

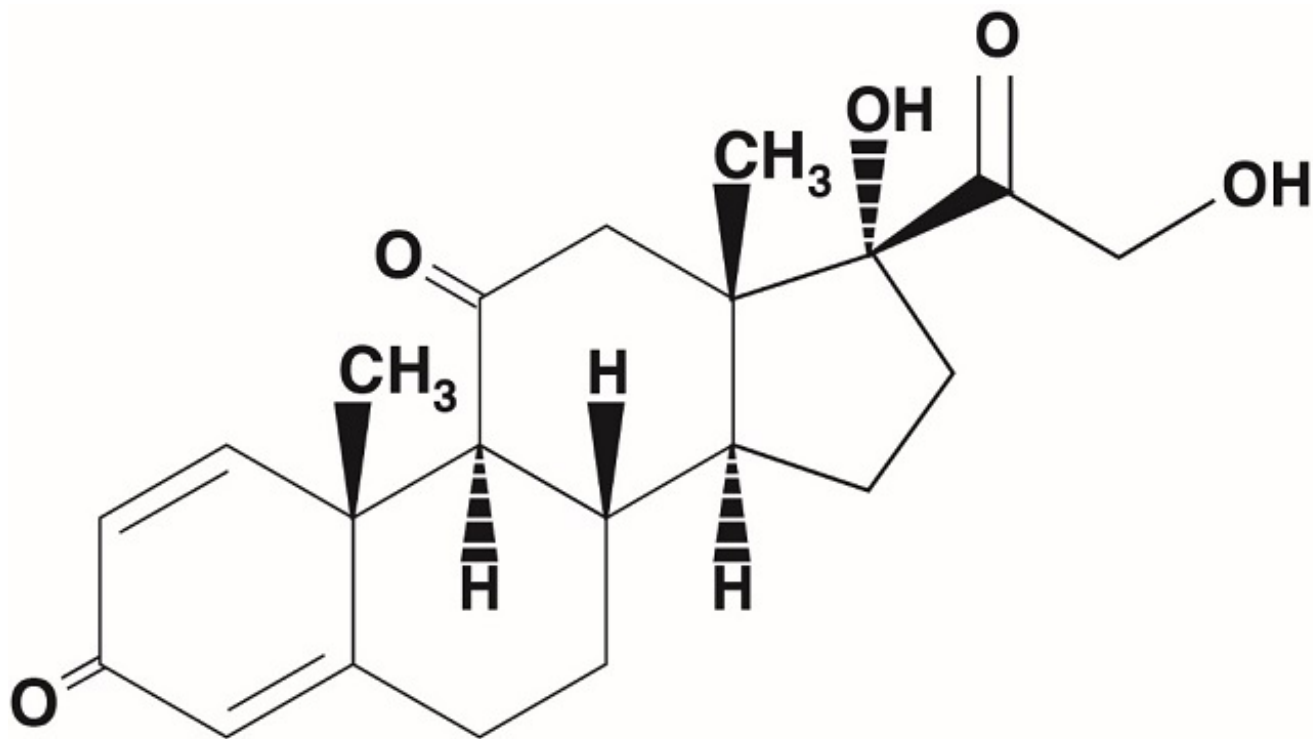
**PREDNISONE- prednisone tablet**  
**Advanced Rx Pharmacy of Tennessee, LLC**

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**Prednisone 5mg Tablet**

**1. Description**

Prednisone is a glucocorticoid. Glucocorticoids are adrenocortical steroids, both naturally occurring and synthetic, which are readily absorbed from the gastrointestinal tract. Prednisone, USP is a white to partially white, crystalline powder. It is very slightly soluble in water; slightly soluble in alcohol, chloroform, dioxane, and methanol.

The chemical name for prednisone is 17,21-dihydroxypregna-1,4-diene-3,11,20-trione. The structural formula is represented below:



Each tablet, for oral administration, contains 1, 2.5, 5, 10, 20, or 50 mg of prednisone. PredniSONE Oral Solution contains 5 mg prednisone per 5 mL, and PredniSONE Intenso!™ Oral Solution [Concentrate] contains 5 mg prednisone per mL.

