

SUMMARY OF PRODUCT CHARACTERISTICS

1 NAME OF THE MEDICINAL PRODUCT

ZELDOX 20 mg/ml powder for solution for injection.

2 QUALITATIVE AND QUANTITATIVE COMPOSITION

One vial contains ziprasidone mesilate to deliver 20 mg of ziprasidone. After reconstitution, 1ml of solution for injection contains 20 mg ziprasidone.

For the full list of excipients, see section 6.1.

3 PHARMACEUTICAL FORM

Powder for solution for injection.

White to off-white powder

4 CLINICAL PARTICULARS

4.1 Therapeutic indications

Ziprasidone powder for solution for injection is indicated for the rapid control of agitation in patients with schizophrenia, when oral therapy is not appropriate, for a maximum of 3 consecutive days.

Treatment with ziprasidone powder for solution for injection should be discontinued, and the use of oral ziprasidone should be initiated, as soon as clinically appropriate.

4.2 Posology and method of administration

Posology

For intramuscular use only.

Intravenous administration must be avoided.

Treatment with the intramuscular formulation should only be used in patients, where treatment with an oral formulation is considered to be inappropriate.

Adults

The recommended dose is 10 mg administered as required up to a maximum dose of 40 mg per day. Doses of 10 mg may be administered every 2 hours. Some patients may require an initial dose of 20 mg, which can be followed by a further dose of 10 mg after 4 hours. Thereafter, doses of 10 mg may be given every 2 hours up to the

maximum daily dose of 40 mg. Intramuscular administration of ziprasidone for more than 3 consecutive days has not been studied.

If long-term therapy is indicated, oral ziprasidone hydrochloride capsules, up to 80 mg twice daily, should replace the intramuscular administration as soon as possible.

Elderly

The clinical experience with intramuscular treatment in elderly patients (> 65 years) is limited. Treatment with intramuscular injection is not recommended to these patients (see section 4.4).

Paediatric population

The safety and efficacy in children under 18 years have not been established.

Patients with renal impairment

Ziprasidone intramuscular injection should be administered with caution in patients with impaired renal function (see section 5.2).

Patients with hepatic impairment

In patients with hepatic insufficiency, lower doses should be considered (see section 4.4 and 5.2).

For instructions for reconstitution, see section 6.6.

4.3 Contraindications

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

Known QT interval prolongation. Congenital long QT syndrome. Recent acute myocardial infarction. Uncompensated heart failure. Arrhythmias treated with Class IA and III antiarrhythmic medicinal products.

Concomitant treatment with medicinal products that prolong the QT interval such as Class IA and III antiarrhythmics, arsenic trioxide, halofantrine, levomethadyl acetate, mesoridazine, thioridazine, pimozide, sparfloxacin, gatifloxacin, moxifloxacin, dolasetron mesilate, mefloquine, sertindole or cisapride (see section 4.4 and section 4.5).

4.4 Special warnings and precautions for use

QT interval

Ziprasidone causes a mild to moderate dose-related prolongation of the QT-interval (see section 4.8 and 5.1).

Ziprasidone should not be given together with medicinal products that are known to prolong the QT interval (see section 4.3 and 4.5). Caution is advised in patients with significant bradycardia. Electrolyte disturbances such as hypokalaemia and hypomagnesaemia increase the risk for malignant arrhythmias and should be corrected before treatment with ziprasidone is started. If patients with stable cardiac disease are treated, an ECG review should be considered before treatment is started.

If cardiac symptoms such as palpitations, vertigo, syncope or seizures occur, then the possibility of a malignant cardiac arrhythmia should be considered and a cardiac evaluation, including an ECG should be performed. If the QTc-interval is > 500 msec, then it is recommended that the treatment should be stopped (see section 4.3).

There have been rare post-marketing reports of torsade de pointes in patients with multiple confounding risk factors taking ziprasidone.

Paediatric population

The safety and efficacy of ziprasidone intramuscular injection in children under 18 years have not been established.

Elderly (> 65 years)

Elderly patients have not been included in clinical trials in sufficient numbers. Thus, no recommendations as regards dosing could be given and intramuscular treatment in these patients is not recommended.

