SUMMARY OF PRODUCT CHARACTERISTICS

1. NAME OF THE MEDICINAL PRODUCT

Miflonide Breezhaler 200 microgram inhalation powder, hard capsules
Miflonide Breezhaler 400 microgram inhalation powder, hard capsules

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

Each 200 microgram capsule contains 230 micrograms of budesonide and delivers 200 micrograms of budesonide from the mouthpiece of the device when used in conjunction with the (inhaler device called) Miflonide Breezhaler.
Each 400 microgram capsule contains 460 micrograms of budesonide and delivers 400 micrograms of budesonide from the mouthpiece of the device when used in conjunction with the (inhaler device called) Miflonide Breezhaler.

For the full list of excipients, see section 6.1

3. PHARMACEUTICAL FORM

Inhalation powder, hard capsule.
The 200 microgram capsule has a light pink opaque cap and a colourless transparent body, printed logo/BUDE 200.
The 400 microgram capsule has a pink opaque cap and a colourless transparent body, printed logo/BUDE 400.

4. CLINICAL PARTICULARS

4.1 Therapeutic indications

Bronchial asthma

Miflonide is indicated in asthmatic patients aged 6 years and older for:

- Long term anti inflammatory control of persistent asthma including prophylaxis of acute exacerbations of asthma.

COPD (chronic obstructive pulmonary disease)

Chronic obstructive bronchitis, in which corticosteroid therapy is indicated.

4.2 Posology and method of administration

The dosage should be carefully titrated individually to the minimum effective dose to control asthma symptoms.

The lowest dosage in a single capsule is 200 micrograms. If a single dose of less than 200 micrograms is required, this product cannot be used. Miflonide is contraindicated in children under 6 years of age (see section 4.3)

Adults:
Treatment of adults with mild asthma may be initiated at the minimum effective dose of 200 micrograms once daily. Usual recommended dose is 200-1600 micrograms divided in 2 doses. The

maintenance dose should be titrated to the lowest dose at which effective control of Asthma is maintained. If this requires the use of 200 micrograms divided in 2 doses daily this product can not be used.

Special populations

Paediatric population (6 years of age and above)

Due to the absence of clinical experience in children under 6 years of age, Miflonide Breezhaler should not be used in this age group.

Treatment of children aged 6 years and older with mild asthma may be initiated at 200 micrograms once daily. Usual recommended dose is 200-400 micrograms divided in 2 doses daily. In severe cases of asthma doses up to 800 micrograms daily in divided doses may be necessary.

The maintenance dose should be titrated to the lowest dose at which effective control of Asthma is maintained. If this requires the use of 200 micrograms divided in 2 doses daily this product cannot be used. If the maintenance dose is below 800 micrograms divided in 2 doses daily, the 400 micrograms/dose strength of this product cannot be used.

Renal impairment

There are no clinical studies in patients with renal impairment. On the basis of pharmacokinetic data with oral budesonide it is unlikely that systemic exposure of the drug will be altered to clinically significant level in such patients.

Hepatic impairment

There are no data to suggest dosage adjustment in patients with hepatic impairment. However, since budesonide is predominantly cleared by hepatic metabolism caution should be exercised when using Miflonide in patients with severe hepatic impairment. On the basis of pharmacokinetic data with oral budesonide, patients with mild to moderate hepatic impairment are unlikely to have clinically significant alteration in drug exposure.

Elderly (above 65 years of age)

There is no evidence to suggest that patients above 65 years of age require a different dosage from that used in younger adult patients.

Administration

The dose should be retitrated individually when transferring a patient from one inhalation device to another. It is recommended to rinse the mouth well with water and subsequently spit out the rinsing water, after each dose administration, in order to help prevent hoarseness, throat irritation and candida infection of the mouth and throat and possibly reduce the risk of systemic effects. The contents of the capsule are inhaled by means of an inhaler device called Miflonide Breezhaler.

To ensure proper administration of the drug, a physician or other health professional should:

- Instruct the patient in the proper use of the Breezhaler in accordance with the user instructions to ensure that the drug reaches the target areas in the lungs
- Instruct the patient that the capsules are only for inhalation use and not to be swallowed (see section 4.4 special warnings and precautions for use)

Detailed handling instructions are included in the package leaflet. Also see section 6.6.

