

Important information. Please read carefully.

IMEXA®

Film-Coated Tablet

Powder for Oral Suspension

COMPOSITION

Imexa Film-Coated Tablet : Each tablet contains Azithromycin Dihydrate equivalent to Azithromycin 250 mg.

Imexa Powder for Oral Suspension: On reconstitution with water, each 5 ml of suspension contains Azithromycin Dihydrate equivalent to Azithromycin 200 mg.

PHARMACODYNAMICS

Azithromycin is an azalide, derived from the macrolide class of antibiotics. The mode of action of azithromycin is inhibition of protein synthesis in bacteria by binding to the 50s ribosomal subunit and preventing translocation of peptides.

Azithromycin demonstrates activity *in vitro* against a wide variety of Gram-positive and Gram-negative bacteria including: *Staphylococcus aureus*, *Streptococcus pneumoniae*, *Streptococcus pyogenes* (Group A) and other Streptococcal species; *Haemophilus influenzae* and *parainfluenzae*; *Branhamella catarrhalis*; anaerobes including *Bacteroides fragilis*; *Escherichia coli*; *Bordetella pertussis*; *Bordetella parapertussis*; *Borrelia burgdorferi*; *Haemophilus ducreyi*; *Neisseria gonorrhoeae* and *Chlamydia trachomatis*. Azithromycin also demonstrates *in vitro* activity against *Legionella pneumophila*, *Mycoplasma pneumoniae* and *hominis*, *Campylobacter* sp., *Toxoplasma gondii* and *Treponema pallidum*.

PHARMACOKINETICS

Following oral administration in humans, azithromycin is widely distributed throughout the body; bioavailability is approximately 37%. The time taken to peak plasma levels is 2-3 hours. The plasma terminal elimination half-life closely reflects the tissue depletion half-life of 2 to 4 days.

Kinetic studies have shown markedly higher azithromycin levels in tissue than in plasma (up to 50 times the maximum observed concentration in plasma) indicating that the drug is heavily tissue bound. Concentrations in target tissues such as lung, tonsil, and prostate exceed the MIC90 for likely pathogens after a single dose of 500mg.

Following a single dose of azithromycin 1 gram orally, the pharmacokinetics in subjects with mild to moderate renal impairment (GFR 10 - 80ml/min) were not affected. Statistically significant differences in AUC 0-120 (8.8 µg·h/ml vs. 11.7 µg·h/ml), Cmax (1.0 µg/ml vs. 1.6 µg/ml) and CLr (2.3 ml/min/kg vs. 0.2 ml/min/kg) were observed between the group with normal renal function and the group with severe renal impairment (GFR <10 ml/min).

INDICATIONS

Imexa is indicated for infections caused by susceptible organisms; in lower respiratory tract infections including bronchitis and pneumonia, in skin and soft tissue infections, in otitis media and in upper respiratory tract infections including sinusitis and pharyngitis/tonsillitis. (Penicillin is the usual drug of choice in the treatment of *Streptococcus pyogenes* pharyngitis, including the prophylaxis of rheumatic fever. Azithromycin is generally effective in the eradication of streptococci from the oropharynx, however, data establishing the efficacy of azithromycin and the subsequent prevention of rheumatic fever are not available at present.)

In sexually transmitted diseases in men and women, **Imexa** is indicated in the treatment of uncomplicated genital infections due to *Chlamydia trachomatis*. It is also indicated in the treatment of uncomplicated genital infection due to non-multiresistant *Neisseria gonorrhoea*, concurrent infection with *Treponema pallidum* should be excluded.

Imexa is indicated, either alone or in combination with rifabutin, for prophylaxis against *Mycobacterium avium – intracellulare complex* (MAC) infection, an opportunistic infection prevalent in patients with advanced human immunodeficiency virus (HIV).

DOSEAGE AND ADMINISTRATION

To be administered orally.

Imexa should be given as a single daily dose. The period of dosing with regard to infection is given below.

Imexa can be taken with food.

In adults: For the treatment of sexually transmitted diseases caused by *Chlamydia trachomatis*, or susceptible *Neisseria gonorrhoea*, the dose is 1000 mg as a single oral dose.

For prophylaxis against MAC infections in patients infected with the human immunodeficiency virus (HIV), the dose is 1200 mg once per week.

According to the 1999 USPHS/IDSA Guidelines for the Prevention of Opportunistic Infections in Persons Infected with Human Immunodeficiency Virus, the optimal criteria for discontinuing MAC prophylaxis remain to be defined. However, a reasonable option would be to consider discontinuing prophylaxis in patients with a CD4+ T-lymphocyte count greater than 100 cells/microlitre for a sustained period (eg.greater than 3-6 months.)