Neuroleptic malignant syndrome (NMS)

NMS is a rare but potentially fatal complex that has been reported in association with other antipsychotic medicinal products, including ziprasidone. The management of NMS should include immediate discontinuation of all antipsychotic medicinal products.

Severe Cutaneous Adverse Reactions

Drug reaction with eosinophilia and systemic symptoms (DRESS) has been reported with ziprasidone exposure. DRESS consists of a combination of three or more of the following: cutaneous reaction (such as rash or exfoliative dermatitis), eosinophilia, fever, lymphadenopathy and one or more systemic complications such as hepatitis, nephritis, pneumonitis, myocarditis, and pericarditis.

Other severe cutaneous adverse reactions, such as Stevens-Johnson syndrome, have been reported with ziprasidone exposure.

Severe cutaneous adverse reactions are sometimes fatal. Discontinue ziprasidone if severe cutaneous adverse reactions occur.

Cardiovascular disease

Patients with cardiovascular disease have not been included in the clinical trials in sufficient numbers. Thus, the safe use of the intramuscular product has not been established (see section 4.3).

Blood pressure

Dizziness, tachycardia and postural hypotension are not unusual in patients following intramuscular administration of ziprasidone. Single cases of hypertension have also been reported. Caution should be exercised, particularly in ambulatory patients.

Tardive dyskinesia

There is a potential for ziprasidone to cause tardive dyskinesia and other tardive extrapyramidal syndromes after long-term treatment. If signs and symptoms of tardive dyskinesia appear, dose reduction or discontinuation of ziprasidone should be considered.

Falls

Ziprasidone may cause somnolence, dizziness, postural hypotension, gait disturbance, which may lead to falls. Caution should be taken when treating patients at higher risk, and a lower starting dose should be considered (e.g. elderly or debilitated patients) (see section 4.2).

Seizures

Caution is advised when treating patients with a history of seizures.

Hepatic Impairment

There is a lack of experience in patients with severe hepatic insufficiency and ziprasidone should be used with caution in this group (see section 4.2 and 5.2).

Increased risk of cerebrovascular accidents in the dementia population

An approximately 3-fold increased risk of cerebrovascular adverse events has been seen in randomised placebo-controlled clinical trials in the dementia population with some atypical antipsychotics. The mechanism for this increased risk is not known. An increased risk cannot be excluded for other antipsychotics or other patient populations. Zeldox should be used with caution in patients with risk factors for stroke.

Increased Mortality in Elderly people with Dementia

Data from two large observational studies showed that elderly people with dementia who are treated with antipsychotics are at a small increased risk of death and/or potentially, cerebrovascular adverse events compared with those who are not treated. There are insufficient data to give a firm estimate of the precise magnitude of the risk and the cause of the increased risk is not known.

Zeldox is not licensed for the treatment of dementia-related behavioural disturbances.

Venous Thromboembolism

Cases of venous thromboembolism (VTE) have been reported with antipsychotic drugs. Since patients treated with antipsychotics often present with acquired risk factors for VTE, all possible risk factors for VTE should be identified before and during treatment with ziprasidone and preventive measures undertaken.

Priapism

Cases of priapism have been reported with antipsychotic use, including ziprasidone. This adverse reaction, as with other psychotropic drugs, did not appear to be dose-dependent and did not correlate with the duration of treatment.

Post-marketing Reports of Mortality

As with other IM antipsychotics, fatalities with the use of ziprasidone IM, generally in patients with multiple confounding risk factors, have been reported. Although a causal relationship has not been established, ziprasidone IM should be used with caution.

Zeldox contains sodium

Zeldox contains less than 1 mmol sodium (23 mg) per ml of reconstituted solution for injection. Patients on low sodium diets can be informed that this medicinal product is essentially 'sodium free'.

4.5 Interaction with other medicinal products and other forms of interaction

Pharmacokinetic and pharmacodynamic studies between ziprasidone and other medicinal products that prolong the QT interval have not been performed. An additive effect of ziprasidone and these medicinal products cannot be excluded, therefore ziprasidone should not be given with medicinal products that prolong the QT interval, such as Class IA and III antiarrhythmics, arsenic trioxide, halofantrine, levomethadyl acetate, mesoridazine, thioridazine, pimozide, sparfloxacin, gatifloxacin, moxifloxacin, dolasetron mesilate, mefloquine, sertindole or cisapride (see section 4.3).

