or 100 tablets.

Not all pack sizes may be marketed.

6.6 Special precautions for disposal

No special requirements.

7. MARKETING AUTHORISATION HOLDER

[To be completed nationally]

8. MARKETING AUTHORISATION NUMBER(S)

[To be completed nationally]

9. DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUTHORISATION

[To be completed nationally]

10. DATE OF REVISION OF THE TEXT

2026-03-26