For all other indications, the total dosage of 1500 mg should be given as 500 mg daily for 3 days. As an alternative, the same total dose can be given over 5 days with 500 mg given on day 1, then 250 mg daily on days 2 to 5.

In the elderly: The same dose range as in younger patients may be used in elderly.

In patients with renal impairment: No dose adjustment is necessary in patients with mild to moderate (GFR 10 - 80 ml/min) or severe (GFR < 10 ml/min) renal impairment (see section Warnings and Precautions).

In patients with hepatic impairment: See section Warnings and Precautions.

In children: With the single exception of the treatment of streptococcal pharyngitis, the total dose in children is 30 mg/kg which should be given as a single daily dose of 10 mg/kg daily for 3 days or as an alternative, given 5 days with a single daily dose of 10 mg/kg on day 1, then 5 mg/kg on days 2-5.

Treatment of acute otitis media in children may be given as either a single dose of 30 mg/kg or as 10 mg/kg daily for 3 days. For children weighing less than 15 kg, **Imexa Powder for Oral Suspension** should be measured as closely as possible. For children weighing 15kg or more, **Imexa Powder for Oral Suspension** should be administered according to the guide provided below:

Imexa Powder for Oral Suspension		
Weight (kg)	3-Day Regimen	5-Day Regimen
<15	10 mg/kg once daily on days 1-3.	10 mg/kg on day 1, then 5 mg/kg once daily on days 2-5.
15-25	200 mg (5 ml) once daily on days 1-3.	200 mg (5 ml) on day 1, then 100 mg (2.5 ml) once daily on days 2-5.
26-35	300 mg (7.5 ml) once daily on days 1-3.	300 mg (7.5 ml) on day 1, then 150 mg (3.75ml) once daily on days 2-5.
36-45	400 mg (10 ml) once daily on days 1-3.	400 mg (10 ml) on day 1, then 200 mg (5 ml) once daily on days 2-5.
>45	Dose as per adults.	

Treatment of acute otitis media in children: The recommended dose of **Imexa Powder for Oral Suspension** for the treatment of children with acute otitis media is either 30 mg/kg given as a single dose, according to the table below, or as 10 mg/kg daily for 3 days.

OTITIS MEDIA: (One Day Regimen)				
Dosing calculated on 30 mg/kg as a single dose				
Weight		200 mg/5ml	Total ml. per Treatment Course	Total mg per Treatment Course
Kg	Lbs	Day 1		
5	11	3.75 ml	3.75 ml	150 mg
10	22	7.5 ml	7.5 ml	300 mg
20	44	15 ml	15 ml	600 mg
30	66	22.5 ml	22.5 ml	900 mg
40	88	30 ml	30 ml	1200 mg
50 and above	110 and above	37.5 ml	37.5 ml	1500 mg

Imexa Film-Coated Tablet should only be administered to children weighing more than 45 kg.

Safety and efficacy for the prevention of MAC in children have not been established. Based on pediatric pharmacologic data, a dose of 20 mg/kg would be similar to the adult dose of 1200 mg but with higher Cmax.

For pediatric streptococcal pharyngitis, azithromycin given as a single dose of 10 mg/kg or 20 mg/kg for 3 days has been shown to be effective; however, do not exceed a daily dose of 500 mg. In clinical trials comparing these two dosage regimens, similar clinical efficacy was observed but greater bacteriologic eradication was evident at the 20 mg/kg/day dose. However, penicillin is the usual drug of choice in the treatment of *Streptococcus pyogenes* pharyngitis, including prophylaxis of rheumatic fever.

CONTRAINDICATIONS

Imexa is contra-indicated in patients with a known hypersensitivity to azithromycin or any of the macrolide antibiotics.

Because of the theoretical possibility of ergotism, azithromycin and ergot derivatives should not be coadministered.

WARNINGS AND PRECAUTIONS

Hypersensitivity

As with erythromycin and other macrolides, rare serious allergic reactions, including angioedema and anaphylaxis (rarely fatal), dermatologic reactions including Stevens-Johnson Syndrome (SJS), Toxic Epidermal Necrolysis (TEN) (rarely fatal), and Drug Reaction with Eosinophilia and Systemic Symptoms (DRESS) have been reported. Some of these reactions with azithromycin have resulted in recurrent symptoms and required a longer period of observation and treatment. In the event of severe acute hypersensitivity reactions, such as anaphylaxis, severe cutaneous adverse reactions (SCARs) (e.g. Stevens-Johnson Syndrome (SJS), toxic epidermal necrolysis (TEN), drug reaction with eosinophilia and systemic symptoms (DRESS) & acute generalized exanthematous pustulosis (AGEP)), **Imexa** should be discontinued immediately and appropriate treatment should be urgently initiated.

Physicians should be aware that reappearance of the allergic symptoms may occur when symptomatic therapy is discontinued.

