EQUAGESIC® CIV
(meprobamate and aspirin tablets)

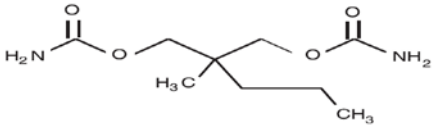
Rx only

DESCRIPTION

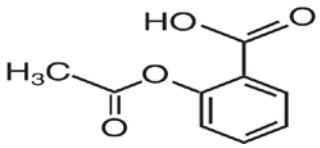
Each tablet of EQUAGESIC, for oral administration, contains 200 mg meprobamate and 325 mg aspirin. Chemically, meprobamate is 2-methyl-2-propyl-1,3- propanediol dicarbamate. Its molecular formula is $C_9H_{18}N_2O_4$ with a molecular weight of 218.25.

Chemically, aspirin is benzoic acid 2-(acetyloxy). Its molecular formula is $C_9H_8O_4$ with a molecular weight of 180.16. It occurs as an odorless white, needle like crystalline or powdery substance. When exposed to moisture, aspirin hydrolyzes into salicylic and acetic acids, and gives off a vinegary odor. It is highly lipid soluble and slightly soluble in water. The structural formulas of meprobamate and aspirin are:

MEPROBAMATE



ASPIRIN



The inactive ingredients present are cellulose, D&C Yellow 10, FD&C Red 3, FD&C Yellow 6, hydrogenated vegetable oil, magnesium stearate, polacrilin potassium, and starch.

CLINICAL PHARMACOLOGY

Meprobamate is a carbamate derivative which has been shown (in animal and/or human studies) to have effects at multiple sites in the central nervous system, including the thalamus and limbic system. Aspirin is a nonnarcotic analgesic with antipyretic and anti-inflammatory properties.

INDICATIONS AND USAGE

As an adjunct in the short-term treatment of pain accompanied by tension and/or anxiety in patients with musculoskeletal disease. Clinical trials have demonstrated that in these situations relief of pain is somewhat greater than with aspirin alone. EQUAGESIC is not intended for use longer than 10 days.

CONTRAINDICATIONS

Usage in Pregnancy and Lactation

An increased risk of congenital malformations associated with the use of minor tranquilizers (meprobamate, chlordiazepoxide, and diazepam) during the first trimester of pregnancy has been

suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided.

Because of the known effect of non-steroidal anti-inflammatory drugs (NSAIDs) on the fetal cardiovascular system (closure of the ductus arteriosus), use during the third trimester of pregnancy should be avoided. Salicylate products have also been associated with alterations in maternal and neonatal hemostasis mechanisms, decreased birth weight, and perinatal mortality. The possibility that a woman of childbearing potential may be pregnant at the time of institution of therapy should be considered. Patients should be advised that if they become pregnant during therapy or intend to become pregnant they should communicate with their physicians about the desirability of discontinuing the drug. Meprobamate passes the placental barrier. It is present both in umbilical-cord blood at or near maternal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breast-feeding patients, the drug's higher concentrations in breast milk as compared to maternal plasma levels should be considered.

EQUAGESIC is contraindicated in patients with acute intermittent porphyria and in patients with allergic or idiosyncratic reactions to aspirin, meprobamate, or related compounds, such as carbromal, carisoprodol, mebutamate, nonsteroidal anti-inflammatory drug products, salicylates, or tybamate. EQUAGESIC is also contraindicated in patients with the syndrome of asthma, rhinitis, and nasal polyps. The aspirin component of EQUAGESIC may cause severe angioedema, bronchospasm (asthma), or urticaria.

Reye's syndrome: Aspirin should not be used in children or teenagers for viral infections, with or without fever, because of the risk of Reye's syndrome with concomitant use of aspirin in certain viral illnesses.

WARNINGS

EQUAGESIC should be prescribed cautiously and in small quantities to patients with suicidal tendencies.

Additive Effects

Since CNS suppressant effects of meprobamate and alcohol or meprobamate and other psychotropic drugs may be additive, appropriate caution should be exercised with patients who take more than one of these agents simultaneously.

Alcohol Warning

Patients who consume three or more alcoholic drinks every day should be counseled about the bleeding risks involved with chronic, heavy alcohol use while taking aspirin.