CNS medicinal products/alcohol

Given the primary effects of ziprasidone, caution should be used when it is taken in combination with other centrally acting medicinal products and alcohol.

Effect of ziprasidone on other medicinal products

All interaction studies have been conducted with oral ziprasidone.

An *in vivo* study with dextromethorphan showed no marked inhibition of CYP2D6 at plasma concentrations 50% lower than those obtained after 40 mg ziprasidone twice daily. *In vitro* data indicated that ziprasidone may be a modest inhibitor of CYP2D6 and CYP3A4. However, it is unlikely that ziprasidone will affect the pharmacokinetics of medicinal products metabolised by these cytochrome P450 isoforms to a clinically relevant extent.

Oral contraceptives - Ziprasidone administration resulted in no significant change to the pharmacokinetics of oestrogen (ethinyl oestradiol, a CYP3A4 substrate) or progesterone components.

Lithium - Co-administration of ziprasidone had no effect on the pharmacokinetics of lithium.

Effects of other medicinal products on ziprasidone

The CYP3A4 inhibitor ketoconazole (400 mg/day) increased the serum concentrations of ziprasidone by <40%. The serum concentrations of S-methyldihydroziprasidone and ziprasidone sulphoxide, at the expected T_{max} of ziprasidone, were increased by 55% and 8% respectively. No additional QTc prolongation was observed. Changes in pharmacokinetics due to co-administration of potent CYP3A4 inhibitors are unlikely to be of clinical importance, therefore no dosage adjustment is required.

Carbamazepine therapy, 200 mg b.i.d for 21 days, resulted in a decrease of approximately 35% in the exposure to ziprasidone.

Antacid – multiple doses of aluminium and magnesium containing antacid or cimetidine have no clinically significant effect on the pharmacokinetics of ziprasidone under fed conditions.

Serotonergic medicinal products

In isolated cases, there have been reports of serotonin syndrome temporally associated with the therapeutic use of ziprasidone in combination with other serotonergic medicinal products such as SSRIs (see section 4.8). The features of serotonin

syndrome can include confusion, agitation, fever, sweating, ataxia, hyperreflexia, myoclonus and diarrhoea.

Protein binding

Ziprasidone extensively binds to plasma proteins. The *in vitro* plasma protein binding of ziprasidone was not altered by warfarin or propranolol, two highly protein-bound drugs, nor did ziprasidone alter the binding of these drugs in human plasma. Thus, the potential for drug interactions with ziprasidone due to displacement is unlikely.

4.6 Fertility, pregnancy and lactation

Reproductive toxicity studies with ziprasidone have shown undesirable effects on the reproductive process, at doses associated with maternal toxicity and/or sedation. There was no evidence of teratogenicity (see section 5.3).

Pregnancy

No studies have been conducted in pregnant women. As human experience is limited, administration of ziprasidone is not recommended during pregnancy unless the expected benefit to mother outweighs the potential risk to the foetus.

Antipsychotic class labelling

Neonates exposed to antipsychotics during the third trimester of pregnancy are at risk of adverse reactions including extrapyramidal and/or withdrawal symptoms that may vary in severity and duration following delivery. There have been reports of agitation, hypertonia, hypotonia, tremor, somnolence, respiratory distress, or feeding disorder. Consequently, newborns should be monitored carefully.

Breast-feeding

There are no adequate and well-controlled studies in lactating women. A single case report found that ziprasidone was detectable in breast milk. Patients should be advised not to breastfeed if they are receiving ziprasidone. If treatment is necessary, breast-feeding should be discontinued.

Fertility

There are no adequate and well-controlled studies in women and men exposed to ziprasidone.

Contraception – Women of childbearing potential receiving ziprasidone should be advised to use an appropriate method of contraception.

4.7 Effects on ability to drive and use machines

Ziprasidone may cause somnolence and may influence on the ability to drive and use machines. Patients likely to drive or operate machines should be cautioned appropriately.

4.8 Undesirable effects

Ziprasidone intramuscular

The table below contains adverse events with possible, probable or unknown relationship to ziprasidone in phase 2/3 trials. The most common reactions were nausea, sedation, dizziness, injection site pain, headache and somnolence.