Prolongation of the QT Interval

Prolonged cardiac repolarization and QT interval, imparting a risk of developing cardiac arrhythmia and torsades de pointes, have been seen in treatment with macrolides, including azithromycin (see section Side Effects). Prescribes should consider the risk of QT prolongation, which can be fatal, when weighing the risks and benefits of azithromycin for at risk groups including:

- Patients with congenital or documented QT prolongation
- Patients currently receiving treatment with other active substances known to prolong QT interval, such as antiarrhythmics of Classes IA and III, antipsychotic agents, antidepressants, and fluoroquinolones
- Patients with electrolyte disturbance, particularly in cases of hypokalemia and hypomagnesemia
- Patients with clinically relevant bradycardia, cardiac arrhythmia or cardiac insufficiency
- Elderly patients: elderly patients may be more susceptible to drug-associated effects on the QT interval

Infantile hypertrophic pyloric stenosis (IHPS)

Infantile hypertrophic pyloric stenosis (IHPS) has been reported following the use of azithromycin in infants (treatment up to 42 days of life). Parents and caregivers should be informed to contact their physician if vomiting and / or irritability with feeding occurs.

Use in renal impairment: In patients with severe renal impairment (GFR<10 ml/min) a 33% increase in systemic exposure to azithromycin was observed (see section Pharmacokinetics).

Use in hepatic impairment: As the liver is the principal route of excretion of azithromycin, it should not be used in patients with hepatic disease. As with any antibiotic preparation, observation for signs of superinfection with non-susceptible organisms, including fungi is recommended.

DRUG INTERACTIONS

Antacids: In patients receiving azithromycin and antacids, azithromycin should be taken at least 1 hour before or 2 hours after the antacid.

Carbamazepine: In a pharmacokinetic interaction study in healthy volunteers, no significant effect was observed on the plasma levels of carbamazepine or its active metabolite.

Cimetidine: A single dose of cimetidine administered 2 hours before azithromycin had no effect on the pharmacokinetics of azithromycin.

Cyclosporin: In a pharmacokinetic study with healthy volunteers that were administered a 500 mg/day oral dose of azithromycin for 3 days and were then administered a single 10 mg/kg oral dose of cyclosporin, the resulting cyclosporine Cmax and AUC0-5 were found to be significantly elevated (by 24% and 21% respectively), however no significant changes were seen in AUC0-∞. Consequently, caution should be exercised before considering coadministration of these two drugs. If coadministration is necessary, cyclosporin levels should be monitored and the dose adjusted accordingly.

Digoxin: Some of the macrolide antibiotics have been reported to impair the metabolism of digoxin (in the gut) in some patients. Therefore, in patients receiving concomitant azithromycin and digoxin the possibility of raised digoxin levels should be borne in mind, and digoxin levels monitored.

Ergot derivatives: Because of the theoretical possibility of ergotism, azithromycin and ergot derivatives should not be coadministered.

Methylprednisolone: In a pharmacokinetic interaction study in healthy volunteers, azithromycin had no significant effect on the pharmacokinetics of methylprednisolone.

Terfenadine: Because of the occurrence of serious dysrhythmias secondary to prolongation of the QTc interval in patients receiving other anti-infectives in conjunction with terfenadine, pharmacokinetic interaction studies have been performed. These studies have reported no evidence of an interaction between azithromycin and terfenadine. There have been rare cases reported where the possibility of such an interaction could not be entirely excluded; however there was no specific evidence that such an interaction had occurred. As with other macrolides, azithromycin should be administered with caution in combination with terfenadine.

Theophylline: Theophylline levels may be increased in patients taking azithromycin.

Coumarin-Type Oral Anticoagulants: In a pharmacodynamic interaction study, azithromycin did not alter the anticoagulant effect of a single 15mg dose of warfarin administered to healthy volunteers. There have been reports received in the post-marketing period of potentiated anticoagulation subsequent to coadministration of azithromycin and coumarin-type oral anticoagulants. Although a causal relationship has not been established, consideration should be given to the frequency of monitoring prothrombin time when azithromycin is used in patients receiving coumarin-type oral anticoagulants.

Zidovudine: Single 1000 mg doses and multiple 1200 mg or 600 mg doses of azithromycin did not affect the plasma pharmacokinetics or urinary excretion of zidovudine or its glucuronide metabolite. However, administration of azithromycin increased the concentrations of phosphorylated zidovudine, the clinically active metabolite, in peripheral blood mononuclear cells. The clinical significance of this finding is unclear, but it may be of benefit to patients.

Didanosine: Coadministration of daily doses of 1200mg azithromycin with didanosine in 6 subjects did not appear to affect the pharmacokinetics of didanosine as compared with placebo.

