LEVOFLOXACIN - levofloxacin injection, solution, concentrate
AuroMedics Pharma LLC

**HIGHLIGHTS OF PRESCRIBING INFORMATION**

These highlights do not include all the information needed to use LEVOFLOXACIN INJECTION safely and effectively. See full prescribing information for LEVOFLOXACIN INJECTION.

**LEVOFLOXACIN injection, for intravenous use**

Initial U.S. Approval: 1996

**WARNING: SERIOUS ADVERSE REACTIONS INCLUDING TENDINITIS, TENDON RUPTURE, PERIPHERAL NEUROPATHY, CENTRAL NERVOUS SYSTEM EFFECTS AND EXACERBATION OF MYASTHENIA GRAVIS**

See full prescribing information for complete boxed warning.

Fluoroquinolones, including levofloxacin, have been associated with disabling and potentially irreversible serious adverse reactions that have occurred together (5.1), including:

- Tendinitis and tendon rupture (5.2)
- Peripheral neuropathy (5.3)
- Central nervous system effects (5.4)

Discontinue levofloxacin immediately and avoid the use of fluoroquinolones, including levofloxacin, in patients who experience any of these serious adverse reactions (5.3).

Fluoroquinolones, including levofloxacin, may exacerbate muscle weakness in patients with myasthenia gravis. Avoid levofloxacin in patients with a known history of myasthenia gravis (see Warnings and Precautions (5.5)).

Because fluoroquinolones, including levofloxacin, have been associated with serious adverse reactions (5.4-5.3), reserve levofloxacin for use in patients who have no alternative treatment options for the following indications:

- Uncomplicated urinary tract infection (1.12)
- Acute bacterial exacerbation of chronic bronchitis (1.13)
- Acute bacterial sinusitis (1.14)

**INDICATIONS AND USAGE**

Levofloxacin injection is a fluoroquinolone antibacterial indicated in adults (≥18 years of age) with infections caused by designated, susceptible bacteria.

**Dosage and Administration**

**DOSAGE FORMS AND STRENGTHS**

**CONTRAINDICATIONS**

Known hypersensitivity to levofloxacin injection or other quinolones (4, 5.7)

**WARNINGS AND PRECAUTIONS**

- Anaphylactic reactions and allergic skin reactions, serious, occasionally fatal, may occur after first dose (4, 5.7)
- Nephrotoxicity (including agranulocytosis, thrombocytopenia), and seizures/torsades de pointes may occur after multiple doses (5.6)
- Hepatotoxicity: Severe, and sometimes fatal, hepatotoxicity has been reported. Discontinue immediately if signs and symptoms of hepatitis occur (5.8)
- Clostridium difficile-associated colitis: evaluate if diarrhea occurs (5.9)
- Prolongation of the QT interval and isolated cases of torsade de pointes have been reported. Acriflavine in patients with known prolongation, those with hypokalemia, and with other drugs that prolong the QT interval (5.11, 8.5)

**ADVERSE REACTIONS**

The most common reactions (≥3%) were nausea, headache, diarrhea, insomnia, constipation and dizziness (8.2).
The most common reactions (≥3%) were nausea, headache, diarrhea, insomnia, constipation and dizziness.

To report SUSPECTED ADVERSE REACTIONS, contact AuroMedics Pharma LLC at 1-866-850-2876 or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.

DRUG INTERACTIONS

<table>
<thead>
<tr>
<th>Interacting Drug</th>
<th>Interaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multivalent cation-containing products</td>
<td>Do not co-administer the intravenous formulation in the same IV line with</td>
</tr>
<tr>
<td>including antacids, metal cations or</td>
<td>a multivalent cation, e.g., magnesium (2.4, 7.3)</td>
</tr>
<tr>
<td>didanosine</td>
<td></td>
</tr>
<tr>
<td>Warfarin</td>
<td>Effect may be enhanced. Monitor prothrombin time, INR, watch for bleeding (7.2)</td>
</tr>
<tr>
<td>Antidiabetic agents</td>
<td>Carefully monitor blood glucose (5.13, 7.3)</td>
</tr>
</tbody>
</table>

Geriatric: Severe hepatotoxicity has been reported. The majority of reports describe patients 65 years of age or older (5.8, 8.5, 17). May have increased risk of tendinopathy (including rupture), especially with concomitant corticosteroid use (5.2, 8.5, 17). May be more susceptible to prolongation of the QT interval (5.11, 8.5, 17).

Pediatric: Musculoskeletal disorders (arthralgia, arthritis, tendinopathy, and gait abnormality) seen in more levofloxacin-treated patients than in comparator. Shown to cause arthropathy and osteochondrosis in juvenile animals (5.12, 8.4, 13.2). Failure to pediatric patients treated for more than 14 days has not been studied. Risk-benefit appropriate only for the treatment of inhalational anthrax (post-exposure) (1.7, 2.2, 8.4, 14.9) and plague (1.8, 2.2, 8.4, 14.10).

See 17 for PATIENT COUNSELING INFORMATION and Medication Guide.
14.1 Nosocomial Pneumonia
14.2 Community-Acquired Pneumonia: 7 to 14 day Treatment Regimen
14.3 Community-Acquired Pneumonia: 5-day Treatment Regimen
14.4 Acute Bacterial Sinusitis: 5-day and 10 to 14 day Treatment Regimens
14.5 Complicated Skin and Skin Structure Infections
14.6 Chronic Bacterial Prostatitis
14.7 Complicated Urinary Tract Infections and Acute Pyelonephritis: 5-day Treatment Regimen
14.8 Complicated Urinary Tract Infections and Acute Pyelonephritis: 10-day Treatment Regimen
14.9 Inhalational Anthrax (Post-Exposure)
14.10 Plague
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17 PATIENT COUNSELING INFORMATION
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FULL PRESCRIBING INFORMATION