Coagulation Abnormalities

Even low doses of aspirin can inhibit platelet function leading to an increase in bleeding time. This can adversely affect patients with inherited (hemophilia) or acquired (liver disease or vitamin K deficiency) bleeding disorders.

Gastrointestinal Side Effects (GI)
GI side effects include gross GI bleeding, heartburn, nausea, stomach pain, and vomiting. Although minor upper GI symptoms, such as dyspepsia, are common and can occur anytime during therapy, physicians should remain alert for signs of ulceration and bleeding, even in the absence of previous GI symptoms. Physicians should inform patients about the signs and symptoms of GI side effects and what steps to take if they occur.

Peptic Ulcer Disease
Patients with a history of active peptic ulcer disease should avoid using aspirin, which can cause gastric mucosal irritation and bleeding.

Potentially Hazardous Tasks
Patients should be warned that meprobamate may impair the mental and/or physical abilities required for performance of potentially hazardous tasks, such as driving a motor vehicle or operating machinery. Such tasks should be avoided while taking this product.

Fetal Toxicity

Premature Closure of Fetal Ductus Arteriosus

Avoid use of NSAIDs, including EQUAGESIC, in pregnant women at about 30 weeks gestation and later. NSAIDs, including EQUAGESIC, increase the risk of premature closure of the fetal ductus arteriosus at approximately this gestational age.

Oligohydramnios/Neonatal Renal Impairment

Use of NSAIDs, including EQUAGESIC, at about 20 weeks gestation or later in pregnancy may cause fetal renal dysfunction leading to oligohydramnios and, in some cases, neonatal renal impairment. These adverse outcomes are seen, on average, after days to weeks of treatment, although oligohydramnios has been infrequently reported as soon as 48 hours after NSAID initiation. Oligohydramnios is often, but not always, reversible with treatment discontinuation. Complications of prolonged oligohydramnios may, for example, include limb contractures and delayed lung maturation. In some postmarketing cases of impaired neonatal renal function, invasive procedures such as exchange transfusion or dialysis were required.

If NSAID treatment is necessary between about 20 weeks and 30 weeks gestation, limit EQUAGESIC use to the lowest effective dose and shortest duration possible. Consider ultrasound monitoring of amniotic fluid if EQUAGESIC treatment extends beyond 48 hours. Discontinue EQUAGESIC if oligohydramnios occurs and follow up according to clinical practice *[see PRECAUTIONS; Pregnancy]*.

Drug Reaction with Eosinophilia and Systemic Symptoms (DRESS)

Drug Reaction with Eosinophilia and Systemic Symptoms (DRESS) has been reported in patients taking NSAIDs such as EQUAGESIC. Some of these events have been fatal or life-threatening. DRESS typically, although not exclusively, presents with fever, rash, lymphadenopathy, and/or

facial swelling. Other clinical manifestations may include hepatitis, nephritis, hematological abnormalities, myocarditis, or myositis. Sometimes symptoms of DRESS may resemble an acute viral infection. Eosinophilia is often present. Because this disorder is variable in its presentation, other organ systems not noted here may be involved. It is important to note that early manifestations of hypersensitivity, such as fever or lymphadenopathy, may be present even though rash is not evident. If such signs or symptoms are present, discontinue EQUAGESIC and evaluate the patient immediately.

PRECAUTIONS

General

EQUAGESIC should be prescribed with caution in certain special-risk populations, such as elderly or debilitated patients and those with acute abdominal conditions, Addison's disease, coagulation disorders, elevated intracranial pressure, head injuries, hypothyroidism, impairment of liver or kidney function, prostatic hypertrophy, or urethral stricture. Meprobamate is metabolized in the liver and excreted by the kidney. To avoid its excess accumulation, caution should be exercised in the administration to patients with compromised liver or kidney function. Meprobamate occasionally may precipitate seizures in epileptic patients.

Information for Patients

Patients should be informed that EQUAGESIC contains aspirin and should not be taken by patients with an aspirin allergy. Patients with a predisposition for gastrointestinal bleeding should be cautioned that concomitant use of medications containing aspirin and/or alcohol may have an additive effect in this regard.

Serious Skin Reactions, including DRESS

Advise patients to stop taking EQUAGESIC immediately if they develop any type of rash or fever and to contact their healthcare provider as soon as possible *[see WARNINGS]*.