4.3 Contraindications

Not to be used in children under 6 years of age.
Hypersensitivity (allergy) to budesonide or to any of the excipients (see section 6.1).
Use is contraindicated in patients with active pulmonary tuberculosis.

4.4 Special warnings and precautions for use

Prophylactic nature of therapy
Patients should be made aware of the prophylactic nature of therapy with inhaled budesonide, and that it should be taken regularly every day even when they are asymptomatic for optimum control of asthma. Budesonide does not relieve an acute bronchospasm, neither is it appropriate for the primary treatment of status asthmaticus nor other acute asthmatic episodes.

Pneumonia in patients with COPD
An increase in the incidence of pneumonia, including pneumonia requiring hospitalisation, has been observed in patients with COPD receiving inhaled corticosteroids. There is some evidence of an increased risk of pneumonia with increasing steroid dose but this has not been demonstrated conclusively across all studies.

There is no conclusive clinical evidence for intra-class differences in the magnitude of the pneumonia risk among inhaled corticosteroid products.

Physicians should remain vigilant for the possible development of pneumonia in patients with COPD as the clinical features of such infections overlap with the symptoms of COPD exacerbations.

Risk factors for pneumonia in patients with COPD include current smoking, older age, low body mass index (BMI) and severe COPD.

Concomitant conditions
Patients who have had lung tuberculosis should be monitored. Patients with fungal- or viral infections of the airways should also be monitored.

Caution is necessary in treating patients with pulmonary disorders such as bronchiectasis and pneumoconiosis in view of the possibility of fungal infections.

Asthma exacerbations
Acute exacerbations of asthma may need increase in the dose of budesonide or additional treatment with a short course of oral corticosteroids and/or an antibiotic if there is an infection. Patients should always keep a short-acting inhaled bronchodilator available as rescue medication to alleviate acute asthma symptoms.
Patients should be advised to contact their doctor if their asthma deteriorates (increased frequency of short acting inhaled bronchodilator treatment or persistent respiratory symptoms).The patient should be reassessed and the need for increased anti-inflammatory therapy, an increase in the dose of inhaled or oral corticosteroid, should be considered.

Paradoxical bronchospasm
In rare cases inhalation can cause paradoxical bronchospasm after dosing. If paradoxical bronchospasm occurs, Miflonide inhalation must be withdrawn immediately and if necessary be replaced with another treatment.

Systemic effects
Systemic effects of inhaled corticosteroids may occur, particularly at high doses prescribed for prolonged periods. These effects are much less likely to occur with inhalation treatment than with oral corticosteroids. Possible systemic effects include adrenal suppression,

hypercorticism/Cushing's syndrome, growth retardation in children and adolescents, decrease in bone mineral density, cataract, glaucoma, and more rarely, a range of psychological or behavioural effects including psychomotor hyperactivity, sleep disorders, anxiety, depression and aggression (particularly in children). Therefore, it is important that the dose of inhaled corticosteroid is titrated to the lowest dose at which effective control of asthma is maintained.

Effect on growth

It is recommended that the height of children receiving prolonged treatment with inhaled corticosteroids is regularly monitored. If reduction of growth velocity is noted, therapy should be re-evaluated with the aim of reducing the dose of inhaled corticosteroid, if possible, to the lowest effective dose at which effective control of asthma is maintained. The benefits of the corticosteroid therapy and the possible risks of growth suppression must be carefully weighed. In addition, consideration should be given to referring the patient to a paediatric respiratory specialist. The long-term effects of this reduction in growth velocity associated with inhaled corticosteroids, including the impact on final adult height, are unknown. The potential for "catch up" growth following discontinuation of treatment with orally inhaled corticosteroids has not been adequately studied.

Concomitant medications

Concomitant treatment with itraconazole and ritonavir or other potent CYP3A4 inhibitors (eg several azole antimycotics, protease inhibitors and macrolide antibiotics) should be avoided (see section 4.5).

