MEDICINES NOTIFICATION

CLASS 4 MEDICINES DEFECT INFORMATION, EL(26)A/38

Caution In Use

Issued 17 September 2026

Distribute to Pharmacy/Wholesaler Level

MARKETING AUTHORISATION HOLDER (MAH)

Martindale Pharmaceuticals Ltd

MEDICINE DETAILS

Clobazam Martindale Pharma 5 mg/5 mL Oral Suspension 150ml
PL 00156/0322
Active Ingredient: clobazam
SNOMED code: 42289011000001100
GTIN: 5014124144224

AFFECTED LOT BATCH NUMBERS

Batch No.	Expiry Date	Pack Size	First Distributed
0162858	05/2028	1	18/08/2026
0163605	07/2028	1	14/09/2026

MEDICINE DETAILS

Clobazam Martindale Pharma 10 mg/5 mL Oral Suspension 150ml
PL 00156/0323
Active Ingredient: clobazam
SNOMED code: 42289711000001100
GTIN: 5014124144231

AFFECTED LOT BATCH NUMBERS

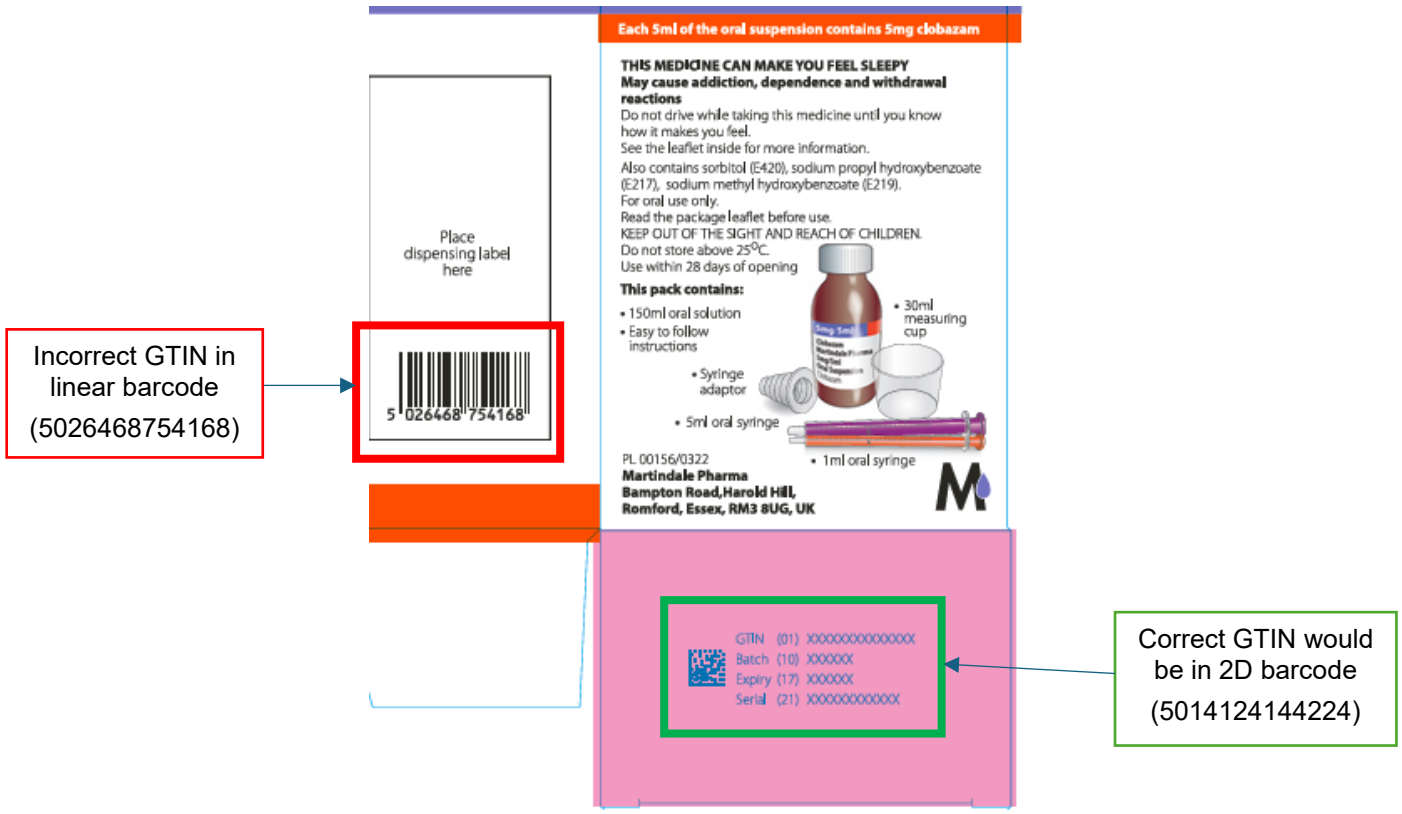
Batch No.	Expiry Date	Pack Size	First Distributed
0163858	07/2028	1	14/09/2026

Background

Martindale Pharmaceuticals has informed the MHRA of an error with the linear barcode of some batches of Clobazam 5mg/5mL and 10mg/5mL Oral Suspension 150mL.

The above batches were packaged in cartons containing an incorrect pre-printed linear barcode. The linear barcode present represents the GTIN for the branded version of the product (Tapclob). It should instead reflect the generic name: Clobazam. The code in the 2D printed barcode is correct.

Example for 5mg/5mL 150mL pack:



The associated strength and bottle size documented on the pre-printed package remain correct and unchanged.

Full batch quantities:

Batch 0162858: 5,544 units

Batch 0163605: 2,277 units

Batch 0163858: 4,631 units

Future batches of Clobazam for both strengths and pack size will have the barcode corrected via the application of a sticker until new cartons are available to maintain supply for patients.

Advice for Healthcare Professionals:

There is no risk to product quality as a result of this issue, therefore the affected batches are not being recalled.

Healthcare professionals are advised to note the above-mentioned batches of Clobazam Oral Suspension and use the serialized 2D barcode for authentication and traceability, as it remains accurate. The linear barcode on the carton should not be used for product identification.

Additional precautions should be considered by wholesalers and pharmacies using the linear barcode in a wholesale facility.

Advice for Healthcare Professionals to Provide to Patients:

This notification relates to a barcode error on the outer packaging of the product. The medicine itself is not affected, and patients do not need to take any action.

Patients who experience adverse reactions or have any questions about their medication should seek medical attention. Any suspected adverse reactions should also be reported via the MHRA Yellow Card scheme.

Additional information:

For further information, medical enquiries and stock information, contact: Licensed@ethypharm.com

Recipients of this Medicines Notification should bring it to the attention of relevant contacts by copy of this notice. NHS regional teams are asked to forward this to community pharmacists and dispensing general practitioners for information.

Yours faithfully

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