Pregnancy

Embryo-Fetal Toxicity

Inform pregnant women to avoid use of aspirin and other NSAIDs starting at 30 weeks gestation because of the risk of the premature closing of the fetal ductus arteriosus. If treatment with EQUAGESIC is needed for a pregnant woman between about 20 to 30 weeks gestation, advise her that she may need to be monitored for oligohydramnios, if treatment continues for longer than 48 hours *[see WARNINGS; Fetal Toxicity, PRECAUTIONS; Pregnancy]*.

Drug Interactions

Angiotensin Converting Enzyme (ACE) Inhibitors: The hyponatremic and hypotensive effects of ACE inhibitors may be diminished by the concomitant administration of aspirin due to its indirect effect on the renin angiotensin conversion pathway.

Acetazolamide
Concurrent use of aspirin and acetazolamide can lead to high serum concentrations of acetazolamide (and toxicity) due to competition at the renal tubule for secretion.

Alcohol, General Anesthetics, Narcotic Analgesics, Sedative Hypnotics, Tranquilizers such as Chlordiazepoxide, or Other CNS Depressants: The effects of these substances may be enhanced, causing increased CNS depression.

Anticoagulant Therapy (Heparin and Warfarin): Patients on anticoagulation therapy are at increased risk for bleeding because of drug-drug interactions and the effect on platelets. Aspirin can displace warfarin from protein binding sites, leading to prolongation of both the prothrombin time and the bleeding time. Aspirin can increase the anticoagulant activity of heparin, increasing bleeding risk.

Anticonvulsants: Salicylates can displace protein-bound phenytoin and valproic acid, leading to a decrease in the total concentration of phenytoin and an increase in serum valproic acid levels. *Beta*

Blockers: The hypotensive effects of beta blockers may be diminished by the concomitant administration of aspirin due to inhibition of renal prostaglandins, leading to decreased renal blood flow and salt and fluid retention.

Corticosteroids: In patients receiving concomitant corticosteroids and chronic use of medications containing aspirin, withdrawal of corticosteroids may result in salicylism because corticosteroids enhance renal clearance of salicylates and their withdrawal is followed by return to normal rates of renal clearance.

Diuretics: The effectiveness of diuretics in patients with underlying renal or cardiovascular disease may be diminished by the concomitant administration of aspirin due to inhibition of renal prostaglandins, leading to decreased renal blood flow and salt and fluid retention.

6-Mercaptopurine and Methotrexate: Bone marrow toxicity and blood dyscrasia may result from displacing these drugs from secondary binding sites, and in the case of methotrexate, also reducing its excretion.

Nonsteroidal Anti-Inflammatory Drugs (NSAIDs): The concurrent use of aspirin with other NSAIDs should be avoided because this may increase bleeding or lead to decreased renal function.

Oral Hypoglycemics: Moderate doses of aspirin may increase the effectiveness of oral hypoglycemic drugs, leading to hypoglycemia.

Uricosuric Agents (Probenicid and Sulfinpyrazone): Salicylates antagonize the uricosuric action, reducing their effectiveness in the treatment of gout. Aspirin competes with these agents for protein binding sites.

Laboratory Test Interactions
Aspirin may interfere with the following laboratory determinations in blood: blood urea nitrogen,

cholesterol, elevated hepatic enzymes including aspartate aminotransferase (AST), fasting blood glucose, hyperkalemia, prolonged bleeding time, protein, prothrombin time, serum amylase, serum creatinine, and uric acid. Aspirin may interfere with the following laboratory determinations in urine: 5-hydroxyindoleacetic acid, diacetic acid, Gerhardt ketone, glucose, proteinuria, uric acid, spectrophotometric detection of barbiturates, and vanillylmandelic acid (VMA).

Carcinogenesis, Mutagenesis, Impairment of Fertility
Administration of aspirin for 68 weeks at 0.5 percent in the feed of rats was not carcinogenic. In the Ames Salmonella assay, aspirin was not mutagenic; however, aspirin did induce chromosome aberrations in cultured human fibroblasts.

Pregnancy

Risk Summary

Use of NSAIDs, including EQUAGESIC, can cause premature closure of the fetal ductus arteriosus and fetal renal dysfunction leading to oligohydramnios and, in some cases, neonatal renal impairment. Because of these risks, limit dose and duration of EQUAGESIC use between about 20 and 30 weeks of gestation, and avoid EQUAGESIC use at about 30 weeks of gestation and later in pregnancy (*see Clinical Considerations, Data*).