Visual disturbance

Visual disturbance may be reported with systemic and topical corticosteroid use. If a patient presents with symptoms such as blurred vision or other visual disturbances, the patient should be considered for referral to an ophthalmologist for evaluation of possible causes which may include cataract, glaucoma or rare condition diseases such as Central serous chorioretinopathy (CSCR) which have been reported after use of systemic and topical corticosteroids.

Prolonged treatment with high doses of inhaled corticosteroids, particularly higher than the recommended dose, may result in clinically significant adrenal suppression. Additional systemic corticosteroid cover should be considered during periods of stress or elective surgery.
Adrenal function should be monitored regularly as the dose of systemic steroid is reduced when transferring patients on systemic corticosteroids to inhaled corticosteroids and in those patients in whom high doses are used for prolonged periods.
The 200 microgram capsules contain 24.77 mg lactose monohydrate; the 400 microgram capsules contain 24.54 mg lactose monohydrate. This amount will not elicit lactose intolerance reactions.

Special precautions:

Patients starting treatment with steroids A therapeutic effect is usually reached within 10 days. In patients with excessive mucus secretion in the bronchi, a short (about 2 weeks) additional corticosteroid regimen can be given initially.

Steroid dependent patients

Miflonide may permit replacement or significant reduction in dosage of oral glucocorticoids while maintaining asthma control. When transferring from oral steroids to Miflonide, the patient should be in a relatively stable phase. A high dose of budesonide should be given in combination with the previously used oral steroid for about 10 days. After that the oral dose should be gradually reduced

(by for example 2.5 mg prednisolone or the equivalent each month) to the lowest possible level. In many cases, it is possible to completely substitute the oral steroid with Miflonide Breezhaler.

During switching from oral steroid therapy to Miflonide, a number of patients will experience a reduced general steroid effect. Previous allergic symptoms such as rhinitis and eczema may reoccur and patients may be troubled with lethargy, muscle or joint pain, and sometimes nausea and vomiting. In these cases active medical support may be necessary in order to encourage patients to continue therapy with Miflonide and continue the withdrawal of the oral steroid, unless this is not medically justified.

The allergies should be treated with antihistamines and/or topical preparations, including topical corticosteroids. A temporary increase of the oral steroid dose might also be justified.

Treatment with supplementary systemic corticosteroids or budesonide should not be stopped abruptly.

Particular caution is to be observed during the first months of switching from systemic corticosteroids to budesonide to ensure that the patient's adrenocortical reserve is adequate to counter specific crisis situations such as trauma, surgery or severe infections.

Incorrect route of administration
There have been reports of patients who have mistakenly swallowed Miflonide capsules instead of placing the capsules in the Aerolizer inhalation device. The majority of these ingestions were not associated with side effects. Healthcare providers should instruct the patient on the correct use of Miflonide Breezhaler (see section 4.2).). If a patient who is prescribed Miflonide Breezhaler does not experience breathing improvement, the healthcare provider should ask how the patient is using Miflonide Breezhaler.

4.5 Interaction with other medicinal products and other forms of interaction

Agents resulting in CYP34A4 inhibition
Co-treatment with CYP3A inhibitors, including cobicistat-containing products, is expected to increase the risk of systemic side-effects. The combination should be avoided unless the benefit outweighs the increased risk of systemic corticosteroid side-effects, in which case patients should be monitored for systemic corticosteroid side-effects.

The main route of metabolism of budesonide and also cause for major first-pass metabolism is catalysed by CYP3A4). Concomitant administration of known inhibitors of CYP3A4 (e.g. itraconazole, ketoconazole, ritonavir, saquinavir, nelfinavir, amiodarone, clarythromycin, telithromycin and erythromycin) may markedly increase the systemic exposure to budesonide. (seesection 4.4). Concomitant use of potent CYP3A4 inhibitors should be avoided. If this is not possible the time interval between the administrations of the interacting drugs should be as long as possible and the adrenocortical function should be monitored. A reduction of budesonide dose could also be considered.

Agents resulting in CYP3A4
Concomitant administration of strong inducers of CYP3A4 (e.g. rifampicin) increases the metabolism of, and decrease the systemic exposure to budesonide (see section 5.2). It is unknown whether the pulmonary exposure is affected.