WARNING: SERIOUS ADVERSE REACTIONS INCLUDING TENDINITIS, TENDON RUPTURE, PERIPHERAL NEUROPATHY, CENTRAL NERVOUS SYSTEM EFFECTS AND EXACERBATION OF MYASTHENIA GRAVIS

- Fluoroquinolones, including levofloxacin, have been associated with disabling and potentially irreversible serious adverse reactions that have occurred together [see Warnings and Precautions (5.1)], including:
  - Tendinitis and tendon rupture [see Warnings and Precautions (5.2)]
  - Peripheral neuropathy [see Warnings and Precautions (5.3)]
  - Central nervous system effects [see Warnings and Precautions (5.4)]
  - Myasthenia gravis [see Warnings and Precautions (5.5)]

Discontinue levofloxacin immediately and avoid the use of fluoroquinolones, including levofloxacin, in patients who experience any of these serious adverse reactions [see Warnings and Precautions (5.1)]

- Fluoroquinolones, including levofloxacin, may exacerbate muscle weakness in patients with myasthenia gravis. Avoid levofloxacin in patients with a known history of myasthenia gravis [see Warnings and Precautions (5.5)].

- Because fluoroquinolones, including levofloxacin, have been associated with serious adverse reactions [see Warnings and Precautions (5.3)], reserve levofloxacin for use in patients who have no alternative treatment options for the following indications:
  - Uncomplicated urinary tract infection [see Indications and Usage (1.12)]
  - Acute bacterial exacerbation of chronic bronchitis [see Indications and Usage (1.13)]
  - Acute bacterial sinusitis [see Indications and Usage (1.14)]

1 INDICATIONS AND USAGE

Levofloxacin injection is indicated for the treatment of adults (≥18 years of age) with mild, moderate, and severe infections caused by susceptible isolates of the designated microorganisms in the conditions listed in this section. Levofloxacin injection is indicated when intravenous administration offers a route of administration advantageous to the patient (e.g., patient cannot tolerate an oral dosage form).

1.1 Nosocomial Pneumonia

Levofloxacin injection is indicated for the treatment of nosocomial pneumonia due to methicillin-susceptible Staphylococcus aureus, Pseudomonas aeruginosa, Serratia marcescens, Escherichia coli, Klebsiella pneumoniae, Haemophilus influenzae, or Streptococcus pneumoniae. Adjunctive therapy should be used as clinically indicated. Where Pseudomonas aeruginosa is documented or presumptive, combination therapy with an anti-pseudomonal β-lactam is recommended [see Clinical Studies (14.1)].

1.2 Community-Acquired Pneumonia: 7 to 14 day Treatment Regimen

Levofloxacin injection is indicated for the treatment of community-acquired pneumonia due to methicillin-susceptible Staphylococcus aureus, Streptococcus pneumoniae (including multi-drug-resistant Streptococcus pneumoniae [MDRSP]), Haemophilus influenzae, Haemophilus parainfluenzae, Klebsiella pneumoniae, Moraxella catarrhalis, Chlamydia pneumoniae, Legionella pneumophila, or Mycoplasma pneumoniae [see Dosage and Administration (2.1) and Clinical Studies (14.2)].

MDRSP isolates are isolates resistant to two or more of the following antibiotics: penicillin (MIC ≥2 mg/L), 2nd generation cephalosporins, e.g., cefuroxime, macrolides, tetracyclines and trimethoprim/sulfamethoxazole.

1.3 Community-Acquired Pneumonia: 5-day Treatment Regimen

Levofloxacin injection is indicated for the treatment of community-acquired pneumonia due to Streptococcus pneumoniae (excluding multi-drug-resistant isolates [MDRSP]), Haemophilus influenzae, Haemophilus parainfluenzae, Mycoplasma pneumoniae, or Chlamydia pneumoniae [see Dosage and Administration (2.1) and Clinical Studies (14.3)].

1.4 Complicated Skin and Skin Structure Infections

Levofloxacin injection is indicated for the treatment of complicated skin and skin structure infections due to methicillin-susceptible Staphylococcus aureus, Enterococcus faecalis, Streptococcus pyogenes, or Proteus mirabilis [see Clinical Studies (14.3)].

1.5 Uncomplicated Skin and Skin Structure Infections

Levofloxacin injection is indicated for the treatment of uncomplicated skin and skin structure infections (mild to moderate) including abscesses, cellulitis, furuncles, impetigo, pyoderma, wound infections, due to methicillin-susceptible Staphylococcus aureus, or Streptococcus pyogenes.

1.6 Chronic Bacterial Prostatitis

Levofloxacin injection is indicated for the treatment of chronic bacterial prostatitis due to Escherichia coli, Enterococcus facaealis, or methicillin-susceptible Staphylococcus epidermidis [see Clinical Studies (14.6)].

1.7 Inhalational Anthrax (Post-Exposure)

Levofloxacin injection is indicated for inhalational anthrax (post-exposure) to reduce the incidence or progression of disease following exposure to aerosolized Bacillus anthracis. The effectiveness of levofloxacin injection is based on plasma concentrations achieved in humans, a surrogate endpoint reasonably likely to predict clinical benefit. Levofloxacin injection has not been tested in humans for the post-exposure prevention of inhalational anthrax. The safety of levofloxacin injection in adults for
Table 1: Dosage in Adult Patients with Normal Renal Function (creatinine clearance ≥ 50 mL/min)