Premature Closure of Fetal Ductus Arteriosus

Use of NSAIDs, including EQUAGESIC, at about 30 weeks gestation or later in pregnancy increases the risk of premature closure of the fetal ductus arteriosus.

Oligohydramnios/Neonatal Renal Impairment

Use of NSAIDs at about 20 weeks gestation or later in pregnancy has been associated with cases of fetal renal dysfunction leading to oligohydramnios, and in some cases, neonatal renal impairment.

Data from observational studies regarding other potential embryofetal risks of NSAID use in women in the first or second trimesters of pregnancy are inconclusive. Based on animal data, prostaglandins have been shown to have an important role in endometrial vascular permeability, blastocyst implantation, and decidualization. In animal studies, administration of prostaglandin synthesis inhibitors such as aspirin, resulted in increased pre- and post-implantation loss. Prostaglandins also have been shown to have an important role in fetal kidney development. In published animal studies, prostaglandin synthesis inhibitors have been reported to impair kidney development when administered at clinically relevant doses.

The estimated background risk of major birth defects and miscarriage for the indicated population(s) is unknown. All pregnancies have a background risk of birth defect, loss, or other adverse outcomes. In the U.S. general population, the estimated background risk of major birth defects and miscarriage in clinically recognized pregnancies is 2% to 4% and 15% to 20%, respectively.

Clinical Considerations

Fetal/Neonatal Adverse Reactions

Premature Closure of Fetal Ductus Arteriosus:

Avoid use of NSAIDs in women at about 30 weeks gestation and later in pregnancy, because NSAIDs, including EQUAGESIC, can cause premature closure of the fetal ductus arteriosus (*see Data*).

Oligohydramnios/Neonatal Renal Impairment:

If an NSAID is necessary at about 20 weeks gestation or later in pregnancy, limit the use to the lowest effective dose and shortest duration possible. If EQUAGESIC treatment extends beyond 48 hours, consider monitoring with ultrasound for oligohydramnios. If oligohydramnios occurs, discontinue EQUAGESIC and follow up according to clinical practice (*see Data*).

Data

Human Data

Premature Closure of Fetal Ductus Arteriosus:

Published literature reports that the use of NSAIDs at about 30 weeks of gestation and later in pregnancy may cause premature closure of the fetal ductus arteriosus.

Oligohydramnios/Neonatal Renal Impairment:

Published studies and postmarketing reports describe maternal NSAID use at about 20 weeks gestation or later in pregnancy associated with fetal renal dysfunction leading to oligohydramnios, and in some cases, neonatal renal impairment. These adverse outcomes are seen, on average, after days to weeks of treatment, although oligohydramnios has been infrequently reported as soon as 48 hours after NSAID initiation. In many cases, but not all, the decrease in amniotic fluid was transient and reversible with cessation of the drug. There have been a limited number of case reports of maternal NSAID use and neonatal renal dysfunction without oligohydramnios, some of which were irreversible. Some cases of neonatal renal dysfunction required treatment with invasive procedures, such as exchange transfusion or dialysis.

Methodological limitations of these postmarketing studies and reports include lack of a control group; limited information regarding dose, duration, and timing of drug exposure; and concomitant use of other medications. These limitations preclude establishing a reliable estimate of the risk of adverse fetal and neonatal outcomes with maternal NSAID use. Because the published safety data on neonatal outcomes involved mostly preterm infants, the generalizability of certain reported risks to the full-term infant exposed to NSAIDs through maternal use is uncertain.

Nursing Mothers

Nursing mothers should avoid using aspirin because salicylate is excreted in breast milk. Use of high doses may lead to rashes, platelet abnormalities, and bleeding in nursing infants. Because of the potential for serious adverse reactions in nursing infants, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother (*See also CONTRAINDICATIONS*).

Pediatric Use
Safety and effectiveness have not been established for pediatric patients under the age of 12 years (*See CONTRAINDICATIONS*).

Geriatric Use
Clinical studies of meprobamate with aspirin did not include sufficient numbers of subjects aged 65 and over to determine whether they respond differently from younger subjects. In general, dose selection for an elderly patient should be cautious, usually starting at the low end of the dosing range, reflecting the greater frequency of decreased hepatic, renal, or cardiac function, and of concomitant disease or other drug therapy.