4.6 Fertility, pregnancy and lactation

Pregnancy

There are no adequate well-controlled studies using Miflonide in pregnant women. Most results from prospective epidemiological studies and world-wide post-marketing data have not been able to detect an increased risk for adverse effects for the foetus and newborn child from the use of inhaled budesonide during pregnancy. It is important for both foetus and mother to maintain an adequate asthma treatment during pregnancy. As with other drugs administered during pregnancy, the benefit of the administration of budesonide for the mother should be weighed against the risks to the foetus.

Data on approximately 2000 exposed pregnancies indicate no increased teratogenic risk associated with the use of inhaled budesonide. In animal studies glucocorticoids have been shown to induce malformations (see section 5.3). This is not likely to be relevant for humans given recommended inhalation doses.

Animal studies have also identified an involvement of excess prenatal glucocorticoids in increased risk for intrauterine growth retardation, adult cardiovascular disease and permanent changes in glucocorticoid receptor density, neurotransmitter turnover and behaviour at exposures below the teratogenic dose range.

Breast-feeding

Inhaled budesonide is secreted in the breast milk. Plasma concentrations achieved in infants would be expected to reach around 1/600 of the concentrations found in the mothers' plasma (see Section 11.Clinical pharmacology). While these low amounts of budesonide suggest that Miflonide can be used during breast-feeding, the clinical impact on suckling infants during long-term treatment is unknown.

Administration of budesonide to women who are breast-feeding should only be considered if the expected benefit to the mother is greater than any possible risk to the child.

Fertility

There are no data available on the use of budesonide and its effect on fertility in humans. In rats, subcutaneously administered budesonide did not have an adverse effect on fertility. There is no special recommendation for women of child-bearing potential.

4.7 Effects on ability to drive and use machines

No studies on the effects on the ability to drive and use machines have been performed. Such an effect is considered unlikely to occur.

4.8 Undesirable effects

Adverse drug reactions (Table 1) are listed according to system organ classes in MedDRA. Within each system organ class, the adverse drug reactions are ranked by frequency, with the most frequent reactions first. Within each frequency grouping, adverse drug reactions are presented in order of decreasing seriousness. In addition, the corresponding frequency category using the following convention (CIOMS III) is also provided for each adverse drug reaction: very common (≥1/10); common (≥1/100, <1/10); uncommon (≥1/1,000, <1/100); rare (≥1/10,000, <1/1,000); very rare (<1/10,000).

Infections and Infestations	
Common	Pneumonia (in COPD patients)
Endocrine disorders	
Rare	Adrenal suppression, growth retardation in children and adolescents, hypoadrenocorticism, hyperadrenocorticism, Cushing's syndrome
Gastrointestinal disorders	
Common	Oropharyngeal candidiasis

Respiratory, thoracic and mediastinal disorders	
Common	Dysphonia, throat irritation
Rare	Paradoxical bronchospasml, cough
Immune System Disorders	
Rare	Hypersensitivity, rash, urticaria, angioedema, pruritus
Eye disorders	
Uncommon	Cataract***, Vision blurred****
Rare	glaucoma
Musculoskeletal and connective tissue disorders	
Uncommon	Muscle spasm, tremor
Rare	Decrease in bone mineral density
Psychiatric disorders	
Uncommon	Anxiety, depression**
Not known	Sleep disorders, , aggression (predominantly in children)

**Clinical trials with 13119 patients on inhaled budesonide and 7278 patients on placebo have been pooled.
The frequency of anxiety was 0.52% on inhaled budesonide and 0.63% on placebo; that of depression was
0.67% on inhaled budesonide and 1.15% on placebo
*** In placebo-controlled studies, cataract was equally observed with frequency uncommon in the placebo
group
**** see also section 4.4.

Hoarseness and irritation of the throat is reversible and disappears after discontinuation of therapy, reduction of the dose and/or resting of the voice.
If Candida infection in the oropharynx occurs patients are advised to rinse the mouth with water or brush their teeth after each administration. In most cases, this condition will respond to topical anti-fungal therapy without discontinuing treatment with Budesonide".

There is an increased risk of pneumonia in patients with newly diagnosed COPD starting treatment with inhaled corticosteroids. However a weighted assessment of 8 pooled clinical trials involving 4643 COPD patients treated with budesonide and 3643 patients randomized to non-ICS treatments does did not demonstrate an increased risk for pneumonia. The results from the first 7 of these 8 trials have been published as a metaanalysis.

