

SUMMARY OF THE PRODUCT CHARACTERISTICS

1 NAME OF THE MEDICINAL PRODUCT

Kalcipos-D mite 500 mg/200 IU film-coated tablet

2 QUALITATIVE AND QUANTITATIVE COMPOSITION

Each film-coated tablet contains:
500 mg calcium (as calcium carbonate) and
5 microgram cholecalciferol (equivalent to 200 IU)

Excipient with known effect: sucrose 0.4 mg.

For the full list of excipients, see section 6.1.

3 PHARMACEUTICAL FORM

Film-coated tablet
White, oval, engraved with R 118, 8.5 × 19 mm.

4 CLINICAL PARTICULARS

4.1 Therapeutic indications

Prevention and treatment of calcium and vitamin D deficiency. Vitamin D and calcium supplement in adjunct to specific osteoporosis treatment of patients who are at risk of vitamin D and calcium deficiency.

4.2 Posology and method of administration

Posology

Adjunctive therapy in osteoporosis

One tablet 2-3 times per day

Calcium and vitamin D deficiency

Adults: 1 tablet 1-3 times per day

Children: 1 tablet 1-2 times per day

Hepatic impairment

No dose adjustment is required.

Renal impairment

Kalcipos-D mite tablets should be used with caution in patients with renal impairment (see section 4.4).

Method of administration

To be swallowed whole, divided or crushed before intake.

4.3 Contraindications

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

- Hypercalciuria and hypercalcaemia and diseases and/or conditions resulting in hypercalcaemia and/or hypercalciuria (e.g. myeloma, bone metastases, primary hyperparathyroidism)
- Nephrolithiasis
- Nephrocalcinosis
- Hypervitaminosis D
- Renal failure

4.4 Special warnings and precautions for use

Sarcoidosis

Calcium/cholecalciferol tablets should be prescribed with caution to patients suffering from sarcoidosis due to risk of increased metabolism of vitamin D into its active form. These patients should be monitored with regard to the calcium content in serum and urine.

Monitoring of calcium levels

During long-term treatment, serum calcium levels should be followed and renal function should be monitored through measurements of serum creatinine. Monitoring is especially important in patients on concomitant treatment with cardiac glycosides or diuretics (see section 4.5) and in patients with a high tendency to calculus formation. If signs of hypercalcaemia and/or hypercalciuria occur treatment must be discontinued. Treatment should be reduced or temporarily stopped if urinary calcium levels exceed 7.5 mmol/24 h (300 mg/24 h) in adults or 0.10 mmol/kg/24 h (4 mg/kg/24 h) in children.

Renal impairment

This product should be used with caution in patients with renal impairment and the effect on calcium and phosphate levels should be monitored. The risk of soft tissue calcification should be taken into account. In patients with severe renal impairment, vitamin D in the form of cholecalciferol might not be activated normally. The physician may decide if other forms of vitamin D should be supplemented (see section 4.2).

Osteoporosis

Calcium/cholecalciferol tablets should be used with caution in immobilised patients with osteoporosis due to increased risk of hypercalcaemia.

Vitamin D therapy

The content of vitamin D (200 IU) in calcium/cholecalciferol tablets should be considered when prescribing other medicinal products containing vitamin D. Additional doses of calcium or vitamin D should be taken under close medical supervision. In such cases it is necessary to monitor serum calcium levels and urinary calcium excretion frequently. Milk-alkali syndrome (Burnett's syndrome), i.e. hypercalcaemia, alkalosis and renal impairment, can develop when large amounts of calcium are ingested with absorbable alkali.

Kalcipos-D mite contains Sucrose

Kalcipos-D mite contains 0.4 mg sucrose. Patients with rare hereditary problems of fructose intolerance, glucose-galactose malabsorption or sucrase-isomaltase insufficiency should not take this medicine.

Sodium content

This medicine contains less than 1 mmol sodium (23 mg) per tablet, that is to say essentially 'sodium-free'

4.5 Interaction with other medicinal products and other forms of interaction

Thiazide diuretics

Thiazide diuretics reduce the urinary excretion of calcium. Due to increased risk of hypercalcaemia, serum calcium should be regularly monitored during concomitant use of thiazide diuretics.

Phenytoin / barbiturates

Concomitant use of phenytoin or barbiturates may enhance the metabolism of vitamin D₃ and thereby reduce its effect.