**Inactive Ingredients:**

PredniSONE Tablets, USP contain the following inactive ingredients: lactose monohydrate, magnesium stearate, microcrystalline cellulose, pregelatinized starch, sodium starch glycolate and stearic acid (1 mg, 2.5 mg, and 5 mg only).

PredniSONE Oral Solution, USP contains alcohol 5% and the following inactive ingredients: anhydrous citric acid, edetate disodium, fructose, hydrochloric acid, maltol, peppermint oil, polysorbate 80, propylene glycol, saccharin sodium, sodium benzoate, vanilla flavor and purified water.

PredniSONE Intenso!™ Oral Solution (Concentrate) contains alcohol 30% and the

following inactive ingredients: anhydrous citric acid, poloxamer 188, propylene glycol and purified water.

## **2. Actions**

Naturally occurring glucocorticoids (hydrocortisone and cortisone), which also have salt-retaining properties, are used as replacement therapy in adrenocortical deficiency states. Their synthetic analogs are primarily used for their potent anti-inflammatory effects in disorders of many organ systems.

Glucocorticoids cause profound and varied metabolic effects. In addition, they modify the body's immune responses to diverse stimuli.

## **3. Indications and Usage**

Prednisone tablets and solutions are indicated in the following conditions:

### **1. Endocrine Disorders**

Primary or secondary adrenocortical insufficiency (hydrocortisone or cortisone is the first choice; synthetic analogs may be used in conjunction with mineralocorticoids where applicable; in infancy mineralocorticoid supplementation is of particular importance)

Congenital adrenal hyperplasia

Hypercalcemia associated with cancer

Nonsuppurative thyroiditis

### **2. Rheumatic Disorders**

As adjunctive therapy for short-term administration (to tide the patient over an acute episode or exacerbation) in:

Psoriatic arthritis

Rheumatoid arthritis, including juvenile rheumatoid arthritis (selected cases may require low-dose maintenance therapy)

Ankylosing spondylitis

Acute and subacute bursitis

Acute nonspecific tenosynovitis

Acute gouty arthritis

Post-traumatic osteoarthritis

Synovitis of osteoarthritis

Epicondylitis

### **3. Collagen Diseases**

During an exacerbation or as maintenance therapy in selected cases of:

Systemic lupus erythematosus

Systemic dermatomyositis (polymyositis)

Acute rheumatic carditis

#### 4. Dermatologic Diseases

Pemphigus

Bullous dermatitis herpetiformis

Severe erythema multiforme (Stevens-Johnson syndrome)

Exfoliative dermatitis

Mycosis fungoides

Severe psoriasis

Severe seborrheic dermatitis

#### 5. Allergic States

Control of severe or incapacitating allergic conditions intractable to adequate trials of conventional treatment:

Seasonal or perennial allergic rhinitis

Bronchial asthma

Contact dermatitis

Atopic dermatitis

Serum sickness

Drug hypersensitivity reactions

#### 6. Ophthalmic Diseases

Severe acute and chronic allergic and inflammatory processes involving the eye and its adnexa such as:

Allergic corneal marginal ulcers

Herpes zoster ophthalmicus

Anterior segment inflammation

Diffuse posterior uveitis and choroiditis

Sympathetic ophthalmia

Allergic conjunctivitis

Keratitis

Chorioretinitis

Optic neuritis

Iritis and iridocyclitis

#### 7. Respiratory Diseases

Symptomatic sarcoidosis

Loeffler's syndrome not manageable by other means

Berylliosis

Fulminating or disseminated pulmonary tuberculosis when used concurrently with appropriate antituberculous chemotherapy

Aspiration pneumonitis

#### 8. Hematologic Disorders

Idiopathic thrombocytopenic purpura in adults

Secondary thrombocytopenia in adults

Acquired (autoimmune) hemolytic anemia

Erythroblastopenia (RBC anemia)

Congenital (erythroid) hypoplastic anemia

#### 9. Neoplastic Diseases

For palliative management of:

Leukemias and lymphomas in adults

Acute leukemia of childhood

#### 10. Edematous States

To induce a diuresis or remission of proteinuria in the nephrotic syndrome, without uremia, of the idiopathic type or that due to lupus erythematosus.