<table>
<thead>
<tr>
<th>Type of Infection</th>
<th>Dosed Every 24 hours</th>
<th>Duration (days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nosocomial Pneumonia</td>
<td>750 mg</td>
<td>7 to 14</td>
</tr>
<tr>
<td>Community Acquired Pneumonia</td>
<td>500 mg</td>
<td>7 to 14</td>
</tr>
<tr>
<td>Community Acquired Pneumonia</td>
<td>750 mg</td>
<td>5</td>
</tr>
<tr>
<td>Complicated Skin and Skin Structure Infections (SSSI)</td>
<td>750 mg</td>
<td>7 to 14</td>
</tr>
<tr>
<td>Uncomplicated SSI</td>
<td>500 mg</td>
<td>7 to 10</td>
</tr>
<tr>
<td>Chronic Bacterial Prostatitis</td>
<td>500 mg</td>
<td>28</td>
</tr>
<tr>
<td>Inhalational Anthrax (Post-Exposure), adult and pediatric patients &gt; 50 kg *†</td>
<td>500 mg</td>
<td>60*</td>
</tr>
</tbody>
</table>
Table 3: Dosage Adjustment in Adult Patients with Renal Impairment (creatinine clearance < 50 mL/min

<table>
<thead>
<tr>
<th>Dosage in Normal Renal Function Every 24 hours</th>
<th>Creatinine Clearance to 49 mL/min</th>
<th>Creatinine Clearance 19 mL/min</th>
<th>10 to Hemodialysis or Chronic Ambulatory Peritoneal Dialysis (CAPD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>750 mg</td>
<td>750 mg every 48 hours</td>
<td>750 mg initial dose, then 500 mg every 48 hours</td>
<td>500 mg initial dose, then 250 mg every 48 hours</td>
</tr>
<tr>
<td>500 mg</td>
<td>500 mg every 48 hours</td>
<td>500 mg initial dose, then 250 mg every 48 hours</td>
<td>250 mg every 48 hours</td>
</tr>
</tbody>
</table>
2.4 Drug Interaction With Chelation Agents: Antacids, Sucralfate, Metal Cations, Multivitamins

Levofloxacin injection should not be co-administered with any solution containing multivalent cation, e.g., magnesium, through the same intravenous line [see Dosage and Administration (2.6)].

2.5 Administration Instructions

Caution: Rapid or bolus intravenous infusion of levofloxacin injection has been associated with hypotension and must be avoided. Levofloxacin injection should be infused intravenously slowly over a period of not less than 60 or 90 minutes, depending on the dosage. Levofloxacin injection should be administered only by intravenous infusion. It is not for intramuscular, intrathecal, intraperitoneal, or subcutaneous administration.

Hydration for Patients Receiving Levofloxacin Injection

Adequate hydration of patients receiving intravenous levofloxacin injection should be maintained to prevent the formation of highly concentrated urine. Crystalluria and cylindruria have been reported with quinolones [see Adverse Reactions (6.1) and Patient Counseling Information (17)].

2.6 Preparation of Intravenous Product

Parenteral drug products should be inspected visually for particulate matter and discoloration prior to administration, whenever solution and container permit.

Because only limited data are available on the compatibility of levofloxacin injection with other intravenous substances, additives or other medications should not be added to levofloxacin injection in single-dose vials, or infused simultaneously through the same intravenous line. If the same intravenous line is used for sequential infusion of several different drugs, the line should be flushed before and after infusion of levofloxacin injection with an infusion solution compatible with levofloxacin injection and with any other drug(s) administered via this common line.

Levofloxacin Injection in Single-Dose Vials

Single-dose vials require dilution prior to administration.

Levofloxacin injection is supplied in single-dose vials containing a concentrated levofloxacin solution with the equivalent of 500 mg (20 mL vial) and 750 mg (30 mL vial) of levofloxacin in Water for Injection, USP. The 20 mL and 30 mL vials each contain 25 mg of levofloxacin/mL. These levofloxacin injection single-dose vials must be further diluted with an appropriate solution prior to intravenous administration [see Table 4]. The concentration of the resulting diluted solution should be 5 mg/mL prior to administration.

Compatible Intravenous Solutions: Any of the following intravenous solutions may be used to prepare a 5 mg/mL levofloxacin solution with the approximate pH values:

<table>
<thead>
<tr>
<th>Intravenous Fluids</th>
<th>Final pH of Levofloxacin Solution</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.9% Sodium Chloride Injection, USP</td>
<td>4.71</td>
</tr>
<tr>
<td>5% Dextrose Injection, USP</td>
<td>4.58</td>
</tr>
<tr>
<td>5% Dextrose/0.9% NaCl Injection</td>
<td>4.62</td>
</tr>
<tr>
<td>5% Dextrose in Lactated Ringers</td>
<td>4.92</td>
</tr>
<tr>
<td>Plasma-Lyte® 56/5% Dextrose Injection</td>
<td>5.03</td>
</tr>
<tr>
<td>5% Dextrose, 0.4% Sodium Chloride, and</td>
<td>4.61</td>
</tr>
<tr>
<td>0.15% Potassium Chloride Injection</td>
<td></td>
</tr>
<tr>
<td>Sodium Lactate Injection (M/6)</td>
<td>5.54</td>
</tr>
</tbody>
</table>

Since no preservative or bacteriostatic agent is present in this product, aseptic technique must be used in preparation of the final intravenous solution. Since the vials are for single-dose only, any unused portion remaining in the vial should be discarded. When used to prepare two 250 mg doses from the 20 mL vial containing 500 mg of levofloxacin, the full content of the vial should be withdrawn at once using a single-entry procedure, and a second dose should be prepared and stored for subsequent use [see Stability of Levofloxacin Injection Following Dilution].

Prepare the desired dosage of levofloxacin according to Table 5:

<table>
<thead>
<tr>
<th>Desired Dosage Strength</th>
<th>From Appropriate Vial, Withdraw Volume</th>
<th>Volume of Diluent</th>
<th>Infusion Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>250 mg</td>
<td>10 mL (20 mL Vial)</td>
<td>40 mL</td>
<td>60 min</td>
</tr>
<tr>
<td>500 mg</td>
<td>20 mL (30 mL Vial)</td>
<td>80 mL</td>
<td>60 min</td>
</tr>
<tr>
<td>750 mg</td>
<td>30 mL (30 mL Vial)</td>
<td>120 mL</td>
<td>90 min</td>
</tr>
</tbody>
</table>

For example, to prepare a 500 mg dose using the 20 mL vial (25 mg/mL), withdraw 20 mL and dilute with a compatible intravenous solution to a total volume of 100 mL.

