

Prenoxad 1mg/ml Solution for Injection in a pre-filled syringe, Macarthys Laboratories, (Aurum Pharmaceuticals Ltd), caution due to potential missing needles in sealed kits

Date of Issue: 10-1	Nov-22	Reference No:	NatPSA/2022/009/MHRA		
This alert is for action by: prima	ary and secondary care,	specifically those involv	ved in outreach services		
This is a safety critical and straightfor leader (or equivalent role in organisat Procurement/Supplies or equivalent r Directors of Public Health/Commissio	tions without executive boards oles, as well as leaders in ge ners and providers of drug tre	 supported by Chief Pharma neral practice and community eatment and prevention service 	acists, Chief Nurse and Head of pharmacy, in collaboration with ces and other relevant service.		
DMRC Medicines Defect Classification Class 4 Medicines Defect Information: Caution In Use					
Explanation of identified safe	ety issue:	Actions required	\triangle		
Macarthys Laboratories (trading a Ethypharm Group Company), has limited number of Prenoxad kits (pain France have missing needles. Although no reports of UK marketed have been received to date, the p fewer than two (2) needles in all dist 2) cannot be excluded based on company. However, due to the critic the specified batches are not being Prenoxad kits are packed with two inch needles, along with the pre-fil active ingredient (naloxone hydro Information Leaflet. Naloxone is a drug that reverses overdose. If no needles are present that patients, members of the professionals may not be able to act of naloxone from these kits in an em the treatment for a patient with an op result in delay to intervention and point Healthcare professionals and serv the actions required before supplyin We ask providers to contact in Prenoxad kits where possible and kits contain two (2) needles in each provided to individuals with kits who their kits. See page 2 and <u>supplement</u> Please see the <u>Summary of Pr</u> additional information on safety of the professional information on safety of the professional information on safety of the professional information on safety of the provided to individuals with kits who their kits.	notified the MHRA that a acks) in a batch marketed d kits with missing needles botential for kits to contain tributed batches (see page the investigation by the tical need for this product, recalled. (2) Terumo 23 gauge 1¼ led syringe containing the bochloride), and a Patient a the effects of an opioid ht in the kit, there is a risk public and/or healthcare dminister life-saving doses bergency. This may impede pioid overdose, which may ossible death. tice providers should note ng Prenoxad kits. individuals supplied with support checks to ensure ch kit. Support should be to are unsure how to check entary information.	 <u>4 Medicines Defect Inform</u> November 2022. This incl. Check all Prenoxad kits the batches specified in Visually inspect the from 2D matrix facing you) a (2) needle packets are <u>MHRA Class 4 Medicine</u> If needles cannot be cleat the kit(s), the kit(s) can presence of two (2) need the Medicines Notificativisual inspection. As the broken as part of the recommended that kit(s) dispensing or supplying that they are aware of the that the clear plastic can must remain intact in medicinal product (see <u>Medicines Defect Inform</u> Where there are kit(s) in quarantine these immediation arrange for replacement concerns around visual contact Ethypharm for replacement kit(s). Report any defective kits including if kits were you lnclude the batch numbine. If urgent use of Prenoxis needles are missing from needles or reasonable for intramuscular adminine. If patients or members without two (2) needles and visually check for the supplying this. 	in place at your organisation against this alert. at of the kit (with the Lot number and against a light source to confirm two present in the kit (see images in the es Defect Information). early seen by the visual inspection of be physically opened to confirm the edles inside the kit(s) (see images in ion). The kit(s) can be closed after e tamper evident seal (TES) will be physical inspection process, it is s) are only opened at the point of to a patient/member of the public, so he reason for breaking the seal. Note p at the end of the pre-filled syringe order to maintain sterility of the e images in the <u>MHRA Class 4</u> nation). In your stock without two (2) needles, ediately and contact Ethypharm to nt kit(s). Similarly, where there are I or physical inspection of the kit(s), or further advice or to arrange s via the <u>MHRA Yellow Card scheme</u> , without two (2) needles in the kit. er in this report. ad is required in an emergency and m the kit, Terumo 23 gauge 1¼ inch alternative needles should be used		

For further detail, resources and supporting materials see: www.gov.uk/drug-device-alerts

For any enquiries about this alert contact: DMRC@mhra.gov.uk

Additional information:

Product Information: Macarthys Laboratories (Marketing Authorisation Holder: Aurum Pharmaceuticals Ltd)

	Injection in a pre-filled syring		PL12064/0125
Batch/Lot Number	Expiry Date	Kit Size	First Distributed
0116917	02/2023	1 kit	27 March 2020
0119973	02/2023	1 kit	09 April 2020
0120140	02/2023	1 kit	09 April 2020
0125553	04/2023	1 kit	13 May 2020
0125555	04/2023	1 kit	24 July 2020
0125724	04/2023	1 kit	09 June 2020
0126941	05/2023	1 kit	03 July 2020
0126943	06/2023	1 kit	16 July 2020
0130203	08/2023	1 kit	06 October 2020
0130732	08/2023	1 kit	16 October 2020
0130843	09/2023	1 kit	15 October 2020
0134251	01/2024	1 kit	26 February 2021
0136031	04/2024	1 kit	01 July 2021
0136536	05/2024	1 kit	03 August 2021
0136551	05/2024	1 kit	03 August 2021
0137656	09/2024	1 kit	24 October 2021
0137768	10/2024	1 kit	07 December 2021
0138525	11/2024	1 kit	26 January 2022
0138904	01/2025	1 kit	14 March 2022
0139907	04/2025	1 kit	17 May 2022
0140236	04/2025	1 kit	10 June 2022
0141035	06/2025	1 kit	22 September 2022
0141812	07/2025	1 kit	21 October 2022
0141969	08/2025	1 kit	11 October 2022

Defective Medicines Report Centre Reference: MDR 219-10/22

Further advice for all healthcare professionals and service providers, including community pharmacies, emergency services and prisons

Where healthcare professionals, service providers and local teams (including those involved in needle and syringe programmes), are able to contact patients and members of the public who have been supplied with Prenoxad, they should inform them to check their kits to ensure they contain two (2) needles in each kit. This action will depend on the local procedures for record keeping, but efforts should be made to inform all likely holders of Prenoxad. Please see <u>Supplementary Information</u> provided.

Advice for patients and members of the public, including peers, friends, family, carers

It is possible that some Prenoxad kits contain fewer than two (2) needles in each kit. Anyone with a Prenoxad kit is asked to visually check the contents by holding them against a light source to confirm the presence of two (2) needle packets. Detailed instructions are available in the <u>Supplementary Information</u> provided.

Where a kit is found to have fewer than two (2) needles included, this should be taken back to the provider who initially supplied the kit, or to a community pharmacy involved in needle and syringe programmes or a local substance misuse team or service provider for a replacement.

As per the advice stated in the Patient Information Leaflet, Prenoxad Injection should be carried by people at risk of an opioid overdose, therefore it is important that you have a replacement provided to you when you return the affected kit. There are no concerns about the medicine in these kits.

If you, or somebody you observe, has taken an opioid and are experiencing the opioid overdose symptoms (see list in the Medicines Notification using the link below), please seek medical assistance or visit the nearest accident and emergency centre. If you have nasal naloxone or injectable naloxone (with a needle) available, administer it according to the instructions in the kit. If someone has symptoms of an opioid overdose and is not breathing, call 999 and ask for an ambulance immediately. Please see <u>Patient Information Leaflet</u> for further information.

For more information on licensed stock and resupply queries for the licensed presentation, please contact licensed@ethypharm.com; or 0800 028 7933. For medical information queries and other enquiries, please contact medinfo@ethypharm.com; or 01277 266 600.

Reference Information:

MHRA Class 4 Medicines Defect Information: Caution In Use (including reference images and Supplementary Information) – <u>Click</u> <u>Here</u>

Defective Medicines Report Centre/ Medicines and Healthcare products Regulatory Agency, 10 South Colonnade, Canary Wharf, London, E14 4PU | Telephone +44 (0)20 3080 6574 / DMRC@mhra.gov.uk.

Please check website <u>www.gov.uk/drug-device-alerts</u> for when actions should be ceased or advice to check for date restrictions are lifted.

For any enquiries about this alert contact: DMRC@mhra.gov.uk

To learn more on how alert issuing bodies are working together in England to issues alerts please go to https://www.england.nhs.uk/patient-safety/national-patient-safety-alerting-committee/