1. NAME OF THE MEDICINAL PRODUCT

Pneumococcal Polysaccharide Conjugate Vaccine (Adsorbed) (10-Valent) **(PNEUMOSIL®)**

Injectable, Suspension for injection.

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

Composition per unit dose (as per label claim):

PNEUMOSIL (10-valent) (Single and Multi-dose)
Each dose of 0.5 ml contains:

Saccharide for serotypes 1, 5, 6A, 7F, 9V, 14, 19A, 19F and 23F	2 mcg each
Saccharide for serotype 6B	4 mcg
Conjugated to CRM197 carrier protein	19 to 48 mcg
Aluminium (as Aluminium phosphate)	0.125 mg

Dose: 0.5 ml by intramuscular injection.

Excipients:

L-Histidine	1.55 mg
Succinic acid	1.18 mg
Sodium Chloride	4.50 mg
Polysorbate-20	0.05 mg
Thiomersal*	0.005 %
Water for Injection	q.s. to 0.5 ml

* Added only in multi-dose presentation

3. PHARMACEUTICAL FORM

Suspension for injection.
Whitish turbid liquid.

4. CLINICAL PARTICULARS

4.1 Therapeutic indications

For active immunization against invasive disease & pneumonia caused by *Streptococcus pneumoniae* serotypes 1, 5, 6A, 6B, 7F, 9V, 14, 19A, 19F & 23F in infants from 6 weeks of age group for 3 dose regimen (dosing schedules: 6, 10 &14 weeks and 6 weeks, 14 weeks & 9 months).

4.2 Posology and method of administration

For intramuscular use only: The dose is 0.5 ml given intramuscularly, with care to avoid Injection into or near nerves and blood vessels. The product is a suspension containing an adjuvant, shake vigorously immediately prior to use to obtain a homogenous, whitish turbid liquid in the vaccine container. The vaccine should be given by intramuscular injection. The preferred sites are anterolateral aspect of the thigh in infants or the deltoid muscle of the upper arm in young children. The vaccine should not be injected in the gluteal area. Do not administer Pneumococcal Polysaccharide Conjugate Vaccine (Adsorbed) (10-valent) [PNEUMOSIL] intravascularly. The vaccine should not be injected intradermally, subcutaneously or intravenously, since the safety and immunogenicity of these routes have not been evaluated.

Once opened, multi-dose vials should be kept between +2°C and +8°C. Multi-dose vials of Pneumococcal Polysaccharide Conjugate Vaccine (Adsorbed) (10-valent) [PNEUMOSIL] from which one or more doses of vaccine have been removed during an immunization session may be used in subsequent immunization sessions for up to a maximum of 28 days, provided that all of the following conditions are met (as described in the WHO policy statement: Handling of multi dose vaccine vials after opening, WHO/IVB/14.07):

- The vaccine is currently prequalified by WHO.
- The vaccine is approved for use for up to 28 days after opening the vial, as determined by WHO.
- The expiry date has not passed.
- The vaccine vial has been, and will continue to be, stored at WHO or manufacturer recommended temperatures; furthermore, the vaccine vial monitor, if one is attached, is visible on the vaccine label and is not past its discard point, and the vaccine has not been damaged by freezing. The vaccine should be visually inspected for any foreign particulate matter and / or variation of physical aspect prior to administration. In event of either being observed, discard the vaccine.

4.2.1 Vaccination schedule

Pneumococcal Polysaccharide Conjugate Vaccine (Adsorbed) (10-valent) is to be administered as a three-dose primary series at 6, 10, and 14 weeks of age. The minimum interval between doses should be 4 weeks.

Alternatively, Pneumococcal Polysaccharide Conjugate Vaccine (Adsorbed) (10-valent) is to be administered as a two-dose primary series at 6 and 14 weeks of age with a booster dose at 9-10 months of age.

Vaccination Schedules for Infants				
Dosage Schedules	**Dose 1 [a, b]**	**Dose 2 [b]**	**Dose 3 [b]**	**Dose 4 [c]**
3p+0	6 weeks	10 weeks	14 weeks	--
2p+1	6 weeks	--	14 weeks	9 – 10 months
a Dose 1 may be given as early as 6 weeks of age. **b** The recommended dosing interval is 4-8 weeks. **c** A booster dose is recommended at the age of 9-10 months of age.				