This intravenous drug product should be inspected visually for particulate matter prior to administration. Samples containing visible particles should be discarded.

Stability of Levofloxacin Injection Following Dilution: Levofloxacin injection, when diluted in a compatible intravenous fluid to a concentration of 5 mg/mL, is stable for 72 hours when stored at or below 25°C (77°F) and for 14 days when stored under refrigeration at 5°C (41°F) in plastic intravenous containers. Solutions that are diluted in a compatible intravenous solution and frozen in glass bottles or plastic intravenous containers are stable for 6 months when stored at -20°C (-4°F). These frozen solutions at room temperature 25°C (77°F) or in a refrigerator 8°C (46°F). Do not force thaw by microwave irradiation or water bath immersion. Do not refreeze after initial thawing.

3 DOSAGE FORMS AND STRENGTHS

Single-dose vials of concentrated solution for dilution for intravenous infusion, clear yellow to a clear greenish yellow in appearance

- 20 mL vial of 25 mg/mL levofloxacin solution, equivalent to 500 mg of levofloxacin
Levofloxacin injection is contraindicated in persons with known hypersensitivity to levofloxacin, or other quinolone antibacterials [see Warnings and Precautions (5.3)].

5 WARNINGS AND PRECAUTIONS

5.1 Disabling and Potentially Irreversible Serious Adverse Reactions Including Tendinitis and Tendon Rupture, Peripheral Neuropathy, and Central Nervous System Effects

Fluoroquinolones, including levofloxacin, have been associated with disabling and potentially irreversible serious adverse reactions from different body systems that can occur together in the same patient. Commonly seen adverse reactions include tendinitis, tendon rupture, arthralgia, myalgia, peripheral neuropathy, and central nervous system effects (hallucinations, anxiety, depression, insomnia, severe headaches, and confusion). These reactions can occur within hours to weeks after starting levofloxacin. Patients of any age or without pre-existing risk factors have experienced these adverse reactions [see Warnings and Precautions (5.2, 5.3, 5.4)].

Discontinue levofloxacin immediately at the first sign or symptoms of any serious adverse reaction. In addition, avoid the use of fluoroquinolones, including levofloxacin, in patients who have experienced any of these serious adverse reactions associated with fluoroquinolones.

5.2 Tendinitis and Tendon Rupture

Fluoroquinolones, including levofloxacin, have been associated with an increased risk of tendinitis and tendon rupture in all ages [see Warnings and Precautions (5.1) and Adverse Reactions (6.2)]. This adverse reaction most frequently involves the Achilles tendon and has also been reported with the rotator cuff (the shoulder), the bicep, the thumb, and other tendon sites. Tendinitis or tendon rupture can occur within hours or days of starting levofloxacin or as long as several months after completion of fluoroquinolone therapy. Tendinitis and tendon rupture can occur bilaterally.

The risk of developing fluoroquinolone-associated tendinitis and tendon rupture is increased in patients over 60 years of age, in those taking corticosteroid drugs, and in patients with kidney, heart or lung transplants. Other factors that may independently increase the risk of tendon rupture include strenuous physical activity, renal failure, and previous tendon disorders such as rheumatoid arthritis. Tendinitis and tendon rupture have been reported in patients taking fluoroquinolones who do not have the above risk factors. Discontinue levofloxacin immediately if the patient experiences pain, swelling, inflammation or rupture of a tendon. Patients should be advised to rest at the first sign of tendinitis or tendon rupture, and to contact their healthcare provider regarding changing to a non-quinolone antimicrobial drug. Avoid levofloxacin in patients who have a history of tendon disorders or tendon rupture [see Adverse Reactions (6.3); Patient Counseling Information (17)].

5.3 Peripheral Neuropathy

Fluoroquinolones, including levofloxacin, have been associated with an increased risk of peripheral neuropathy. Cases of sensory or sensorimotor axonal polyneuropathy of affecting small and/or large axons resulting in paresthesia, hypoaesthesia, dysesthesia and weakness have been reported in patients receiving fluoroquinolones, including levofloxacin. Symptoms may occur soon after initiation of levofloxacin and may be irreversible in some patients [see Warnings and Precautions (5.1) and Adverse Reactions (6.1, 6.2)].

Discontinue levofloxacin immediately if the patient experiences symptoms of neuropathy including pain, burning, tingling, numbness, and/or weakness or other alterations of sensation including light touch, pain, temperature, position sense, and vibratory sensation. Avoid fluoroquinolones, including levofloxacin, in patients who have previously experienced peripheral neuropathy [see Adverse Reactions (6), Patient Counseling Information (17)].

5.4 Central Nervous System Effects

Psychiatric Adverse Reactions

Fluoroquinolones, including levofloxacin, have been associated with an increased risk of psychiatric adverse reactions, including: toxic psychoses, hallucinations, or paranoia; depression, or suicidal thoughts; anxiety, agitation, restlessness, or nervousness; confusion, delirium, disorientation, or fluctuations in attention; insomnia or nightmares; memory impairment. Attempted or completed suicide have been reported, especially in patients with a medical history of depression, or an underlying risk factor for depression. These reactions may occur following the first dose. If these reactions occur in patients receiving levofloxacin, discontinue levofloxacin and institute appropriate measures.