ADVERSE REACTIONS

Body as a Whole: Fever, hypothermia, thirst.

Allergic or Idiosyncratic: Severe hypersensitivity reactions, including anaphylaxis, angioneurotic edema, anuria, asthma, bronchospasm, bullous dermatitis, chills, erythema multiforme, exfoliative erythroderma, laryngeal edema, oliguria, proctitis, purpura, Stevens-Johnson syndrome, stomatitis, and urticaria. Milder reactions are characterized by an itchy, erythematous maculopapular, or urticarial rash which may be generalized or confined to the groin. Other reactions have included acute non thrombocytopenic purpura, adenopathy, cross-sensitivity between meprobamate/mebutamate and meprobamate/carbromal, ecchymoses, eosinophilia, fixed-drug eruption with cross-reaction to carisoprodol, leukopenia, peripheral edema, and petechiae.

Cardiovascular: Various forms of arrhythmia, hypotension, palpitation, syncope, tachycardia, and transient ECG changes.

Central Nervous System: Agitation, ataxia, cerebral edema, coma, confusion, dizziness, drowsiness, dysphoria, euphoria, fast EEG activity, headache, impairment of visual accommodation, lethargy, overstimulation, paradoxical excitement, paresthesias, sedation, slurred speech, subdural or intracranial hemorrhage, seizures, vertigo, and weakness.

Fluid and Electrolyte: Dehydration, hyperkalemia, metabolic acidosis, and respiratory alkalosis.

Gastrointestinal Abdominal pain, constipation, diarrhea, dyspepsia, epigastric discomfort, gastric distress, gastrointestinal bleeding, heartburn, hepatitis, nausea, pancreatitis, Reye's syndrome, transient elevations of hepatic enzymes, ulceration and perforation, and vomiting.

Hematologic (see also "Allergic or Idiosyncratic"): Agranulocytosis and aplastic anemia have been reported, although no causal relationship has been established, coagulopathy, disseminated

intravascular coagulation, exacerbation of porphyric symptoms, hemolytic anemia, iron deficiency anemia, occult blood loss, prolongation of the prothrombin time, thrombocytopenia, and thrombocytopenic purpura.

Musculoskeletal: Rhabdomyolysis

Metabolism: Hyperglycemia and hypoglycemia

Reproductive: Prolonged pregnancy and labor, stillbirths, lower birth weight infants, and antepartum and postpartum bleeding.

Respiratory: Acute airway obstruction, hyperpnea, pulmonary edema, and tachypnea.

Special Senses: Hearing loss and tinnitus.

Urogenital: Interstitial nephritis, papillary necrosis, proteinuria, and renal insufficiency and failure.

DRUG ABUSE AND DEPENDENCE

Physical dependence, psychological dependence, and abuse have occurred. Chronic intoxication from prolonged ingestion of, usually, greater-than-recommended doses is manifested by ataxia, slurred speech, and vertigo. Therefore, careful supervision of dose and amounts prescribed is advised, as well as avoidance of prolonged administration, especially for alcoholics and other patients with a known propensity for taking excessive quantities of drugs. Sudden withdrawal of the drug after prolonged and excessive use may precipitate recurrence of preexisting symptoms, such as anorexia, anxiety, or insomnia, or withdrawal reactions, such as ataxia, confusional states, hallucinosis, muscle twitching, tremors, vomiting, and, rarely, convulsive seizures. Such seizures are more likely to occur in persons with central nervous system damage or preexistent or latent convulsive disorders. Onset of withdrawal symptoms occurs usually within 12 to 48 hours after discontinuation of meprobamate; symptoms usually cease within the next 12- to 48-hour period. When excessive dosage has continued for weeks or months, dosage should be reduced gradually over a period of 1 to 2 weeks rather than abruptly stopped. Alternatively, a long-acting barbiturate may be substituted, then gradually withdrawn.