All adverse reactions are listed by class and frequency: *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*).

The adverse reactions listed below may also be associated with the underlying disease and/or concomitant medications.

System Organ Class	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 $< 1/1,000$	Frequency not known (cannot be estimated from available data)
Immune system disorders					Anaphylactic reaction, hypersensitivity
Metabolism and nutrition disorders			Decreased appetite		
Psychiatric disorders		Agitation, insomnia	Mania, psychotic disorder, antisocial behaviour, tic		Hypomania
Nervous system disorders		Dystonia, extrapyramidal disorder, akathisia, tremor, somnolence, headache, dizziness, sedation	Syncope, dyskinesia, parkinsonism, cogwheel rigidity, dysarthria, dyspraxia, dizziness postural		Neuroleptic malignant syndrome, serotonin syndrome, facial droop, tardive dyskinesia
Ear and labyrinth disorders			Vertigo		
Cardiac disorders		Tachycardia	Bradycardia		Torsade de pointes
Vascular disorders		Hypertension, hypotension	Orthostatic hypotension, flushing		Embolism venous
Respiratory, thoracic and mediastinal disorders			Laryngospasm		
Gastrointestinal disorders		Vomiting, nausea, constipation, dry mouth	Diarrhoea, loose stools	Dysphagia	
Skin and subcutaneous tissue disorders			Hyperhidrosis, rash		Drug reaction with eosinophilia and systemic symptoms (DRESS), angioedema
Musculoskeletal and		Muscle rigidity			

System Organ Class	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	Frequency not known (cannot be estimated from available data)
connective tissue disorders					
Renal and urinary disorders				Dysuria, urinary incontinence	Enuresis
Pregnancy, puerperium and perinatal conditions					Drug withdrawal syndrome neonatal
Reproductive system and breast disorders			Priapism		Galactorrhoea
General disorders and administratio n site conditions		Asthenia, injection site pain, injection site burning, fatigue	Drug withdrawal syndrome, influenza like illness, injection site discomfort, injection site irritation		
Investigation s			Blood pressure decreased, hepatic enzyme increased		

The most common cardiovascular adverse events reported from fixed dose clinical trials with intramuscular ziprasidone were: dizziness (10 mg - 11%, 20 mg – 12%), tachycardia (10 mg - 4%, 20 mg – 4%) and postural dizziness (10 mg – 2%, 20 mg – 2%), orthostatic hypotension, 20 mg – 5%) and hypotension (10 mg – 2%).

In premarketing fixed dose clinical trials with ziprasidone intramuscular injection, increased blood pressure and hypertension were observed in 2.2% of patients receiving 10 mg and increased blood pressure was observed in 2.8% of patients receiving 20 mg.

In short-term and long-term ziprasidone schizophrenia and bipolar mania clinical trials, the incidence of tonic clonic seizures and hypotension was uncommon, occurring in less than 1% of ziprasidone treated patients.

Ziprasidone causes a mild to moderate dose-related prolongation of the QT interval (see section 5.1). In schizophrenia clinical trials, an increase of 30 to 60 msec was seen in 12.3% (976/7941) of ECG tracings from ziprasidone-treated and 7.5% (73/975) of ECG tracings from placebo-treated patients. A prolongation of >60 msec was seen in 1.6% (128/7941) and 1.2% (12/975) of tracings from ziprasidone and placebo-treated patients, respectively. The incidence of QTc interval prolongation above 500 msec was 3 in a total of 3266 (0.1%) in ziprasidone treated patients and 1 in a total of 538 (0.2%) in placebo treated patients. Comparable findings were observed in bipolar mania clinical trials.

In long term maintenance treatment in schizophrenia clinical trials, prolactin levels in patients treated with ziprasidone were sometimes elevated, but, in most patients,

returned to normal ranges without cessation of treatment. In addition, potential clinical manifestations (e.g. gynaecomastia and breast enlargement) were rare.

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 listed in [Appendix V](#).

4.9 Overdose

Experience with ziprasidone in overdose is limited. The largest confirmed single ingestion of ziprasidone is 12,800 mg. In this case extrapyramidal symptoms and a QTc interval of 446 msec (with no cardiac sequelae) were reported. In general, the most commonly reported symptoms following overdose are, extrapyramidal symptoms, somnolence, tremor and anxiety.