Occasionally, signs or symptoms of systemic glucocorticosteroid-side effects may occur with inhaled glucocorticosteroids, probably depending on dose, exposure time, concomitant and previous corticosteroid exposure, and individual sensitivity.

Skin reactions such as a rash may occur in rare cases.

As with other inhalation therapy, paradoxical bronchospasm is possible. If it occurs budesonide treatment should be discontinued immediately and an alternative therapy should be instituted, if necessary and treatment with a fast-acting inhaled bronchodilator should be immediate.

Reporting of suspected adverse reactions
Reporting suspected adverse reactions after authorisation of the medicinal product is important. It allows continued monitoring of the benefit/risk balance of the medicinal product. Healthcare professionals are asked to report any suspected adverse reactions via the national reporting system ADR Reporting Website: www.medicinesauthority.gov.mt/adrportal.

Adverse drug reactions from post-marketing experience (Frequency not known)

The following adverse drug reactions have been derived from post-marketing experience with Miflonide Breezhaler. Because these reactions are reported voluntarily from a population of uncertain size, it is not possible to reliably estimate their frequency which is therefore categorized as not known.

Psychiatric disorders: Psychomotor hyperactivity, sleep disorders, anxiety, depression, aggression, behavioural changes (predominantly in children).

Immune system disorders: Contact dermatitis (a Type IV (delayed) hypersensitivity reaction.

4.9 Overdose

The acute toxicity of budesonide is low. Inhalation of high doses of the drug over a short period may lead to the suppression of the hypothalamic-pituitary-adrenal (HPA) function. No special emergency action needs to be taken. Treatment with budesonide should be continued at the lowest dose at which effective control of asthma is maintained.

5. PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: Other drugs for obstructive airway diseases, inhalants; Glucocorticoid for inhalation.
ATC code: R 03 BA 02

Budesonide is a corticosteroid with topical action. Like other inhaled glucocorticoids, budesonide exerts its pharmacologic effects through interaction with intracellular glucocorticoid receptors. The production of many different cytokines, chemokines, enzymes, and cell adhesion molecules is inhibited. Maximum benefit of the treatment with budesonide inhalation powder is reached within approximately 10 days after initiation of treatment. Regular use of budesonide reduces the chronic inflammation of the asthmatic lungs. Thereby, budesonide improves lung function and asthma symptoms, reduces bronchial hyper-reactivity and prevents asthma exacerbations.

Paediatric population
While there is no specific data available for Miflonide Breezhaler, data from inhaled budesonide delivered via different type of inhaler in children aged 5-16 years was not associated with an increased occurrence of posterior sub-capsular cataract.

Influence on plasma cortisol concentration
Studies in healthy volunteers with budesonide have shown dose-related effects on plasma and urinary cortisol.

5.2 Pharmacokinetic properties

Absorption
The amount of budesonide deposited in the lungs is rapidly and completely absorbed. Peak plasma concentrations are reached immediately after administration. About 25-30 % of a single dose is deposited in the lungs. Only 10 to 13 % of the swallowed fraction of an inhaled dose is bioavailable due to significant presystemic metabolism in the liver. Systemic exposure of budesonide in the recommended dosing range from Miflonide Breezhaler can be expected to be dose-proportional as observed with other budesonide dry powder inhalers

Distribution

The plasma protein binding of budesonide is 85 to 90 % over the concentration range 1 to 100 nmoL. Budesonide is widely distributed into tissues, with a volume of 183 to 301 L at steady state. It also passes into breast milk, with a milk to plasma concentration ratio of around 0.46. The estimated daily infant dose is 0.3% of the daily maternal dose, and the estimated average plasma concentration in infants is estimated to be 1/600th of the concentrations observed in maternal plasma, even after assuming complete infant oral bioavailability. Animal studies have shown high concentrations in spleen, lymph glands, thymus, adrenal cortex, reproductive organs, and bronchi. Budesonide crosses the placental barrier in mice

Biotransformation
Budesonide is not metabolised in the lungs. After absorption it is extensively metabolised in the liver and converted to metabolites (including 6 β-hydroxybudesonide and 16 α-hydroxyprednisolone) with low glucocorticosteroid activity.