Clinical Trials with PNEUMOSIL

PNEUMOSIL (10-valent) has been extensively evaluated in 7 randomized controlled clinical trials and has demonstrated comparable safety and immunogenicity against licensed pneumococcal vaccines across diverse populations of India and Africa, where **PNEUMOSIL** was administered to adults, toddlers and infants using different vaccination schedules, with all sera samples being tested (WHO standard ELISA and MOPA) at the WHO Pneumococcal Reference Laboratory in the UK;

Study No. / Phase / Location	**Study Population**	**Schedule of vaccination / Control**	**No. Subjects**	
			PNEUMOSIL	**Comparator**
PCV-10-001 / Phase 1 / India	PCV-naïve adults (18-40 years inclusive)	Single dose / Pneumovax®23	17	17
	In a Prospective, Randomized, Two-Arm, Active Controlled, Double-Blind Study; • A single dose of **PNEUMOSIL** was well tolerated and showed no safety concerns in healthy Indian adults, demonstrating a safety profile comparable with the licensed comparator.			
VAC-017 / Phase 1/2 / The Gambia	PCV-naïve adults (18-40 years inclusive)	Single dose / Pneumovax®23	17	17
	PCV-primed toddlers (12-15 months inclusive)	Single dose / Prevenar 13®	56	56
	PCV-naïve infants (6 to 8 weeks inclusive)	3-dose primary vaccination series (at 6, 10 and 14 weeks of age) / Prevenar13®	100	100
		Booster vaccination at 10-14 months of age in a subset / Prevenar 13®	49	47

Study No. / Phase / Location	Study Population	Schedule of vaccination / Control	No. Subjects	
			PNEUMOSIL	**Comparator**
	In a Phase 1/2, Prospective, Single Centre, Randomized, Active-Controlled, Double-Blind, Age De-escalation Study; • **PNEUMOSIL** demonstrated similar safety and tolerability profile in all three age groups to the licensed comparator/s. • **PNEUMOSIL** was immunogenic in all three age groups as measured both with IgG antibody level and functional activity (OPA). • IgG GMCs were > 1µg/ml for all serotypes in both **PNEUMOSIL** and the licensed comparator group. Post booster GMCs were comparable between groups. • **PNEUMOSIL** elicited a strong booster response for all 10 serotypes, comparable to the licensed comparator. • **PNEUMOSIL** did not appear to interfere with the responses to concomitantly administered vaccinations. • Pre-booster vaccination IgG GMCs were generally comparable between both **PNEUMOSIL** and licensed comparator groups, and were lower than the respective post primary series GMCs for both groups.			
PCV-10-002 / Phase 2 / India	PCV-naïve toddlers (12-15 months inclusive)	Two dose Catch-up schedule, 8 weeks apart / Prevenar 13®	57	57
	In a Phase 2, Prospective, Multi-centre, Randomized, Two-arm, Active Controlled, Double-blind Study; • **PNEUMOSIL** was well tolerated and no safety signals were identified, demonstrating a similar safety and tolerability profile to the licensed comparator • Overall immune responses (both IgG by ELISA, as well as functional responses by OPA) following **PNEUMOSIL** were robust and comparable to those following the licensed comparator**, with** IgG GMCs > 1µg/ml for all 10 serotypes in both treatment groups.			
VAC-056 / Phase 3 / The Gambia (3+1)	PCV-naïve infants (6 to 8 weeks inclusive on Day 0)	3-dose primary vaccination series (at 6, 10 and 14 weeks of age) / Synflorix®	1,503	747
		Booster vaccination at 9-10 months of age in a subset / Synflorix®	428	213