Central Nervous System Adverse Reactions of Seizures, Increased Intracranial Pressure, and Tremors

Fluoroquinolones, including levofloxacin, have been associated with an increased risk of seizures (convulsions), increased intracranial pressure (including pseudotumor cerebri), tremors, and lightheadedness. As with other fluoroquinolones, levofloxacin should be used with caution in patients with a known or suspected central nervous system (CNS) disorder that may predispose them to seizures or lower the seizure threshold (e.g., severe cerebral arteriosclerosis, epilepsy) or in the presence of other risk factors that may predispose them to seizures or lower the seizure threshold (e.g., certain drug therapy, renal dysfunction). If these reactions occur in patients receiving levofloxacin, discontinue levofloxacin and institute appropriate measures. [see Adverse Reactions (6); Drug Interactions (7.4, 7.5); Patient Counseling Information (17)].

5.5 Exacerbation of Myasthenia Gravis

Fluoroquinolones, including levofloxacin, have neuromuscular blocking activity and may exacerbate muscle weakness in patients with myasthenia gravis. Postmarketing serious adverse reactions including deaths and requirement for ventilatory support, have been associated with fluoroquinolone use in patients with myasthenia gravis. Avoid levofloxacin in patients with a known history of myasthenia gravis [see Adverse Reactions (6.3); Patient Counseling Information (17)].

5.6 Other Serious and Sometimes Fatal Adverse Reactions

Other serious and sometimes fatal adverse reactions, some due to hypersensitivity, and some due to uncertain etiology, have been reported rarely in patients receiving therapy with fluoroquinolones, including levofloxacin. These events may be severe and generally occur following the administration of multiple doses. Clinical manifestations may include one or more of the following:

• fever, rash, or severe dermatologic reactions (e.g., toxic epidermal necrolysis, Steven-Johnson Syndrome);
• vasculitis; arthralgia; myalgia; serum sickness;
• allergic pneumonitis;
• interstitial nephritis; acute renal insufficiency or failure;
• hepatitis; jaundice; acute hepatic necrosis or failure;
• anemia, including hemolytic and aplastic; thrombocytopenia, including thrombotic thrombocytopenic purpura; leukopenia; agranulocytosis; pancytopenia; and/or other hematologic abnormalities.
Discontinue levofloxacin immediately at the first appearance of skin rash, jaundice, or any other sign of hypersensitivity and institute supportive measures [see Adverse Reactions (6); Patient Counseling Information (17)].

5.7 Hyperensitivity Reactions
Serious and occasionally fatal hyper sensitivity and/or anaphylactic reactions have been reported in patients receiving therapy with fluoroquinolones, including levofloxacin. These reactions often occur following the first dose. Some reactions have been accompanied by cardiovascular collapse, hypotension/shock, seizure, loss of consciousness, tingling, angioedema (including tongue, laryngeal, throat, or facial edema/swelling), airway obstruction (including bronchospasm, shortness of breath, and acute respiratory distress), dyspnea, urticaria, itching, and other serious skin reactions. Levofloxacin should be discontinued immediately at the first appearance of a skin rash or any other sign of hypersensitivity. Serious acute hyper sensitivity reactions may require treatment with epinephrine and other resuscitative measures, including oxygen, intravenous fluids, antihistamines, corticosteroids, pressor amines, and airway management, as clinically indicated [see Adverse Reactions (6); Patient Counseling Information (17)].

5.8 Hepatotoxicity
Post-marketing reports of severe hepatotoxicity (including acute hepatitis and fatal events) have been received for patients treated with levofloxacin. No evidence of serious drug-associated hepatotoxicity was detected in clinical trials of over 7,000 patients. Severe hepatotoxicity generally occurred within 14 days of initiation of therapy and most cases occurred within 6 days. Most cases of severe hepatotoxicity were not associated with hypersensitivity [see Warnings and Precautions (5.6)]. The majority of fatal hepatotoxicity reports occurred in patients 65 years of age or older and most were not associated with hypersensitivity. Levofloxacin should be discontinued immediately if the patient develops signs and symptoms of hepatitis [see Adverse Reactions (6); Patient Counseling Information (17)].

5.9 Risk of Aortic Aneurysm and Dissection
Epidemiologic studies report an increased rate of aortic aneurysm and dissection within two months following use of fluoroquinolones, particularly in elderly patients. The cause for the increased risk has not been identified. In patients with a known aortic aneurysm or patients who are at greater risk for aortic aneurysm, reserve levofloxacin for use only when there are no alternative antibacterial treatments available.

5.10 Clostridium difficile-Associated Diarrhea
Clostridium difficile-associated diarrhea (CDAD) has been reported with use of nearly all antibacterial agents, including levofloxacin, and may range in severity from mild diarrhea to fatal colitis. Treatment with antibacterial agents alters the normal flora of the colon leading to overgrowth of C. difficile.

C. difficile produces toxins A and B which contribute to the development of CDAD. Hypertoxin producing strains of C. difficile cause increased morbidity and mortality, as these infections can be refractory to antimicrobial therapy and may require colectomy. CDAD must be considered in all patients who present with diarrhea following antibiotic use. Careful medical history is necessary since CDAD has been reported to occur over two months after the administration of antibacterial agents. If CDAD is suspected or confirmed, ongoing antibiotic use not directed against C. difficile may need to be discontinued. Appropriate fluid and electrolyte management, protein supplementation, antibiotic treatment of C. difficile, and surgical evaluation should be instituted as clinically indicated [see Adverse Reactions (6.2); Patient Counseling Information (17)].

5.11 Prolongation of the QT Interval
Some fluoroquinolones, including levofloxacin, have been associated with prolongation of the QT interval on the electrocardiogram and infrequent cases of arrhythmia. Rare cases of torsade de points have been spontaneously reported during postmarketing surveillance in patients receiving fluoroquinolones, including levofloxacin. Levofloxacin should be avoided in patients with known prolongation of the QT interval, patients with uncorrected hypokalemia, and patients receiving Class IA (quinidine, procainamide), or Class III (amiodarone, sotalol) antiarrhythmic agents. Elderly patients may be more susceptible to drug-associated effects on the QT interval [see Adverse Reactions (6.3), Use in Specific Populations (8.5), and Patient Counseling Information (17)].