Corticosteroids

Systemic corticosteroids reduce calcium absorption. During concomitant use, it may be necessary to increase the dose of Kalcipos-D.

Cardiac glycosides

Hypercalcaemia may increase the toxicity of cardiac glycosides during treatment with calcium and vitamin D. Patients should be monitored with regard to electrocardiogram (ECG) and serum calcium levels.

Estramustine

Calcium reduces the gastrointestinal absorption of estramustine by formation of an insoluble complex. Consequently, administration of Kalcipos-D and estramustine containing products should be separated by at least two hours.

Bisphosphonates / sodium fluoride

If a bisphosphonate or sodium fluoride is used concomitantly, this preparation should be administered at least three hours before the intake of Kalcipos-D since gastrointestinal absorption may be reduced.

Ion-exchange resins / laxatives

Simultaneous treatment with ion exchange resins such as cholestyramine or laxatives such as paraffin oil may reduce the gastrointestinal absorption of vitamin D.

Tetracyclines

Calcium carbonate may interfere with the absorption of concomitantly administered tetracycline preparations. For this reason, tetracycline preparations should be administered at least two hours before or four to six hours after oral intake of calcium.

Iron / zinc / strontium ranelate preparations

Calcium salts may decrease the absorption of iron, zinc and strontium ranelate. Consequently, iron, zinc or strontium ranelate preparations should be taken at least two hours before or after Kalcipos-D.

Levothyroxine

The efficacy of levothyroxine can be reduced by the concurrent use of calcium, due to decreased levothyroxine absorption. Administration of calcium and levothyroxine should be separated by at least four hours.

Quinolone antibiotics

The absorption of quinolone antibiotics may be impaired if administered concomitantly with calcium. Quinolone antibiotics should be taken two hours before or six hours after intake of calcium.

Orlistat

Treatment with orlistat may potentially impair the absorption of fat-soluble vitamins (e.g. vitamin D₃).

Oxalic acid / phytic acid

Oxalic acid (found in spinach and rhubarb) and phytic acid (found in whole cereals) may inhibit calcium absorption through formation of insoluble compounds with calcium ions. The patient should not take calcium products within two hours of eating foods high in oxalic acid and phytic acid.

4.6 Fertility, pregnancy and lactation

Pregnancy

Studies in animals have shown reproductive toxicity of high doses of vitamin D (see Section 5.3). There are no indications that vitamin D at therapeutic doses is teratogenic in humans. In pregnant women, overdoses of calcium and vitamin D should be avoided as permanent hypercalcaemia has been related to adverse effects on the developing foetus.

In healthy pregnant women, the daily intake of supplemental calcium and vitamin D should not exceed 1500 mg calcium and 600 IU vitamin D. For pregnant women with a confirmed calcium and vitamin D deficiency, maximum daily doses of 2000 mg calcium and 4000 IU cholecalciferol must not be exceeded.

Breast-feeding

Calcium and vitamin D₃ pass into breast milk and an overdose has to be avoided in the infant. This should be considered when giving additional vitamin D to the child. A decision must be made whether to discontinue breast-feeding or to discontinue Kalcipos-D mite or adjust therapy taking into account the benefit of breast-feeding for the child and the benefit of therapy for the woman.

Fertility

Normal endogenous levels of calcium and vitamin D₃ are not expected to have any adverse effects on fertility.

4.7 Effects on ability to drive and use machines

There are no data about the effect of this product on driving capacity. An effect is, however, unlikely.

4.8 Undesirable effects

Adverse reactions frequencies are defined as:

Very common ($\geq 1/10$)

Common ($\geq 1/100$ to $< 1/10$)

Uncommon ($\geq 1/1,000$ to $< 1/100$)

Rare ($\geq 1/10,000$ to $< 1/1,000$)

Very rare ($< 1/10,000$)

Not known (cannot be estimated from the available data)

Immune system disorders

Not known (cannot be estimated from the available data): Hypersensitivity reactions such as angio-oedema or laryngeal oedema.

Metabolism and nutrition disorders

Uncommon: Hypercalcaemia and hypercalciuria.

Very rare: Milk-alkali syndrome, seen usually only in overdose.

Gastrointestinal disorders

Rare: Constipation, flatulence, nausea, abdominal pain, and diarrhoea.