The main route of metabolism of budesonide is via CYP3A4 and may be affected by known inhibitors or inducers of this enzyme (see section 4.5).

Elimination
In human volunteers inhaling radiolabeled budesonide (via metered dose inhaler) approximately 32 % of the discharged dose was recovered in the urine and 15 % in the faeces. Following inhalation, 16-alpha-hydroxyprednisolone, but no budesonide was detected in the urine.

Budesonide shows high plasma clearance (84 L/h) following intravenous dosing. The elimination half-life was around 2.8 to 5 h.

Special populations

Elderly Patients

The pharmacokinetics of budesonide when administered as Miflonide Breezhaler has not been studied in elderly patients. However, limited data in patients over 65 years of age, suggest no significant difference in pharmacokinetics compared to younger adults after oral and intravenous administration.

Paediatrics

The pharmacokinetics of budesonide when administered as Miflonide Breezhaler has not been studied in the paediatric population. However, data with other inhalational budesonide products suggest that body weight normalized clearance in children above 3 years of age is around 50% higher than in adults.

Patients with hepatic impairment

The pharmacokinetics of inhaled budesonide has not been studied in patients with hepatic impairment. However, after oral administration the systemic availability of budesonide was reported to be 2.5-times higher in patients with cirrhosis than in healthy controls. Mild hepatic impairment is reported to have little effect on systemic exposure of oral budesonide.

Patients with renal impairment

The pharmacokinetics of budesonide has not been studied in patients with renal impairment but no significant effect is anticipated. However, metabolites of budesonide are excreted in the urine and increased risk of adverse events due to metabolite accumulation cannot be excluded in severe renal impairment.

5.3 Preclinical safety data

Repeated dose toxicity

Preclinical data from repeated dose toxicity studies revealed no specific hazard for humans at the intended therapeutic dose.

Mutagenicity and carcinogenicity

Budesonide was shown to have no mutagenic potential in a battery of in vitro and in vivo mutagenicity tests.

Orally administered budesonide was shown to increase the incidence of liver tumors in male rats starting at dose levels of 25 microgram /kg/day. These effects were also observed in a follow-up study including other steroids (prednisolone and triamcinolone acetonide) and are considered a class effect of corticosteroid administration.

Reproductive toxicity

The effects of subcutaneously administered budesonide on decreased viability of pups and maternal toxicity of budesonide in rats and its teratogenic potential and effects on growth retardation and fetal death in rabbits are consistent with the known teratogenic potential of glucocorticoids in animals. There is no evidence that budesonide has any teratogenic or toxic effect in humans (see section 4.6 Fertility, pregnancy and lactation). Subcutaneously administered budesonide did not have an adverse effect on fertility in rats. Glucocorticosteroids, including budesonide, have produced teratogenic effects in animals, including cleft palate and skeletal abnormalities. Similar effects are considered unlikely to occur in humans at therapeutic doses.

6. PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Lactose monohydrate (25mg/capsule which contains milk proteins).

6.2 Incompatibilities

Not applicable.

6.3 Shelf life

3 years

6.4 Special precautions for storage

Do not store above 25°C

6.5 Nature and contents of container

PVC/PVDC/Aluminium blister strip. Each blister contains 10 hard capsules.
Single pack containing 2x10 or 6x10 hard capsules and 1 inhaler.
Multipacks containing 120 (bundle of 2 single packs of 6x10) hard capsules and 2 inhalers.
Multipacks containing 180 (bundle of 3 single packs of 6x10) hard capsules and 3 inhalers.

Not all pack sizes may be marketed.
Not all pack sizes may be marketed.

6.6 Special precautions for disposal and other handling

It is important for the patient to understand that the gelatin capsule may very occasionally break up and small pieces of gelatin reach the mouth or throat after inhalation. The patient may be reassured that the gelatin will soften in the mouth and can be swallowed. The risk of capsule break-up is minimized by not piercing the capsule more than once.

The capsule should be removed from the blister pack only immediately before use.

Any unused product or waste material should be disposed of in accordance with local requirements.