Study No. / Phase / Location	Study Population	Schedule of vaccination / Control	No. Subjects	
			PNEUMOSIL	**Comparator**
	In a Pivotal Phase 3, Randomized, Double-Blind Study; • Lot-to-Lot consistency was established with equivalence demonstrated for the 3 lots of **PNEUMOSIL** evaluated in the study. • Non-inferiority was demonstrated for all 10 serotypes in **PNEUMOSIL** in comparison to the immune responses induced by the licensed comparator, after a 3-dose primary series, on the basis of both % IgG responders (≥ 0.35 µg/mL) as well as IgG GMC ratios. • Robust functional responses were demonstrated for all 10 serotypes in **PNEUMOSIL** by both % OPA responders (≥ 1:8) as well as OPA GMT ratios, favourably comparable to those induced by the licensed comparator. • Robust booster IgG and OPA responses were demonstrated for all 10 serotypes in **PNEUMOSIL**, favourably comparable to those induced by the licensed comparator. • Non-inferior non-interference to all co-administered EPI vaccines was established in comparison to the licensed comparator group. • **PNEUMOSIL** had an acceptable safety and tolerability profile, with no notable difference in comparison with the licensed comparator. • Antibodies elicited by the booster dose were shown to persist at least as well following **PNEUMOSIL** as following the licensed comparator for all serotypes over the 1-year follow-up period post booster.			
PCV-10-003 / Phase 3 / India (3+0)	PCV-naïve infants (6 to 8 weeks inclusive on Day 0)	3-dose vaccination series (at 6, 10 and 14 weeks of age) / Prevenar 13®and Synflorix®	225	223
	In a Phase 3, Randomized, Double-Blind Study; • **PNEUMOSIL** was highly immunogenic in Indian infants and induced robust serotype specific IgG and functional OPA responses for all 10 serotypes. • The study data indicates comparable immunogenicity of **PNEUMOSIL** to both licensed comparators using either of the WHO defined IgG endpoints and/or OPA endpoints for all 10 serotypes and thus demonstrates comparability of **PNEUMOSIL** with both currently licensed PCVs in India, in Indian infants. • The robust OPA results are clinically significant in light of increasing clinical importance assumed by OPA over IgG, as opsonophagocytosis is considered as the primary mechanism of host defence against pneumococcal disease, and is being increasingly observed to correlate well with protection offered against IPD. • **PNEUMOSIL** was safe and well tolerated in a 3+0 vaccination schedule in Indian infants, with a safety and reactogenicity profile favourably comparable to both licensed comparators.			
CVIA-074 / Phase 3 / The Gambia (2+1)	PCV-naïve infants (6 to 8 weeks inclusive on Day 0)	3-dose vaccination series (at 6, 14 weeks and 9 months of age) / Prevenar 13® and Synflorix®	220	440
	In a Phase 3, Randomized, Double-Blind Study; • **PNEUMOSIL** was shown to induce a robust immune response (by both ELISA and OPA) to all pneumococcal serotypes contained in the vaccine 4 weeks after completion of the 2+1 schedule • A substantial immune response was also induced following the 2-dose primary vaccination series with **PNEUMOSIL** which resulted in persistence of detectable levels of antibodies to all serotypes up to the time of the booster dose. • **PNEUMOSIL** was demonstrated to have an acceptable safety profile and be well-tolerated when co-administered with routine Pediatric vaccines through 4 weeks after a booster vaccination. No safety concerns were identified for the vaccine.			

Study No. / Phase / Location	Study Population	Schedule of vaccination / Control	No. Subjects	
			PNEUMOSIL	Comparator
PCV-10-004 / Phase 3 /India (2+1)	PCV-naïve infants (6 to 8 weeks inclusive on Day 0)	3-dose vaccination series (at 6, 14 weeks and 9 months of age) / Prevenar 13® and Synflorix®	168	168
	In a Phase 3, Randomized, Double-Blind Study; • **PNEUMOSIL®** when administered in 2+1 vaccination schedule induces similar immune response to that of Prevenar 13® and Synflorix using WHO defined IgG GMC endpoints and OPA GMT endpoints. • **PNEUMOSIL®** was safe and well tolerated when administered in Indian infant population in a 2+1 vaccination schedule, with a safety and reactogencity profile comparable to both Prevenar 13® and Synflorix.			

4.3 Contraindications

Hypersensitivity to any component of the vaccine, including diphtheria toxoid.

4.4 Special Warnings and Precautions for Use:

4.4.1 Special Warnings

As with all Injectable vaccines, appropriate medical treatment and supervision must always be readily available in case of a rare anaphylactic event following the administration of the vaccine.

4.4.2 Precautions

Adrenaline injection (1:1000) must be immediately available should an acute anaphylactic reaction occur due to any component of the vaccine. For treatment of severe anaphylaxis the initial dose of adrenaline is 0.1- 0.5 mg (0.1- 0.5 ml of 1:1000 injection) given s/c or i/m. Single dose should not exceed 1 mg (1 ml). For infants and children the recommended dose of adrenaline is 0.01 mg/kg (0.01 ml/kg of 1:1000 injection). Single pediatric dose should not exceed 0.5 mg (0.5 ml). The mainstay in the treatment of severe anaphylaxis is the prompt use of adrenaline, which can be lifesaving. It should be used at the first suspicion of anaphylaxis.