Skin and subcutaneous tissue disorders

Rare: Pruritus, rash and urticaria.

Patients with renal impairment are at potential risk of hyperphosphatemia, nephrolithiasis and nephrocalcinosis. See section 4.4.

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.

< To be completed nationally >

4.9 Overdose

Overdose can lead to hypervitaminosis and hypercalcaemia. Symptoms of hypercalcaemia may include anorexia, thirst, nausea, vomiting, constipation, abdominal pain, muscle weakness, fatigue, mental disturbances, polydipsia, polyuria, bone pain, nephrocalcinosis, renal calculi and in severe cases, cardiac arrhythmias. Extreme hypercalcaemia may result in coma and death. Persistently high calcium levels may lead to irreversible renal damage and soft tissue calcification.

Milk-alkali syndrome may occur in patients who ingest large amounts of calcium and absorbable alkali. Symptoms are frequent urge to urinate, continuing headache, continuing loss of appetite, nausea or vomiting, unusual tiredness or weakness, hypercalcaemia, alkalosis and renal impairment.

Treatment of hypercalcaemia: The treatment with calcium and vitamin D must be discontinued. Treatment with thiazide diuretics, lithium, vitamin A, vitamin D and cardiac glycosides must also be discontinued. Rehydration, and, according to severity, isolated or combined treatment with loop diuretics, bisphosphonates, calcitonin and corticosteroids. Serum electrolytes, renal function and diuresis must be monitored. In severe cases, ECG and CVP should be followed.

5 PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: Calcium combinations with vitamin D and/or other drugs.
ATC-code: A12AX

Vitamin D increases the intestinal absorption of calcium.

Administration of calcium and vitamin D₃ counteracts the increase of parathyroid hormone (PTH) which is caused by calcium deficiency and which cause increased bone resorption.

A clinical study of institutionalised patients suffering from vitamin D deficiency indicated that a daily intake of two tablets of calcium 500 mg/vitamin D 400 IU for six months normalised the value of the 25-hydroxylated metabolite of vitamin D₃ and reduced secondary hyperparathyroidism and alkaline phosphatases.

5.2 Pharmacokinetic properties

Calcium

Absorption: The amount of calcium absorbed through the gastrointestinal tract is approximately 30% of the swallowed dose.

Distribution and biotransformation: 99% of the calcium in the body is concentrated in the hard structure of bones and teeth. The remaining 1% is present in the intra- and extracellular fluids. About 50% of the total blood-calcium content is in the physiologically active ionised form with approximately 10% being complexed to citrate, phosphate or other anions, the remaining 40% being bound to proteins, principally albumin.

Elimination: Calcium is eliminated through faeces, urine and sweat. Renal excretion depends on glomerular filtration and calcium tubular reabsorption.

Vitamin D

Absorption: Vitamin D is easily absorbed in the small intestine.

Distribution and biotransformation: Cholecalciferol and its metabolites circulate in the blood bound to a specific globulin. Cholecalciferol is converted in the liver by hydroxylation to the active form 25-hydroxycholecalciferol. It is then further converted in the kidneys to 1,25 hydroxycholecalciferol.

1,25-hydroxycholecalciferol is the metabolite responsible for increasing calcium absorption. Vitamin D which is not metabolised is stored in adipose and muscle tissues.

Elimination: Vitamin D is excreted in faeces and urine.

5.3 Preclinical safety data

At doses far higher than the human therapeutic range teratogenicity has been observed in animal studies. There is further no information of relevance to the safety assessment in addition to what is stated in other parts of the SPC.

6 PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Core: maltodextrin, sucrose, sodium ascorbate, medium chain triglycerides, silicon dioxide, starch sodium octenyl succinate (E1450), all-*rac*-alpha-tocopherol, croscarmellose sodium, colloidal anhydrous silica, magnesium stearate.

Film-coating: hypromellose, macrogol, paraffin.

6.2 Incompatibilities

Not applicable.

6.3 Shelf life

2 years.

6.4 Special precautions for storage

Store below 25°C. Store in the original package in order to protect from light. Keep the container tightly closed in order to protect from moisture.

6.5 Nature and contents of container

60, 120 and 180 tablets in plastic bottles (container: HD-polyethylene, screw cap: polyethylene). Not all pack sizes may be marketed.

6.6 Special precautions for disposal and other handling

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

2026-06-18