#### 11. Gastrointestinal Diseases

To tide the patient over a critical period of the disease in:

Ulcerative colitis

Regional enteritis

#### 12. Nervous System

Acute exacerbations of multiple sclerosis

#### 13. Miscellaneous

Tuberculous meningitis with subarachnoid block or impending block when used concurrently with appropriate antituberculous chemotherapy

Trichinosis with neurologic or myocardial involvement

### **4. Contraindications**

Systemic fungal infections and known hypersensitivity to components.

### **5. Warnings and Precautions**

In patients on corticosteroid therapy subjected to unusual stress, increased dosage of

rapidly acting corticosteroids before, during, and after the stressful situation is indicated.

Corticosteroids may mask some signs of infection, and new infections may appear during their use. There may be decreased resistance and inability to localize infection when corticosteroids are used.

Prolonged use of corticosteroids may produce posterior subcapsular cataracts, glaucoma with possible damage to the optic nerves, and may enhance the establishment of secondary ocular infections due to fungi or viruses.

#### Usage in pregnancy

Since adequate human reproduction studies have not been done with corticosteroids, the use of these drugs in pregnancy, nursing mothers or women of child-bearing potential requires that the possible benefits of the drug be weighed against the potential hazards to the mother and embryo or fetus. Infants born of mothers who have received substantial doses of corticosteroids during pregnancy, should be carefully observed for signs of hypoadrenalism.

Average and large doses of hydrocortisone or cortisone can cause elevation of blood pressure, salt and water retention, and increased excretion of potassium. These effects are less likely to occur with the synthetic derivatives except when used in large doses. Dietary salt restriction and potassium supplementation may be necessary. All corticosteroids increase calcium excretion.

While on corticosteroid therapy patients should not be vaccinated against smallpox. Other immunization procedures should not be undertaken in patients who are on corticosteroids, especially on high dose, because of possible hazards of neurological complications and a lack of antibody response.

The use of prednisone in active tuberculosis should be restricted to those cases of fulminating or disseminated tuberculosis in which the corticosteroid is used for the management of the disease in conjunction with an appropriate anti-tuberculous regimen.

If corticosteroids are indicated in patients with latent tuberculosis or tuberculin reactivity, close observation is necessary as reactivation of the disease may occur. During prolonged corticosteroid therapy, these patients should receive chemoprophylaxis.

Children who are on immunosuppressant drugs are more susceptible to infections than healthy children. Chickenpox and measles, for example, can have a more serious or even fatal course in children on immunosuppressant corticosteroids. In such children, or in adults who have not had these diseases, particular care should be taken to avoid exposure. If exposed, therapy with varicella zoster immune globulin (VZIG) or pooled intravenous immunoglobulin (IVIG), as appropriate, may be indicated. If chickenpox develops treatment with antiviral agents may be considered.

#### General Precautions

Drug-induced secondary adrenocortical insufficiency may be minimized by gradual reduction of dosage. This type of relative insufficiency may persist for months after discontinuation of therapy; therefore, in any situation of stress occurring during that period, hormone therapy should be reinstated. Since mineralocorticoid secretion may be impaired, salt and/or a mineralocorticoid should be administered concurrently.

There is an enhanced effect of corticosteroids on patients with hypothyroidism and in

those with cirrhosis.

Corticosteroids should be used cautiously in patients with ocular herpes simplex because of possible corneal perforation.

The lowest possible dose of corticosteroid should be used to control the condition under treatment, and when reduction in dosage is possible, the reduction should be gradual.

Psychic derangements may appear when corticosteroids are used, ranging from euphoria, insomnia, mood swings, personality changes, and severe depression, to frank psychotic manifestations. Also, existing emotional instability or psychotic tendencies may be aggravated by corticosteroids.

Aspirin should be used cautiously in conjunction with corticosteroids in hypoprothrombinemia.

Steroids should be used with caution in nonspecific ulcerative colitis, if there is a probability of impending perforation, abscess or other pyogenic infection; diverticulitis; fresh intestinal anastomoses; active or latent peptic ulcer; renal insufficiency; hypertension; osteoporosis; and myasthenia gravis.

Growth and development of infants and children on prolonged corticosteroid therapy should be carefully observed.