5.12 Musculoskeletal Disorders in Pediatric Patients and Arthropathic Effects in Animals
Levofloxacin is indicated in pediatric patients (6 months of age and older) only for the prevention of inhalational anthrax (post-exposure) and for plague [see Indications and Usage (1.7)]. An increased incidence of musculoskeletal disorders (arthritis, arthralgia, tendinopathy, and gait abnormality) compared to controls has been observed in pediatric patients receiving levofloxacin [see Use in Specific Populations (8.4)].

In immature rats and dogs, the oral and intravenous administration of levofloxacin resulted in increased osteochondrosis. Histopathological examination of the weight-bearing joints of immature dogs dosed with levofloxacin revealed persistent lesions of the cartilage. Other fluoroquinolones also produce similar erosions in the weight-bearing joints and other signs of arthropathy in immature animals of various species [see Animal Toxicology and/or Pharmacology (13.2)].

5.13 Blood Glucose Disturbances
Fluoroquinolones, including levofloxacin, have been associated with disturbances of blood glucose, including symptomatic hyperglycemia and hypoglycemia, usually in diabetic patients receiving concomitant treatment with an oral hypoglycemic agent (e.g., glyburide) or with insulin. In these patients, careful monitoring of blood glucose is recommended. Severe cases of hypoglycemia resulting in coma or death have been reported. If a hypoglycemic reaction occurs in a patient being treated with levofloxacin, discontinue levofloxacin and initiate appropriate therapy immediately [see Adverse Reactions (6.2); Drug Interactions (7.5); Patient Counseling Information (17)].

5.14 Photosensitivity/Phototoxicity
Moderate to severe photosensitivity/phototoxicity reactions, the latter of which may manifest as exaggerated sunburn reactions (e.g., burning, erythema, exudation, vesicles, blistering, edema) involving areas exposed to light (typically the face, “V” area of the neck, extensor surfaces of the forearm, dorsa of the hands), can be associated with the use of fluoroquinolones after sun or UV light exposure. Therefore, excessive exposure to these sources of light should be avoided. Drug therapy should be discontinued if photosensitivity/phototoxicity occurs [see Adverse Reactions (6.3); Patient Counseling Information (17)].

5.15 Development of Drug Resistant Bacteria
Prescribing levofloxacin in the absence of a proven or strongly suspected bacterial infection or a prophylactic indication is unlikely to provide benefit to the patient and increases the risk of the development of drug-resistant bacteria [see Patient Counseling Information (17)].

6 ADVERSE REACTIONS
6.1 Serious and Otherwise Important Adverse Reactions
The following serious and otherwise important adverse drug reactions are discussed in greater detail in other sections of labeling:

- Disabling and Potentially Irreversible Serious Adverse Reactions [see Warnings and Precautions (5.1)]
- Tendinitis and Tendon Rupture [see Warnings and Precautions (5.2)]
- Peripheral Neuropathy [see Warnings and Precautions (5.3)]
- Central Nervous System Effects [see Warnings and Precautions (5.4)]
- Exacerbation of Myasthenia Gravis [see Warnings and Precautions (5.5)]
- Other Serious and Sometimes Fatal Adverse Reactions [see Warnings and Precautions (5.6)]
- Hypersensitivity Reaction [see Warnings and Precautions (5.7)]
- Hepatotoxicity [see Warnings and Precautions (5.8)]
- Risk of Aortic Aneurysm and Dissection [see Warnings and Precautions (5.9)]
- Clostridium difficile-Associated Diarrhea [see Warnings and Precautions (5.10)]
- Prolongation of the QT Interval [see Warnings and Precautions (5.11)]
- Musculoskeletal Disorders in Pediatric Patients [see Warnings and Precautions (5.12)]
- Blood Glucose Disturbances [see Warnings and Precautions (5.13)]
- Photosensitivity/Phototoxicity [see Warnings and Precautions (5.14)]
- Development of Drug Resistant Bacteria [see Warnings and Precautions (5.15)]

Hypotension has been associated with rapid or bolus intravenous infusion of levofloxacin. Levofloxacin should be infused slowly over 60 to 90 minutes, depending on dosage [see Dosage and Administration (2.5)].

Crystalluria and cylindruria have been reported with quinolones, including levofloxacin. Therefore, adequate hydration of patients receiving levofloxacin should be maintained to prevent the formation of a highly concentrated urine [see Dosage and Administration (2.5)].

6.2 Clinical Trial Experience

Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in practice.

The data described below reflect exposure to levofloxacin in 7537 patients in 29 pooled Phase 3 clinical trials. The population studied had a mean age of 50 years (approximately 74% of the population was <65 years of age), 50% were male, 71% were Caucasian, 19% were Black. Patients were treated with levofloxacin for a wide variety of infectious diseases [see Indications and Usage (1)]. Patients received levofloxacin in doses of 750 mg once daily, 250 mg once daily, or 500 mg once or twice daily. Treatment duration was usually 3 to 14 days, and the mean number of days on therapy was 10 days.

The overall incidence, type and distribution of adverse reactions was similar in patients receiving levofloxacin doses of 750 mg once daily, 250 mg once daily, and 500 mg once or twice daily. Discontinuation of levofloxacin due to adverse drug reactions occurred in 4.3% of patients overall, 3.8% of patients treated with the 250 mg and 500 mg doses and 5.4% of patients treated with the 750 mg dose. The most common adverse drug reactions leading to discontinuation with the 250 and 500 mg doses were gastrointestinal (1.2%), primarily nausea (0.6%), vomiting (0.4%); dizziness (0.3%); and headache (0.2%). The most common adverse drug reactions leading to discontinuation with the 750 mg dose were gastrointestinal (1.2%), primarily nausea (0.6%), vomiting (0.5%); dizziness (0.3%); and headache (0.3%).