As with the use of all vaccines the vaccinee should remain under observation for not less than 30 minutes for possibility of occurrence of immediate or early allergic reactions. Hydrocortisone and antihistaminics should also be available in addition to supportive measures such as oxygen inhalation and IV fluids.

Special care should be taken to ensure that the injection does not enter a blood vessel. **IT IS EXTREMELY IMPORTANT WHEN THE PARENT/GUARDIAN RETURNS FOR THE NEXT DOSE IN THE SERIES THE PARENT/GUARDIAN SHOULD BE QUESTIONED CONCERNING OCCURRENCE OF ANY SYMPTOMS AND/OR SIGNS OF AN ADVERSE REACTION AFTER THE PREVIOUS DOSE.**

Minor illnesses, such as mild respiratory infection, with or without low grade fever, are not generally contraindications to vaccination. The decision to administer or delay vaccination because of a current or recent febrile illness depends largely on the severity of the symptoms and their etiology. The administration of **PNEUMOSIL** (10-valent) should be postponed in subjects suffering from acute severe febrile illness. As with any intramuscular injection, **PNEUMOSIL** (10-valent) should be given with, caution to infants or children with thrombocytopenia or any coagulation disorder, or to those receiving anticoagulant therapy. This vaccine is not intended to be used for treatment of active infection. As with any vaccine, **PNEUMOSIL** (10-valent) may not protect all individuals receiving the vaccine from pneumococcal disease.

4.5 Special Populations:

Safety and immunogenicity data on **PNEUMOSIL** (10-valent) are not available for children in specific groups at higher risk for invasive pneumococcal disease (e.g., children with congenital or acquired splenic dysfunction, HIV infection, malignancy, nephrotic syndrome). Children in these groups may have reduced antibody response to active immunization due to impaired immune responsiveness. Limited data have demonstrated that other pneumococcal conjugate vaccines induce an immune response in children with HIV, sickle cell disease, and children born prematurely with a safety profile similar to that observed in non-high-risk groups. The use of **PNEUMOSIL** (10-valent) in high-risk groups should be considered on an individual basis.

Apnoea in Premature Infants: Based on experience with use of other pneumococcal conjugate vaccines, the potential risk of apnoea and the need for respiratory monitoring for 48-72 hours should be considered when administering the primary immunization series to very premature infants (born ≤ 28 weeks of gestation) and particularly for those with a previous history of respiratory immaturity. As the benefit of vaccination is high in this group of infants, vaccination with **PNEUMOSIL** (10-valent) should not be withheld or delayed.

4.6 Interaction with other medicinal products and other forms of interaction

PNEUMOSIL (10-valent) can be given with any of the following vaccine antigens, either as monovalent or combination vaccines: diphtheria, tetanus, whole-cell pertussis, *Haemophilus influenzae* type b, inactivated or oral poliomyelitis, rotavirus, hepatitis B. Clinical studies demonstrated that the immune responses and the safety profiles of the administered vaccines were unaffected.

Different injectable vaccines should always be given at different injection-sites. Till date **PNEUMOSIL** (10-valent) clinical studies have been conducted in India and The Gambia in toddlers and infants.

In the Gambia Phase 1/2 study, there was no evidence that administration of **PNEUMOSIL** (10-valent) interfered with the immune response to any component of co-administered pentavalent vaccine.

In the Gambia Phase 3 study, non-inferiority of the immune responses induced by EPI vaccines between treatment groups was demonstrated for all EPI vaccines co-administered during the 3-dose primary vaccination series (6 weeks, 10 weeks and 14 weeks) – namely, whole-cell pentavalent vaccine (DTwP-HepB-Hib), oral polio vaccine, inactivated polio

vaccine, and oral rotavirus vaccine. Standard EPI vaccines based on the Gambian EPI schedule (measles-rubella vaccine and yellow fever virus vaccine) were co-administered with the booster dose of study vaccine. Safety on co-administration and non-inferiority of the immune responses was demonstrated for these co-administered EPI vaccines.

4.7 Pregnancy and lactation

Human data on the use during pregnancy or lactation are not available.

4.8 Paediatric use

Pneumococcal Polysaccharide Conjugate Vaccine (Adsorbed) I.P. (10-valent) is not intended for use in children below the age of 6 weeks. The safety and effectiveness in children below the age of 6 weeks has not been established.

4.9 Effects on ability to drive and use machines:

The vaccine is unlikely to produce an effect on the ability to drive and use machines.

