



## **Direct Healthcare Professional Communication**

**For the attention of all pharmacy/hospital sites to whom the below product has been supplied.**

### **Prulab Pharma Clopidogrel Oral Solution 75mg in 5ml: advice for pharmacists regarding risk of incorrect dosing**

Dear Healthcare professional,

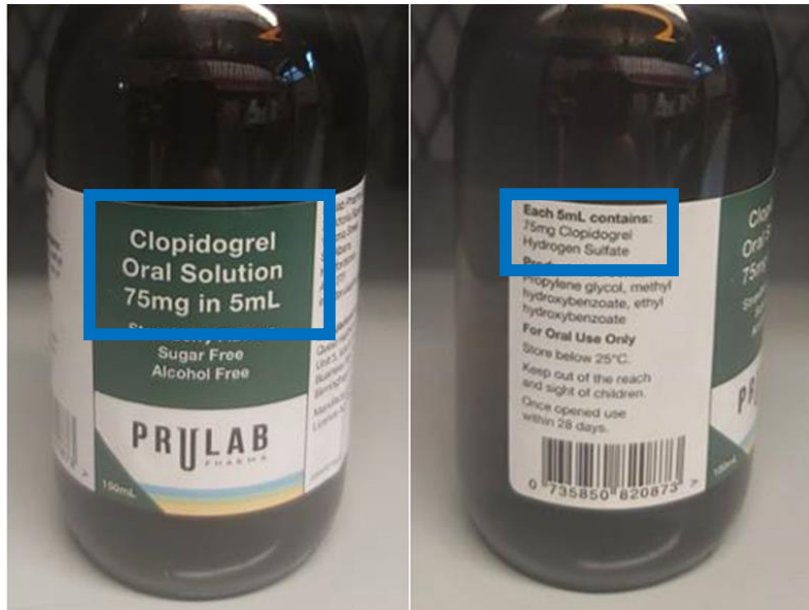
Prulab Pharma Limited in agreement with the Medicines & Healthcare products Regulatory Agency (MHRA) would like to inform you of the following required actions to ensure that you have prescribed, dispensed, or administered this product to your patients correctly.

#### **Summary**

- Prulab Pharma Limited is recalling the batch D2207227403B of Clopidogrel Oral Solution 75mg in 5ml [unlicensed medicine] due to a safety concern that the label may have caused confusion and patients may be receiving an underdose of this medicine, which may result in the treatment being less effective.
- Follow the advice in the Company Led Medicines Recall issued 25 January 2023 and stop supplying this batch immediately. Quarantine all remaining stock and return it to your supplier using your supplier's approved process.
- Clopidogrel doses are generally expressed in terms of the base: 75mg of clopidogrel is equivalent to 97.86mg of clopidogrel hydrogen sulfate. For this product, each 5ml contains 75mg clopidogrel hydrogen sulfate, which is equivalent to 57.48mg of clopidogrel. Without taking into account the equivalence of the active pharmaceutical ingredient in this product, a patient may be receiving an underdose of this medicine.
- Pharmacists who have dispensed this medicine are asked to review all prescriptions dispensed from August 2022 to ensure that the volume of administration corresponds to the dose prescribed – follow the steps on page 2 for further advice.

#### **Background on the safety concern**

Clopidogrel doses are generally expressed in terms of the base: 75mg of clopidogrel is equivalent to 97.86mg of clopidogrel hydrogen sulfate.



As can be seen from the side label (image on the right), each 5ml contains 75mg clopidogrel hydrogen sulfate and not the base, which the main label may suggest. Therefore the content of clopidogrel (base) in 5ml of the product is only 57.48mg and not 75mg. This means a volume of 6.524ml would be required to deliver 75mg of clopidogrel base and not 5ml as the label may suggest.

We are concerned that because the label on the front of the product states “Clopidogrel Oral Solution 75mg in 5ml” that you may have thought this is equivalent to the base.

**There is a safety concern that the label may have caused confusion and patients may be receiving an underdose of this medicine, which may result in the treatment being ineffective. Only one complaint has been received for this product concern presently at this time.**

**A decision has not been made as yet if a new batch will be manufactured however Prulab Pharma Limited will advise accordingly**

Action for pharmacists

1. Check all prescriptions against which this product had been dispensed from August 2022. Pharmacists may wish to check in a reverse chronological order as patients who have been dispensed this product most recently are more likely to still be taking the medicine.
2. Review the volume that was calculated for the dose prescribed on the prescription:
  - As mentioned above, clopidogrel doses are generally expressed in terms of the base and each 5ml of this formulation contains 75mg clopidogrel hydrogen sulfate (and not 75mg of clopidogrel base), therefore the volume to be administered will need to be adjusted accordingly.