Adverse reactions occurring in ≥1% of levofloxacin-treated patients and less common adverse reactions, occurring in 0.1 to <1% of levofloxacin-treated patients, are shown in Table 6 and Table 7, respectively. The most common adverse drug reactions (≥3%) are nausea, headache, diarrhea, insomnia, constipation, and dizziness.

Table 6: Common (≥1%) Adverse Reactions Reported in Clinical Trials with Levofloxacin

<table>
<thead>
<tr>
<th>System/Organ Class</th>
<th>Adverse Reaction</th>
<th>% (N = 7537)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infections and Infestations</td>
<td>meningitis</td>
<td>1</td>
</tr>
<tr>
<td>Psychiatric Disorders</td>
<td>insomnia* [see Warnings and Precautions (5.4)]</td>
<td>4</td>
</tr>
<tr>
<td>Nervous System Disorders</td>
<td>headache</td>
<td>6</td>
</tr>
<tr>
<td>Respiratory, Thoracic and Mediastinal Disorders</td>
<td>dyspnea [see Warnings and Precautions (5.7)]</td>
<td>1</td>
</tr>
<tr>
<td>Gastrointestinal Disorders</td>
<td>nausea</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>diarrhea</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>constipation</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>abdominal pain</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>vomiting</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>dyspepsia</td>
<td>2</td>
</tr>
<tr>
<td>Skin and Subcutaneous Tissue Disorders</td>
<td>rash [see Warnings and Precautions (5.7)]</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>pruritus</td>
<td>1</td>
</tr>
<tr>
<td>Reproductive System and Breast Disorders</td>
<td>vaginitis</td>
<td>1</td>
</tr>
<tr>
<td>General Disorders and Administration Site Conditions</td>
<td>edema</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>injection site reaction</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>chest pain</td>
<td>1</td>
</tr>
</tbody>
</table>

* N = 7274
† N = 3758 (women)

Table 7: Less Common (0.1 to 1%) Adverse Reactions Reported in Clinical Trials with Levofloxacin (N = 7537)

<table>
<thead>
<tr>
<th>System/Organ Class</th>
<th>Adverse Reaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infections and Infestations</td>
<td>genital meningitis</td>
</tr>
<tr>
<td>Blood and Lymphatic System Disorders</td>
<td>anemia</td>
</tr>
<tr>
<td></td>
<td>thrombocytopenia</td>
</tr>
<tr>
<td></td>
<td>granulocytopenia</td>
</tr>
<tr>
<td></td>
<td>[see Warnings and Precautions (5.7)]</td>
</tr>
</tbody>
</table>
In clinical trials using multiple-dose therapy, ophthalmologic abnormalities, including cataracts and multiple punctate lenticular opacities, have been noted in patients undergoing treatment with quinolones, including levofloxacin. The relationship of the drugs to these events is not presently established.

### 6.3 Postmarketing Experience

Table 8 lists adverse reactions that have been identified during post-approval use of levofloxacin. Because these reactions are reported voluntarily from a population of uncertain size, it is not always possible to reliably estimate their frequency or establish a causal relationship to drug exposure.

### Table 8: Postmarketing Reports Of Adverse Drug Reactions

<table>
<thead>
<tr>
<th>System/Organ Class</th>
<th>Adverse Reaction</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Blood and Lymphatic System Disorders</strong></td>
<td>pancytopenia, aplastic anemia, leukopenia, anemia, thrombocytopenia, absolute neutropenia [see Warnings and Precautions (5.6)]</td>
</tr>
<tr>
<td><strong>Immune System Disorders</strong></td>
<td>hypersensitivity reactions, sometimes fatal including anaphylactic/anaphylactoid</td>
</tr>
</tbody>
</table>

---

| Blood and Lymphatic System Disorders | Pancytopenia, aplastic anemia, leukopenia, anemia, thrombocytopenia, absolute neutropenia [see Warnings and Precautions (5.6)] |
| Immune System Disorders | Hypersensitivity reactions, sometimes fatal including anaphylactic/anaphylactoid |

---

| Precautions (5.6) | Hypoglycemia, hyperglycemia, hyperkalemia |
| Precautions (5.7) | Anaphylactic/anaphylactoid |
| Precautions (5.10) | Abnormal renal function, acute renal failure |
| Precautions (5.2) | Arthritis (see Warnings and Precautions (5.5)) |
| Precautions (5.3) | Tendinitis (see Warnings and Precautions (5.2)) |
| Precautions (5.4) | Anxiety, agitation, depression, hallucination, nightmare* (see Warnings and Precautions (5.4)) |
| Precautions (5.5) | Myalgia, skeletal pain |
| Precautions (5.6) | Abnormal renal function, acute renal failure |

---

| Precautions (5.6) | Hemolytic anemia, aplastic anemia |
| Precautions (5.7) | Eosinophilia, increased hepatic enzymes, increased alkaline phosphatase |

---

| Precautions (5.6) | Pancytopenia, aplastic anemia, leukopenia, anemia, thrombocytopenia, absolute neutropenia |
| Precautions (5.7) | Hypersensitivity reactions, sometimes fatal including anaphylactic/anaphylactoid |
| Precautions (5.10) | Abnormal renal function, acute renal failure |