The possibility of obtundation, seizures or dystonic reaction of the head and neck following overdosage may create a risk of aspiration with induced emesis. Cardiovascular monitoring should commence immediately and should include continuous electrocardiographic monitoring to detect possible arrhythmias. There is no specific antidote to ziprasidone.

5 PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: Antipsychotic, indole derivatives, ATC code N05A E04

Ziprasidone has a high affinity for dopamine type 2 (D₂) receptors and substantially higher affinity for serotonin type 2_A (5HT_{2A}) receptors. Receptor blockade, 12 hours after a single oral dose of 40 mg, was greater than 80% for serotonin type 2_A and greater than 50% for D₂ using positron emission tomography (PET). Ziprasidone also interacts with serotonin 5HT_{2C}, 5HT_{1D} and 5HT_{1A} receptors where its affinities for these sites are equal to or greater than its affinity for the D₂ receptor. Ziprasidone has moderate affinity for neuronal serotonin and norepinephrine transporters. Ziprasidone demonstrates moderate affinity for histamine H(1)- and alpha(1)-receptors. Ziprasidone demonstrates negligible affinity for muscarinic M(1)-receptors.

Ziprasidone has been shown to be an antagonist at both serotonin type 2_A (5HT_{2A}) and dopamine type 2 (D₂) receptors. It is proposed that the antipsychotic activity is mediated, in part, through this combination of antagonist activities. Ziprasidone is also a potent antagonist at 5HT_{2C} and 5HT_{1D} receptors, a potent agonist at the 5HT_{1A} receptor and inhibits neuronal reuptake of norepinephrine and serotonin.

Further information on clinical trials

In clinical trials, the safety and tolerability of intramuscular injection and subsequent continuation with oral therapy was demonstrated.

Results of a large post-marketing safety study

A randomised post-approval study of 18,239 schizophrenic patients with observational follow-up for 1 year was conducted to determine whether ziprasidone's effect on the QTc interval is associated with an increased risk of non-suicide mortality. This study, which was conducted in naturalistic clinical practice settings, showed no difference in the rate of over-all non-suicide mortality between ziprasidone and olanzapine treatments (primary end-point). The study also showed no difference in secondary end-points of all-cause mortality, mortality due to suicide, mortality due to sudden death, however, a non-significant numerically higher incidence of cardiovascular mortality was observed in the ziprasidone group. A statistically significantly higher incidence of all-cause hospitalisation, mainly due to differences in the number of psychiatric hospitalisations, was also observed in the ziprasidone group.

5.2 Pharmacokinetic properties

Absorption

The bioavailability of ziprasidone administered intramuscularly is 100%. After intramuscular administration of single doses, peak serum concentrations typically occur at approximately 30-60 minutes post-dose. Exposure increases in a dose-related manner and following 3 days of intramuscular dosing, little accumulation is observed.

Distribution

The volume of distribution is approximately 1.1 L/kg. Ziprasidone is more than 99% protein bound in serum.

Biotransformation and elimination

The mean terminal half-life on the third day of dosing ranged from 8 to 10 hours. The mean terminal half-life of ziprasidone after intravenous administration is 6 hours. Mean clearance of ziprasidone administered intravenously is 5 ml/min/kg. Approximately 20% of the dose is excreted in urine, and approximately 66% is eliminated in faeces.

Ziprasidone is extensively metabolised after oral administration with only a small amount excreted in urine (<1%) or faeces (<4%) as unchanged drug. Ziprasidone is primarily cleared via three proposed metabolic routes to yield four major circulating metabolites, benzisothiazole piperazine (BITP) sulphoxide, BITP sulphone, ziprasidone sulphoxide and S-methyldihydroziprasidone. Unchanged ziprasidone represents about 44% of total drug-related material in serum.

Ziprasidone is primarily metabolised by two pathways: reduction and methylation to generate S-methyldihydroziprasidone which accounts for approximately two-thirds of the metabolism, and oxidative metabolism accounting for the other third. *In vitro* studies using human liver subcellular fractions indicate that

S-methyldihydroziprasidone is generated in two steps. These studies indicate that the first step is mediated primarily by chemical reduction by glutathione as well as by enzymatic reduction by aldehyde oxidase. The second step is methylation mediated by thiol methyltransferase. *In vitro* studies indicate that CYP3A4 is the major cytochrome P450 catalysing the oxidative metabolism of ziprasidone with a potential minor contribution of CYP1A2.