4.10 Undesirable effects:

Summary of the safety profile

Safety assessment of **PNEUMOSIL** (10-valent) was based on clinical trials involving the cumulative administration of 7648 doses into 2363 subjects (34 doses in 34 adults, 168 doses in 113 toddlers and 7446 doses in 2216 infants). **PNEUMOSIL** (10-valent) was administered concomitantly with recommended childhood vaccines, as appropriate. The vast majority of the reactions observed following vaccination were of mild or moderate severity and were of short duration.

In the largest study in infants, the most common adverse reactions observed after primary vaccination were tenderness at the injection site, fever and irritability, which were reported for approximately 49%, 52% and 32% of all infants, respectively. No increase in the incidence or severity was observed following subsequent doses of the primary vaccination course. Following booster vaccination, the most common adverse reaction was tenderness at the injection site, which was reported for approximately 8% of all infants.

The Indian Phase 3 licensure study in infants similarly showed tenderness at the injection site, fever and irritability as the most common adverse reactions observed after primary vaccination, with no change in the incidence or severity observed following subsequent doses of the primary vaccination course. Majority of the solicited AEs were of mild to moderate intensity and resolved completely.

In the Gambian Phase 3 descriptive study in infants, the most common adverse reaction observed were tenderness at the injection site, irritability and fever, which were reported for approximately 31.8%, 47.7% and 44.5% of all infants respectively. Majority of the solicited AEs were of mild to moderate intensity and resolved completely.

The Indian Phase 3 descriptive study in infants similarly showed tenderness at the injection site, fever and irritability as the most common adverse reactions observed after vaccination. Majority of the solicited AEs were of mild to moderate intensity and resolved completely.

Safety was also assessed in 57 previously unvaccinated children during the second year of life; all children received 2 doses of vaccine. PNEUMOSIL (10-valent) has also been used for booster vaccination in 56 children who received another pneumococcal conjugate vaccine for the primary course. The injection site and systemic reactions following catch-up vaccination or booster vaccination during the second year of life were similar to those reported after primary vaccination.

In all studies, the incidence and severity of local and general adverse reactions reported within 7 days of vaccination were comparable to those after vaccination with the licensed comparator PCVs.

Tabulated list of adverse reactions

Adverse reactions (i.e. events considered as related to vaccination) have been categorised by frequency for all age groups.
Frequencies are reported as:
Very common (≥1/10 vaccinees)
Common (≥1/100 vaccinees but < 1/10 vaccinees)
Uncommon (≥1/1000 vaccinees but < 1/100 vaccinees)
Rare (≥1/10,000 vaccinees but < 1/1,000 vaccinees)

System Organ Class	Frequency	Adverse reactions
Gastrointestinal disorders	Uncommon	Diarrhoea
General disorders and administration site conditions	Very common	Pain, Fever ≥ 37.5°C (axillary)
	Common	Erythema, Swelling/induration
	Uncommon	Fever > 39°C (axillary)
Metabolism and nutrition disorders	Common	Decreased appetite
Nervous system disorders	Common	Drowsiness
Psychiatric disorders	Very common	Irritability
Skin and subcutaneous tissue disorders	Common	Rash

4.11 Overdose

No case of overdose has been reported.

5. PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: Vaccines

Pneumococcal Polysaccharide Conjugate Vaccine (Adsorbed) (10-Valent) (PNEUMOSIL®), ATC code J07AL02.

Mode of Action:

PNEUMOSIL (10-valent) is a pneumococcal polysaccharide conjugate vaccine containing 10 pneumococcal capsular polysaccharides (1, 5, 6A, 6B, 7F, 9V, 14, 19A, 19F, 23F) that are

conjugated via CDAP chemistry to a genetically recombinantly-derived carrier protein, CRM_{197}. T-dependent and T-independent mechanistic pathways both come into play in the production of antibodies by B cells stimulated by antigens. Helper T cell (CD4+ T cell) mediated signals to B cells through surface protein engagement and cytokine release causes them to proliferate and differentiate into long-lived plasma cells that keep producing IgG antibodies (among other isotypes), and memory B cells that are primed to produce antibodies whenever re-exposed to the same antigen. Capsular polysaccharides, however, only work via the T-independent pathway, causing B cells recruited to only largely produce IgM antibodies, with no affinity maturation, and no proliferation and differentiation into memory B cells either. Unconjugated polysaccharide vaccines therefore are very poorly (to not at all) immunogenic in infants and toddlers (children under the age of 2 years) and fail in the induction of immune memory at any and all ages as well. It is therefore necessary to conjugate the T-independent capsular polysaccharides to an immunogenic T-dependent protein carrier (like CRM_{197}) to recruit the T-dependent pathway that then results in B cell antibody affinity maturation and the induction of long term immune memory via the proliferation of memory B cells, eliciting then strong boosting in infants and younger children when challenged with the same pneumococcal capsular polysaccharides later in life.