Rifabutin: Coadministration of azithromycin and rifabutin did not affect the serum concentrations of either drug. Neutropenia was observed in subjects receiving concomitant treatment of azithromycin and rifabutin. Although neutropenia has been associated with the use of rifabutin, a causal relationship to combination with azithromycin has not been established (see section Side Effects).

PREGNANCY AND LACTATION

Use in pregnancy: Animal reproduction studies have demonstrated that azithromycin crosses the placenta, but have revealed no evidence of harm to the foetus. There are no adequate and well controlled studies in pregnant women. Since animal studies are not always predictive of human response, Azithromycin should be used during pregnancy only if adequate alternatives are not available.

Use in lactation: No data on secretion of azithromycin in breast milk are available, so that azithromycin should only be used in lactating women where adequate alternatives are not available.

SIDE EFFECTS

Azithromycin is well tolerated with a low incidence of side effects.

Infections and Infestations: Moniliasis and vaginitis

Blood and Lymphatic System Disorders: Thrombocytopenia. Transient mild reductions in neutrophil counts have occasionally been observed in clinical trials. Immune system disorders: Anaphylaxis (rarely fatal) (see section Warnings and Precautions) Metabolism and nutrition disorders: Anorexia

Psychiatric Disorders: Aggressive reaction, nervousness, agitation and anxiety. Nervous System Disorders: Dizziness, convulsions (as seen with other macrolides), headache, somnolence, paraesthesia, hyperactivity and syncope. There have been rare reports of taste perversion.

Ear and Labyrinth Disorders: Vertigo, hearing impairment has been reported with macrolide antibiotics. There have been reports of hearing impairment, including hearing loss, deafness and/or tinnitus in some patients receiving azithromycin. Many of these have been associated with prolonged use of high doses in investigational studies. In those cases where follow-up information were available the majority of these events was reversible.

Cardiac Disorders: Palpitations and arrhythmias including ventricular tachycardia (as seen with macrolides) have been reported. There have been rare reports of QT prolongation and torsades de pointes (see section Warnings and Precautions). Vascular Disorders: Hypotension

Gastrointestinal Disorders: Nausea, vomiting / diarrhoea (rarely resulting in dehydration), loose stools, dyspepsia, abdominal discomfort (pain/cramps), constipation, flatulence, infantile hypertrophic pyloric stenosis, pseudomembranous colitis, pancreatitis and rare reports of tongue discoloration. Hepatobiliary Disorders: Abnormal liver function including hepatitis and cholestatic jaundice have been reported, as well as rare cases of hepatic necrosis and hepatic failure, which have rarely resulted in death.

Skin and Subcutaneous Tissue Disorders (frequency not known): Allergic reactions including pruritus, rash, photosensitivity, oedema, urticaria and angioedema. Rarely, severe cutaneous adverse reactions (SCARs) including erythema multiforme, Stevens-Johnson Syndrome (SJS), toxic epidermal necrolysis (TEN), drug reaction with eosinophilia and systemic symptoms (DRESS) & acute generalized exanthematous pustulosis (AGEP) have occurred. (see section Warnings and Precautions).

Musculoskeletal and Connective Tissue Disorders: Arthralgia. Renal and Urinary Disorders: Interstitial nephritis and acute renal failure. General Disorders and Administration Site Conditions: Asthenia, fatigue and malaise have been reported.

SYMPTOMS AND TREATMENT OF OVERDOSAGE

Adverse events experienced in higher than recommended doses were similar to those seen at normal doses. In the event of overdose, general symptomatic and supportive measures are indicated as required.

STORAGE CONDITION

Imexa Film-Coated Tablet: Store below 30°C.

Imexa Powder for Oral Suspension: (For both powder and reconstituted suspension) Keep container well closed. Store below 30°C. Protect from light.

SHELF LIFE

Imexa Film-Coated Tablet: The expiry date is indicated on the packaging.

Imexa Powder for Oral Suspension: The expiry date is indicated on the packaging. Once reconstituted with water, it has a shelf-life of 5 days.

PRODUCT DESCRIPTION

Imexa Film-Coated Tablet: White, oval shaped, film coated tablet engraved with XS on one side and plain on the other side.

Available as blister strips of 6's in packing of 30 tablets per box.

Imexa Powder for Oral Suspension:

Before reconstitution: White, free flowing powder with fruity odour.

After reconstitution: White colour suspension with fruity flavor.

Available in packing of 20ml.

INSTRUCTION FOR USE AND HANDLING

Imexa Powder for Oral Suspension: Shake to loosen powder. Add 9ml of water to give 20ml suspension. Shake vigorously to disperse powder.

KEEP OUT OF REACH OF CHILDREN

JAUHI DARI KANAK-KANAK

For further information, please consult your pharmacist or physician.

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Manufacturer and Product Registration Holder:

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