Although controlled clinical trials have shown corticosteroids to be effective in speeding the resolution of acute exacerbations of multiple sclerosis, they do not show that corticosteroids affect the ultimate outcome or natural history of the disease. The studies do show that relatively high doses of corticosteroids are necessary to demonstrate a significant effect (see DOSAGE AND ADMINISTRATION).

Since complications of treatment with glucocorticoids are dependent on the size of the dose and the duration of treatment, a risk/benefit decision must be made in each individual case as to dose and duration of treatment and as to whether daily or intermittent therapy should be used.

Convulsions have been reported with concurrent use of methylprednisolone and cyclosporin. Since concurrent use of these agents results in a mutual inhibition of metabolism, it is possible that adverse events associated with the individual use of either drug may be more apt to occur.

## **6. Adverse Reactions Section**

### **ADVERSE REACTIONS**

(listed alphabetically, under each subsection)

The following adverse reactions have been reported with prednisone or other corticosteroids:

#### **Allergic Reactions**

anaphylactoid or hypersensitivity reactions, anaphylaxis, angioedema.

#### **Cardiovascular System**

bradycardia, cardiac arrest, cardiac arrhythmias, cardiac enlargement, circulatory collapse, congestive heart failure, ECG changes caused by potassium deficiency, edema,

fat embolism, hypertension or aggravation of hypertension, hypertrophic cardiomyopathy in premature infants, myocardial rupture following recent myocardial infarction (see WARNINGS: CARDIO-RENAL), necrotizing angitis, pulmonary edema, syncope, tachycardia, thromboembolism, thrombophlebitis, vasculitis.

#### Dermatologic

acne, acneiform eruptions, allergic dermatitis, alopecia, angioedema, angioneurotic edema, atrophy and thinning of skin, dry scaly skin, ecchymoses and petechiae (bruising), erythema, facial edema, hirsutism, impaired wound healing, increased sweating, Kaposi's sarcoma (see PRECAUTIONS: GENERAL PRECAUTIONS), lupus erythematosus-like lesions, perineal irritation, purpura, rash, striae, subcutaneous fat atrophy, suppression of reactions to skin tests, striae, telangiectasis, thin fragile skin, thinning scalp hair, urticaria.

#### Endocrine

Adrenal insufficiency-greatest potential caused by high potency glucocorticoids with long duration of action (associated symptoms include; arthralgias, buffalo hump, dizziness, life-threatening hypotension, nausea, severe tiredness or weakness), amenorrhea, postmenopausal bleeding or other menstrual irregularities, decreased carbohydrate and glucose tolerance, development of cushingoid state, diabetes mellitus (new onset or manifestations of latent), glycosuria, hyperglycemia, hypertrichosis, hyperthyroidism (see WARNINGS: ENDOCRINE), hypothyroidism, increased requirements for insulin or oral hypoglycemic agents in diabetics, lipids abnormal, moon face, negative nitrogen balance caused by protein catabolism, secondary adrenocortical and pituitary unresponsiveness (particularly in times of stress, as in trauma, surgery or illness) (see WARNINGS: ENDOCRINE), suppression of growth in pediatric patients.

#### Fluid and Electrolyte Disturbances

congestive heart failure in susceptible patients, fluid retention, hypokalemia, hypokalemic alkalosis, metabolic alkalosis, hypotension or shock-like reaction, potassium loss, sodium retention with resulting edema.

#### Gastrointestinal

abdominal distention, abdominal pain, anorexia which may result in weight loss, constipation, diarrhea, elevation in serum liver enzyme levels (usually reversible upon discontinuation), gastric irritation, hepatomegaly, increased appetite and weight gain, nausea, oropharyngeal candidiasis, pancreatitis, peptic ulcer with possible perforation and hemorrhage, perforation of the small and large intestine (particularly in patients with inflammatory bowel disease), ulcerative esophagitis, vomiting.

#### Hematologic

anemia, neutropenia (including febrile neutropenia).

#### Metabolic

negative nitrogen balance due to protein catabolism.

#### Musculoskeletal

arthralgias, aseptic necrosis of femoral and humeral heads, increase risk of fracture, loss of muscle mass, muscle weakness, myalgias, osteopenia, osteoporosis (see PRECAUTIONS: MUSCULOSKELETAL), pathologic fracture of long bones, steroid

myopathy, tendon rupture (particularly of the Achilles tendon), vertebral compression fractures.