Instructions for handling and use

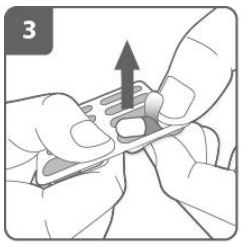


Pull off the cap



Open inhaler

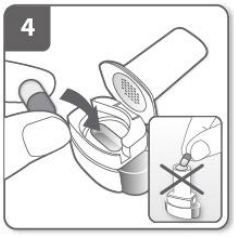
Hold the base of the inhaler firmly and tilt the mouthpiece. This opens the inhaler.



Prepare capsule

Immediately before use, with dry hands, remove one capsule from the blister.

Do not swallow the capsule.



Insert capsule

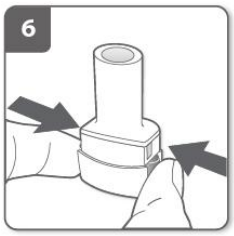
Place the capsule into the capsule chamber.

Never place a capsule directly into the mouthpiece.



Close the inhaler

Close the inhaler until you hear a “click”.

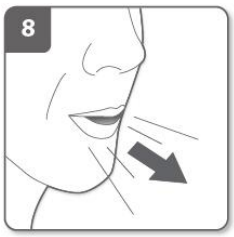


Pierce the capsule

- Hold the inhaler upright with the mouthpiece pointing up.
- Pierce the capsule by firmly pressing together both side buttons at the same time. **Do this only once.**
- You should hear a “click” as the capsule is being pierced.



Release the side buttons fully



Breathe out

Before placing the mouthpiece in your mouth, breathe out fully.

Do not blow into the mouthpiece.



Inhale the medicine

To breathe the medicine deeply into your airways:

- Hold the inhaler as shown in the picture. The side buttons should be facing left and right. Do not press the side buttons.
- Place the mouthpiece in your mouth and close your lips firmly around the mouthpiece.
- Breathe in rapidly but steadily and as deeply as you can.



Note:

As you breathe in through the inhaler, the capsule spins around in the chamber and you should hear a whirring noise. You may experience a sweet flavour as the medicine goes into your lungs.

Additional information

Occasionally, very small pieces of the capsule can get past the screen and enter your mouth. If this happens, you may be able to feel these pieces on your tongue. It is not harmful if these pieces are swallowed or inhaled. The chances of the capsule shattering will be increased if the capsule is accidentally pierced more than once (step 6).

If you do not hear a whirring noise

The capsule may be stuck in the capsule chamber. If this happens:

- Open the inhaler and carefully loosen the capsule by tapping the base of the inhaler. Do not press the side buttons.
- Close the inhaler and inhale the medicine again by repeating steps 8 and 9.



Hold breath

After you have inhaled the medicine:

- Hold your breath for at least 5-10 seconds or as long as you comfortably can while taking the inhaler out of your mouth.
- Then breathe out.
- Open the inhaler to see if any powder is left in the capsule.

If there is powder left in the capsule

- Close the inhaler.
- Repeat steps 8, 9, 10 and 11.

Most people are able to empty the capsule with one or two inhalations.

Additional info

If the capsule is empty, you have received enough of your medicine.



- Open the mouthpiece again and remove the empty capsule by tipping it out of the capsule chamber. Put the empty capsule in your household waste.

If your prescription requires you to take more than 1 capsule, repeat steps 3 – 12 as necessary.

After you have finished taking your medicine

- Close the inhaler and replace the cap.

Rinse your mouth well with water after using your medicine. Spit out the rinse water. This will reduce the risk of developing a fungal infection (thrush) in the mouth.

Do not store the capsules in the Miflonide Breezhaler inhalation device.

7. MARKETING AUTHORISATION HOLDER

Novartis Pharmaceuticals UK Limited
Frimley Business Park

Frimley, Camberley
Surrey, GU16 7SR
England

8. MARKETING AUTHORISATION NUMBERS

Miflonide Breezhaler 200 microgram: 088/02101
Miflonide Breezhaler 400 microgram: 088/02102

9. DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUTHORISATION

Date of first authorisation: 4th January 2007
Date of last renewal: 24th June 2013

10. DATE OF REVISION OF THE TEXT

21st December 2017