Disease burden:

Pneumonia kills more children worldwide than any other infectious cause of death, killing nearly a million-under-five-year olds in 2015 alone. *S. pneumoniae* continues to remain the No. 1 cause of severe pneumonia out of several other bacterial and viral etiologies, also causing other serious invasive pneumococcal diseases (IPD) like meningitis and sepsis that cumulatively contribute to a very huge morbidity and mortality disease burden overall. The greatest incidence of IPD is observed children less than 2 years old and the elderly. Vaccines continue to remain the single most effective solution with the greatest cost-to-benefit ratio to tackle the humungous burden of pneumococcal disease in the world, and especially in the developing world and the middle-income countries, which account for more than 95% of all pneumococcal deaths. Of the approximately 1 million children who die every year because of pneumococcal diseases, about 90% of these deaths occur in low-income countries such as India. The burden of IPD in Indian children remains inordinately high, with the UNICEF estimating that about 400,000 under 5-year-old children die due to pneumonia, around 100,000 of these deaths being caused by pneumococci. PNEUMOSIL (10-valent) incorporates the most prevalent IPD causing serotypes in India, as well as Africa, Asia, and Latin America (serotypes 1, 5, 6A, 6B, 7F, 9V, 14, 19A, 19F, and 23F), offering a cumulative coverage of over 71% against IPD causing serotypes. Additionally, according to the most recent WHO Position Paper (2019) and SAGE research evidence and recommendations on serotypes 6A and 19A, in epidemiologic settings where there is substantial disease burden attributable to 6C (6A offering cross protection) or 19A, a vaccine containing 6A and 19A may provide added benefit, and PNEUMOSIL (10-valent) contains both these important serotypes.

Immunological Data:
Clinical trials performed to assess immunogenicity and reactogenicity of the vaccine and proved that the vaccine is immunogenic.

5.2 Pharmacokinetic properties
Pharmacokinetic studies are not required for vaccines.

5.3 Preclinical safety data
Single and multiple administration of the **PNEUMOSIL** (10-valent) to rats and rabbits were well tolerated and revealed no evidence of any significant local or systemic toxic effects. Observed changes were not considered adverse but rather a consequence of the pharmacological activity of **PNEUMOSIL** (10-valent) and licensed pneumococcal conjugate vaccine comparator.

6. PHARMACEUTICAL PARTICULARS
6.1 Incompatibilities
The vaccine is not to be mixed with other vaccines/products in the same syringe.

6.2 Shelf-life
36 months from the date of manufacture for Vial presentation (1 dose and 5 dose)
24 months from the date of manufacture for PFS presentation (1 dose).

6.3 Special precautions for storage
Pneumococcal Polysaccharide Conjugate Vaccine (Adsorbed) (10-valent) [PNEUMOSIL] should be stored at +2° C to +8° C. DO NOT FREEZE. Discard if the vaccine has been frozen. A fine white deposit with clear colourless supernatant may be observed upon storage of the vial. This does not constitute a sign of deterioration.

6.4 Nature and contents of container

Single dose presentation	:	1 dose vial of 0.5 ml
		1 dose PFS of 0.5 ml
Multi-dose presentation	:	5 dose vial of 2.5 ml

6.5 Special precautions for disposal
Any unused product or waste material should be disposed of in accordance with local requirements.

7. MARKETING AUTHORISATION HOLDER / PREQUALIFICATION HOLDER

Name: Serum Institute of India Pvt. Ltd.
Address: 212/2, Hadapsar, Pune - 411 028, Maharashtra, INDIA.
Telephone No: 91-20-26993900, 91-20-26602378
Fax No: 91-20-26993945

8. MARKETING AUTHORISATION NUMBER(S)

Permission No.: MF/BIO/20/000059 dated 14-Jul-2020

9. DATE OF FIRST AUTHORISATION / RENEWAL OF THE AUTHORISATION

Permission No.: MF/BIO/20/000059 dated 14-Jul-2020
Manufacturing License number: 10

Date of renewal of authorization:

- License Retention Date: 01.01.2022

Date: 31 December 2022