### Neurological/Psychiatric

amnesia, anxiety, benign intracranial hypertension, convulsions, delirium, dementia (characterized by deficits in memory retention, attention, concentration, mental speed and efficiency, and occupational performance), depression, dizziness, EEG abnormalities, emotional instability and irritability, euphoria, hallucinations, headache, impaired cognition, incidence of severe psychiatric symptoms, increased intracranial pressure with papilledema (pseudotumor cerebri) usually following discontinuation of treatment, increased motor activity, insomnia, ischemic neuropathy, long-term memory loss, mania, mood swings, neuritis, neuropathy, paresthesia, personality changes, psychiatric disorders including steroid psychoses or aggravation of pre-existing psychiatric conditions, restlessness, schizophrenia, verbal memory loss, vertigo, withdrawn behavior.

### Ophthalmic

blurred vision, cataracts (including posterior subcapsular cataracts), central serous chorioretinopathy, establishment of secondary bacterial, fungal and viral infections, exophthalmos, glaucoma, increased intraocular pressure (see PRECAUTIONS: OPHTHALMIC), optic nerve damage, papilledema.

### Other

abnormal fat deposits, aggravation/masking of infections, decreased resistance to infection (see WARNINGS: INFECTION), hiccups, immunosuppression, increased or decreased motility and number of spermatozoa, malaise, insomnia, moon face, pyrexia.

## 7. Dosage & Administration Section

### DOSAGE AND ADMINISTRATION

Gastric irritation may be reduced if taken before, during, or immediately after meals or with food or milk.

The maximal activity of the adrenal cortex is between 2 am and 8 am, and it is minimal between 4 pm and midnight. Exogenous corticosteroids suppress adrenocorticoid activity the least when given at the time of maximal activity (am) for single dose administration. Therefore, it is recommended that prednisone be administered in the morning prior to 9 am and when large doses are given, administration of antacids between meals to help prevent peptic ulcers. Multiple dose therapy should be evenly distributed in evenly spaced intervals throughout the day.

Dietary salt restriction may be advisable in patients.

Do not stop taking this medicine without first talking to your doctor. Avoid abrupt withdraw of therapy.

The initial dosage of prednisone may vary from 5 mg to 60 mg per day, depending on the specific disease entity being treated. In situations of less severity lower doses will generally suffice, while in selected patients higher initial doses may be required. The initial dosage should be maintained or adjusted until a satisfactory response is noted. If after a reasonable period of time there is a lack of satisfactory clinical response, prednisone



should be discontinued and the patient transferred to other appropriate therapy. IT SHOULD BE EMPHASIZED THAT DOSAGE REQUIREMENTS ARE VARIABLE AND MUST BE INDIVIDUALIZED ON THE BASIS OF THE DISEASE UNDER TREATMENT AND THE RESPONSE OF THE PATIENT. After a favorable response is noted, the proper maintenance dosage should be determined by decreasing the initial drug dosage in small increments at appropriate time intervals until the lowest dosage which will maintain an adequate clinical response is reached. It should be kept in mind that constant monitoring is needed in regard to drug dosage. Included in the situations which may make dosage adjustments necessary are changes in clinical status secondary to remissions or exacerbations in the disease process, the patient's individual drug responsiveness, and the effect of patient exposure to stressful situations not directly related to the disease entity under treatment; in this latter situation, it may be necessary to increase the dosage of prednisone for a period of time consistent with the patient's condition. If after long-term therapy the drug is to be stopped, it is recommended that it be withdrawn gradually rather than abruptly.

### Multiple Sclerosis

In the treatment of acute exacerbations of multiple sclerosis daily doses of 200 mg of prednisolone for a week followed by 80 mg every other day for 1 month have been shown to be effective. (Dosage range is the same for prednisone and prednisolone.)

### Alternate Day Therapy

Alternate day therapy is a corticosteroid dosing regimen in which twice the usual daily dose of corticoid is administered every other morning. The purpose of this mode of therapy is to provide the patient requiring long-term pharmacologic dose treatment with the beneficial effects of corticoids while minimizing certain undesirable effects, including pituitary-adrenal suppression, the cushingoid state, corticoid withdrawal symptoms, and growth suppression in children.