- E.g. A prescription for clopidogrel 75mg will require 6.524ml of this formulation to be administered (rounded appropriately), **and not 5ml.**
  - **Please review the calculations for all other prescribed doses as appropriate.**
3. If this is not the volume stated on the dispensing label on your records, ascertain from the prescription (e.g. date of dispensing, dose, quantity supplied) whether the patient may still be administering their medicine from this product dispensed.
    - Where applicable, follow the steps below to discuss with the prescriber and patient the right volume to be administered.
    - If the dispensed bottle(s) have been used up, annotate the patient's Summary Care Records or hospital records where patients have received an incorrect dose. The prescriber should be informed accordingly
  4. Discuss with the prescriber as to the appropriate volume that should be administered. Note that this volume may need to be rounded to allow practical administration by the patient.
    - **If patients are advised to administer a different volume to the one stated on the initial dispensing label:**
      - Consider an appropriate measuring device (e.g. syringe) that needs to be supplied to the patient to enable the correct volume of medicine to be administered.
      - Counsel patients on the correct volume to be administered going forward
      - A record of this should be made on the patient's Summary Care Records and/or hospital records as necessary.
    - **Alternatively, the prescriber may wish for the product to be recalled from the patient and have an alternative formulation to be supplied instead.**
      - If the affected product is to be recalled from the patient, please make arrangements with the prescriber for a new prescription and inform the prescriber of the lead time for the alternative product.
      - Note that each formulation has a different qualitative and quantitative composition, therefore the dosing volume may differ across different products. Please check with the relevant manufacturers that the concentration of the oral formulation is expressed as clopidogrel base.
      - Please ensure the alternative preparation is available before recalling the affected product to avoid a treatment disruption for the patient.
  5. Once a corrective course of action has been agreed, discuss with the prescriber on who should contact the patient to advise them of the appropriate next steps.
  6. Irrespective of which corrective action is agreed, patients should be informed that each formulation has a different qualitative and quantitative composition, therefore if they are dispensed with a different preparation in the future, they should note that the dosing volume may not be the same as the one at present.
  7. The recalled product should be returned to:

**Oxford Pharmacy Stores**

Please contact Oxford Pharmacy Stores to arrange collection and refund of products from secondary care.

Contact Name: Nataha Arif

Address: Oxford Pharmacy Stores, 42 Sandford Lane, Oxford OX15RW

Telephone: 01865 904184 / Email: [Nataha.arif@oxfordphealth.co.uk](mailto:Nataha.arif@oxfordphealth.co.uk)

**Ethigen Limited**

Please contact Ethigen Limited to arrange collection and refund of products from community pharmacy / primary care.

Contact Name: Ian Rough

Address: Ethigen Ltd, Ethigen House, 10-16 Colvilles Place, East Kilbride G75 0SN

Telephone: 01355 598 154 or 07977011104 / Email: [ian@ethigen.co.uk](mailto:ian@ethigen.co.uk)

**Call for reporting**

Please continue to report suspected adverse drug reactions (ADRs) or suspected defective medicines to the MHRA through the Yellow Card Scheme.

Please report:

- all suspected ADRs that are serious or result in harm. Serious reactions are those that are fatal, life-threatening, disabling or incapacitating, those that cause a congenital abnormality or result in hospitalisation, and those that are considered medically significant for any other reason
- all suspected ADRs associated with new drugs and vaccines identified by the black triangle ▼

It is easiest and quickest to report ADRs online via the Yellow Card website <https://yellowcard.mhra.gov.uk/> or via the Yellow Card app available from the Apple App Store or Google Play Store. Suspected side effects can also be reported by calling 0800 731 6789 for free.

When reporting please provide as much information as possible, including information about medical history, any concomitant medication, onset timing, treatment dates, and product brand name.

If you have any concerns or questions about the medication, please contact:

Contact Name: Andy Oades (Director of Prulab Pharma Limited)

Telephone: 07921409899

Email: [andy@prulabpharma.co.uk](mailto:andy@prulabpharma.co.uk)

Signed:



25<sup>th</sup> January 2023

Role: Director