Ziprasidone, S-methyldihydroziprasidone, and ziprasidone sulphoxide, when tested *in vitro*, share properties which may predict a QTc-prolonging effect.

S-methyl dihydroziprasidone is mainly eliminated in faeces presumably by biliary excretion with a minor contribution by CYP3A4 catalysed metabolism. Ziprasidone sulphoxide is eliminated through renal excretion and by secondary metabolism catalysed by CYP3A4.

Special populations

Pharmacokinetic screening of patients treated orally has not revealed any significant pharmacokinetic differences between smokers and non-smokers.

No clinically significant age- or gender-differences in the pharmacokinetics were observed following oral administration.

Consistent with the fact that renal clearance contributes very little to its overall clearance, no progressive increases in ziprasidone exposure were noted when ziprasidone was administered to subjects with varying degrees of renal function. Exposures in subjects with mild (creatinine clearance 30-60 ml/min), moderate (creatinine clearance 10-29 ml/min) and severe impairment (requiring dialysis) were 146%, 87% and 75% those of healthy subjects (creatinine clearance >70 ml/min) following oral administration of 20 mg BID for seven days. It is unknown whether serum concentrations of the metabolites are increased in these patients.

In mild to moderate impairment of liver function (Child Pugh A or B) caused by cirrhosis, the serum concentrations after oral administration were 30% higher and the terminal half-life was about 2 hours longer than in normal patients. The effect of liver impairment on serum concentrations of the metabolites is unknown.

5.3 Preclinical safety data

Preclinical safety data on ziprasidone administered orally reveal no special hazard for humans based on conventional studies of safety pharmacology, genotoxicity and carcinogenic potential. In reproductive studies in rats and rabbits, ziprasidone has shown no evidence of teratogenicity. Undesirable effects on fertility and decreased pup weights were observed at doses causing maternal toxicity such as decreased body weight gain. Increased perinatal mortality and delayed functional development of offspring occurred at maternal plasma concentrations extrapolated to be similar to the maximal concentrations in humans given therapeutic doses.

In parenteral studies of ziprasidone there were no adverse findings relevant to the clinical use of the product.

Skeletal variations, but no malformations, were observed in a rabbit teratology study of the excipient SBECD.

6 PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Sulphobutyl ether beta-cyclodextrin sodium.

6.2 Incompatibilities

This medicinal product must not be mixed with other medicinal products or solvents except water for injection mentioned in Section 6.6.

6.3 Shelf-life

3 years.

Chemical and physical in-use stability of the reconstituted product has been demonstrated for 24 hours up to 25°C and 7 days at 2 to 8 °C. However from a microbiological point of view, the product should be used immediately. If not used immediately, in-use storage times and conditions prior to use are the responsibility of the user and would normally not be longer than 24 hours at 2 to 8 °C, unless reconstitution has taken place in controlled and validated aseptic conditions.

6.4 Special precautions for storage

Do not store above 30°C.

Keep container in the outer carton.

6.5 Nature and content of container

Type 1 flint glass vials containing powder (ziprasidone mesilate). The vials are sealed with butyl rubber lyophile stoppers and flip-off aluminium seals.

Pack size: 1 vial per carton.

6.6 Special precautions for disposal

The contents of the vial (powder) should be reconstituted by introduction of 1.2 ml water for injection (solvent), affording a concentration of 20 mg ziprasidone per ml, and shaking until complete dissolution has occurred. Only clear solutions, free of visible particles, should be used. Only one dose (0.5ml corresponding to 10 mg ziprasidone, or 1ml corresponding to 20 mg ziprasidone) should be withdrawn from each vial and the remainder discarded.

7 MARKETING AUTHORISATION HOLDER

[To be completed nationally]

8 MARKETING AUTHORISATION NUMBER

[To be completed nationally]

9 DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUTHORISATION

Date of first authorisation: 17 august 2000

Date of latest renewal: 01 august 2010

10 DATE OF REVISION OF THE TEXT

2023-05-02