The rationale for this treatment schedule is based on two major premises: (a) the anti-inflammatory or therapeutic effect of corticoids persists longer than their physical presence and metabolic effects and (b) administration of the corticosteroid every other morning allows for re-establishment of more nearly normal hypothalamic-pituitary-adrenal (HPA) activity on the off-steroid day.

A brief review of the HPA physiology may be helpful in understanding this rationale. Acting primarily through the hypothalamus a fall in free cortisol stimulates the pituitary gland to produce increasing amounts of corticotropin (ACTH) while a rise in free cortisol inhibits ACTH secretion. Normally the HPA system is characterized by diurnal (circadian) rhythm. Serum levels of ACTH rise from a low point about 10 pm to a peak level about 6 am. Increasing levels of ACTH stimulate adrenocortical activity resulting in a rise in plasma cortisol with maximal levels occurring between 2 am and 8 am. This rise in cortisol dampens ACTH production and in turn adrenocortical activity. There is a gradual fall in plasma corticoids during the day with lowest levels occurring about midnight.

The diurnal rhythm of the HPA axis is lost in Cushing's disease, a syndrome of adrenocortical hyperfunction characterized by obesity with centripetal fat distribution, thinning of the skin with easy bruisability, muscle wasting with weakness, hypertension, latent diabetes, osteoporosis, electrolyte imbalance, etc. The same clinical findings of hyperadrenocorticism may be noted during long-term pharmacologic dose corticoid therapy administered in conventional daily divided doses. It would appear, then, that a

disturbance in the diurnal cycle with maintenance of elevated corticoid values during the night may play a significant role in the development of undesirable corticoid effects. Escape from these constantly elevated plasma levels for even short periods of time may be instrumental in protecting against undesirable pharmacologic effects.

During conventional pharmacologic dose corticosteroid therapy, ACTH production is inhibited with subsequent suppression of cortisol production by the adrenal cortex. Recovery time for normal HPA activity is variable depending upon the dose and duration of treatment. During this time the patient is vulnerable to any stressful situation. Although it has been shown that there is considerably less adrenal suppression following a single morning dose of prednisolone (10 mg) as opposed to a quarter of that dose administered every 6 hours, there is evidence that some suppressive effect on adrenal activity may be carried over into the following day when pharmacologic doses are used. Further, it has been shown that a single dose of certain corticosteroids will produce adrenocortical suppression for two or more days. Other corticoids, including methylprednisolone, hydrocortisone, prednisone, and prednisolone, are considered to be short acting (producing adrenocortical suppression for 1¼ to 1½ days following a single dose) and thus are recommended for alternate day therapy.

The following should be kept in mind when considering alternate day therapy:

1. Basic principles and indications for corticosteroid therapy should apply. The benefits of alternate day therapy should not encourage the indiscriminate use of steroids.
2. Alternate day therapy is a therapeutic technique primarily designed for patients in whom long-term pharmacologic corticoid therapy is anticipated.
3. In less severe disease processes in which corticoid therapy is indicated, it may be possible to initiate treatment with alternate day therapy. More severe disease states usually will require daily divided high dose therapy for initial control of the disease process. The initial suppressive dose level should be continued until satisfactory clinical response is obtained, usually four to ten days in the case of many allergic and collagen diseases. It is important to keep the period of initial suppressive dose as brief as possible particularly when subsequent use of alternate day therapy is intended. Once control has been established, two courses are available: (a) change to alternate day therapy and then gradually reduce the amount of corticoid given every other day or (b) following control of the disease process reduce the daily dose of corticoid to the lowest effective level as rapidly as possible and then change over to an alternate day schedule. Theoretically, course (a) may be preferable.
4. Because of the advantages of alternate day therapy, it may be desirable to try patients on this form of therapy who have been on daily corticoids for long periods of time (e.g., patients with rheumatoid arthritis). Since these patients may already have a suppressed HPA axis, establishing them on alternate day therapy may be difficult and not always successful. However, it is recommended that regular attempts be made to change them over. It may be helpful to triple or even quadruple the daily maintenance dose and administer this every other day rather than just doubling the daily dose if difficulty is encountered. Once the patient is again controlled, an attempt should be made to reduce this dose to a minimum.
- 5.