OVERDOSAGE

Treatment of overdose with EQUAGESIC is essentially symptomatic and supportive. In cases where excessive doses of EQUAGESIC have been taken, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels. Any drug remaining in the stomach should be removed and symptomatic treatment given. After emesis and/or lavage, activated charcoal may reduce absorption of both aspirin and meprobamate. Should respiration or blood pressure become compromised, respiratory assistance, central nervous system stimulants, and pressor agents should be administered cautiously as indicated. Diuresis, osmotic (mannitol) diuresis, peritoneal dialysis, and hemodialysis have been used successfully in removing both aspirin and meprobamate.

Alkalinization of the urine increases the excretion of salicylates. Careful monitoring of urinary output is necessary, and caution should be taken to avoid over hydration. Relapse and death, after initial recovery, have been attributed to incomplete gastric emptying and delayed absorption.

Salicylate toxicity may result from acute ingestion (overdose) or chronic intoxication. Signs and symptoms include abdominal pain, acidbase disturbances with development of metabolic acidosis, convulsions, delirium, hyperpnea, hyperthermia, hypoprothrombinemia, restlessness, tinnitus (ringing in the ears), and vomiting.

The early signs of salicylic overdose (salicylism), including tinnitus, occur at plasma concentrations approaching 200 μg/mL. Plasma concentrations of aspirin above 300 μg/mL are clearly toxic. Severe toxic effects are associated with levels above 400 μg/mL. A single lethal dose of aspirin in adults is not known with certainty but death may be expected at 30 g. For real or suspected overdose, a Poison Control Center should be contacted immediately. Careful medical management is essential. In acute aspirin overdose, severe acid-base and electrolyte disturbances may occur and are complicated by hyperthermia and dehydration. Respiratory alkalosis occurs early while hyperventilation is present, but is quickly followed by metabolic acidosis. Treatment of aspirin overdose consists primarily of supporting vital functions, increasing salicylate elimination, and correcting the acid-base disturbance. Gastric emptying and/or lavage is recommended as soon as possible after ingestion, even if the patient has vomited spontaneously. After lavage and/or emesis administration of activated charcoal, as a slurry, is beneficial, if less than 3 hours have passed since ingestion. Charcoal adsorption should not be employed prior to emesis and lavage. Severity of aspirin intoxication is determined by measuring the blood salicylate level. Acid-base status should be closely followed with serial blood gas and serum pH measurements. Fluid and electrolyte balance should also be maintained. In severe cases, hyperthermia and hypovolemia are the immediate threats to life. Children should be sponged with tepid water. Replacement fluid should be administered intravenously and augmented with correction of acidosis. Plasma electrolytes and pH should be monitored to promote alkaline diuresis of salicylate if renal function is normal. Infusion of glucose may be required to control hypoglycemia. Hemodialysis and peritoneal dialysis can be performed to reduce the body drug content. In patients with renal insufficiency or in cases of life-threatening intoxication, dialysis is usually required. Exchange transfusion may be indicated in infants and young children. Suicidal attempts with meprobamate have resulted in ataxia, coma, drowsiness, lethargy, shock, stupor, and respiratory and vasomotor collapse. Some suicidal attempts have been fatal. The following data have been reported in the literature and from other sources. These data are not expected to correlate with each case (considering factors such as individual susceptibility and length of time from ingestion to treatment) but represent the usual ranges reported. Acute simple overdose (meprobamate alone): Death has been reported with ingestion of as little as 12 grams meprobamate and survival with as much as 40 grams.

Blood Levels

0.5 to 2 mg percent represents the usual blood-level range of meprobamate after therapeutic doses. 3 to 10 mg percent usually corresponds to findings of mild to moderate symptoms of overdosage, such as stupor or light coma. 10 to 20 mg percent usually corresponds to deeper coma, requiring more intensive treatment. Some fatalities occur.

At levels greater than 20 mg percent, more fatalities than survivals can be expected. Acute combined overdose (meprobamate with other CNS psychotropic drugs or alcohol): Since effects can be additive, a history of ingestion of a low dose of meprobamate plus any of these compounds (or of a relatively low blood or tissue level) cannot be used as a prognostic indicator.

DOSAGE AND ADMINISTRATION

The usual dosage of EQUAGESIC is one or two tablets, each tablet containing meprobamate, 200 mg, and aspirin, 325 mg, orally 3 to 4 times daily as needed for the relief of pain when tension or anxiety is present. EQUAGESIC is not recommended for patients 12 years of age and under.

HOW SUPPLIED

The drug product is not being marketed.

Distributed by: The drug product is not being marketed.

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