As indicated above, certain corticosteroids, because of their prolonged suppressive effect on adrenal activity, are not recommended for alternate day therapy (e.g., dexamethasone and betamethasone).

6.

The maximal activity of the adrenal cortex is between 2 am and 8 am, and it is minimal between 4 pm and midnight. Exogenous corticosteroids suppress adrenocortical activity the least, when given at the time of maximal activity (am).

7.

In using alternate day therapy it is important, as in all therapeutic situations to individualize and tailor the therapy to each patient. Complete control of symptoms will not be possible in all patients. An explanation of the benefits of alternate day therapy will help the patient to understand and tolerate the possible flare-up in symptoms which may occur in the latter part of the off-steroid day. Other symptomatic therapy may be added or increased at this time if needed.

8.

In the event of an acute flare-up of the disease process, it may be necessary to return to a full suppressive daily divided corticoid dose for control. Once control is again established alternate day therapy may be re-instituted.

9.

Although many of the undesirable features of corticosteroid therapy can be minimized by alternate day therapy, as in any therapeutic situation, the physician must carefully weigh the benefit-risk ratio for each patient in whom corticoid therapy is being considered.

## **9. How Supplied/Storage and Handling**

PredniSONE Tablets, USP

5 mg – White to off-white, round, biconvex tablet; scored on one side and product identification “54 [above] 612” debossed on the other side.

Bottles of 21 Tablets NDC: 80425-0068-01

Store at 20° to 25°C (68° to 77°F). [See USP Controlled Room Temperature.]

Discard opened bottle after 90 days.

Distr. by: Hikma

Pharmaceuticals USA Inc.

Eatontown, NJ 07724

Distributed by:

Advanced Rx Pharmacy of Tennessee LLC, Nashville, TN 37211

C50000278/03

Revised December 2020

## **Package Label.Principal Display Panel**

Packed By: **Advanced Rx**  
Nashville TN, 37217



Store at 20°-25°C (68°-77°F)  
Caution: Federal law PROHIBITS Transfer of this drug to any person other than the patient for whom it was prescribed.

**PREDNISONE 5MG TABLET**

#21

Compare to STERAPRED  
NDC: 80425-0068-01 Source NDC: 00054-4728-31  
Lot: 21PRE51221 Expires: 1/1/2022



PREDNISONE 5MG TAB #21  
NDC: 80425-0068-01  
Source NDC: 00054-4728-31  
Lot: 21PRE51221 Exp:1/1/2022

ROXANE/WEST-WAR  
S/N: 000000115357

**PREDNISONE**

prednisone tablet

**Product Information**

<b>Product Type</b>	HUMAN PRESCRIPTION DRUG	<b>Item Code (Source)</b>	NDC:80425-0068(NDC:0054-4728)
<b>Route of Administration</b>	ORAL		

**Active Ingredient/Active Moiety**

Ingredient Name	Basis of Strength	Strength
<b>PREDNISONE</b> (UNII: VB0R961HZT) (PREDNISONE - UNII:VB0R961HZT)	PREDNISONE	5 mg

**Product Characteristics**

<b>Color</b>	white	<b>Score</b>	2 pieces
<b>Shape</b>	ROUND	<b>Size</b>	6mm
<b>Flavor</b>		<b>Imprint Code</b>	54;612
<b>Contains</b>			

**Packaging**

#	Item Code	Package Description	Marketing Start Date	Marketing End Date
1	NDC:80425-0068-1	21 in 1 BOTTLE; Type 0: Not a Combination Product	09/15/2022	

**Marketing Information**

Marketing Category	Application Number or Monograph Citation	Marketing Start Date	Marketing End Date
ANDA	ANDA080352	09/15/2022	

**Labeler** - Advanced Rx Pharmacy of Tennessee, LLC (117023142)

## Establishment

Name	Address	ID/FEI	Business Operations
Advanced Rx Pharmacy of Tennessee, LLC		117023142	repack(80425-0068)

Revised: 11/2022

Advanced Rx Pharmacy of Tennessee, LLC