---
<table>
<thead>
<tr>
<th>Reactions</th>
<th>anaphylactic shock, angioneurotic edema, serum sickness [see Warnings and Precautions (5.6, 5.7)]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric Disorders</td>
<td>psychosis, paranoia, isolated reports of suicidal ideation, suicide attempt and completed suicide [see Warnings and Precautions (5.4)]</td>
</tr>
<tr>
<td>Nervous System Disorders</td>
<td>exacerbation of myasthenia gravis [see Warnings and Precautions (5.5)], anosmia, agranulocytosis, parosmia, dysgeusia, peripheral neuropathy (may be irreversible) [see Warnings and Precautions (5.3)], isolated reports of encephalopathy, abnormal electroencephalogram (EEG), dysphoria, pseudotumor cerebri [see Warnings and Precautions (5.4)]</td>
</tr>
<tr>
<td>Eye Disorders</td>
<td>uveitis, vision disturbance, including diplopia, visual acuity reduced, scotoma</td>
</tr>
<tr>
<td>Ear and Labyrinth Disorders</td>
<td>hypoacusis, tinnitus</td>
</tr>
<tr>
<td>Cardiac Disorders</td>
<td>isolated reports of torsade de pointes, electrocardiogram QT prolonged [see Warnings and Precautions (5.11)], tachycardia</td>
</tr>
<tr>
<td>Vascular Disorders</td>
<td>vasodilatation</td>
</tr>
<tr>
<td>Respiratory, Thoracic and Mediastinal Disorders</td>
<td>isolated reports of allergic pneumonitis [see Warnings and Precautions (5.6)]</td>
</tr>
<tr>
<td>Hepatobiliary Disorders</td>
<td>hepatic failure (including fatal cases), hepatitis, jaundice [see Warnings and Precautions (5.6), (5.8)]</td>
</tr>
<tr>
<td>Skin and Subcutaneous Tissue Disorders</td>
<td>bullous eruptions to include: Stevens-Johnson Syndrome, toxic epidermal necrolysis, Acute Generalized Exanthematous Pustulosis (AGEP), fixed drug eruption, erythema multiforme [see Warnings and Precautions (5.6)], photosensitivity/photosensitivity reaction [see Warnings and Precautions (5.14)], leukocytoclastic vasculitis</td>
</tr>
<tr>
<td>Musculoskeletal and Connective Tissue Disorders</td>
<td>tendon rupture [see Warnings and Precautions (5.2)], muscle injury, including rhabdomyolysis</td>
</tr>
<tr>
<td>Renal and Urinary Disorders</td>
<td>interstitial nephritis [see Warnings and Precautions (5.6)]</td>
</tr>
<tr>
<td>General Disorders and Administration Site Conditions</td>
<td>multi-organ failure, pyrexia</td>
</tr>
<tr>
<td>Investigations</td>
<td>prothrombin time prolonged, international normalized ratio prolonged, muscle enzymes increased</td>
</tr>
</tbody>
</table>

### 7 DRUG INTERACTIONS

#### 7.1 Chelation Agents: Antacids, Sucralfate, Metal Cations, Multivitamins

**Levofloxacin Injection**

There are no data concerning an interaction of intravenous fluoroquinolones with oral antacids, sucralfate, multivitamin, didanosine, or metal cations. However, no fluoroquinolone should be co-administered with any solution containing multivalent cations, e.g., magnesium through the same intravenous line [see Dosage and Administration (2.5)].
Pharmacokinetics following intravenous administration of levofloxacin to several species. Quinolones, including levofloxacin, cause arthropathy and osteochondrosis in juvenile animals of various species.

8.4 Pediatric Use

Levofloxacin will be excreted in human milk. Because of the potential for serious adverse reactions in nursing infants, discontinuation of the nursing infant's milk should be considered when levofloxacin is administered concomitantly with the drug to the mother. Based on available data, it can be presumed that levofloxacin will be excreted in human milk. When the decision to discontinue breastfeeding must be made, the benefits of the drug for the mother should be considered along with the potential risks to the infant.

8.3 Nursing Mothers

The concomitant administration of a non-steroidal anti-inflammatory drug with a fluoroquinolone, including levofloxacin, may increase the risk of CNS stimulation and convulsive seizures [see Warnings and Precautions (5.4)].

7.5 Theophylline

No significant effect of levofloxacin on the plasma concentrations, AUC, and other disposition parameters for theophylline was detected in a clinical study involving healthy volunteers. Similarly, no apparent effect of theophylline on levofloxacin absorption and disposition was observed. However, concomitant administration of other fluoroquinolones with theophylline has resulted in prolonged elimination half-life, elevated serum theophylline levels, and a subsequent increase in the risk of theophylline-related adverse reactions in the patient population. Therefore, theophylline levels should be closely monitored and appropriate dosage adjustments made when levofloxacin is concomitantly administered. Adverse reactions, including seizures, may occur with or without an elevation in serum theophylline levels [see Warnings and Precautions (5.4)].

7.6 Cyclosporine

No significant effect of levofloxacin on the peak plasma concentrations, AUC, and other disposition parameters for cyclosporine have been reported in the patient population when co-administered with some other fluoroquinolones. Levofloxacin C_{max} and k_{e} were slightly lower while T_{max} and t_{1/2} were slightly longer in the presence of cyclosporine than those observed in other studies without concomitant medication. The differences, however, are not considered to be clinically significant. Therefore, no dosage adjustment is required for levofloxacin or cyclosporine when administered concomitantly.

7.7 Digoxin

No significant effect of levofloxacin on the peak plasma concentrations, AUC, and other disposition parameters for digoxin was detected in a clinical study involving healthy volunteers. Levofloxacin absorption and disposition kinetics were similar in the presence or absence of digoxin. Therefore, no dosage adjustment for levofloxacin or digoxin is required when administered concomitantly.

7.8 Probenecid and Cimetidine

No significant effect of probenecid or cimetidine on the C_{max} of levofloxacin was observed in a clinical study involving healthy volunteers. The AUC and t_{1/2} of levofloxacin were higher while CL/F and CL_{ur} were lower during concomitant treatment of levofloxacin with probenecid or cimetidine as compared to levofloxacin alone. However, these changes do not warrant dosage adjustment for levofloxacin when probenecid or cimetidine is co-administered.

7.9 Interactions with Laboratory or Diagnostic Testing

Some fluoroquinolones, including levofloxacin, may produce false-positive urine screening results for opiates using commercially available immunoassay kits. Confirmation of positive opiate screens by more specific methods may be necessary.

8 USE IN SPECIFIC POPULATIONS

8.1 Pregnancy

Pregnancy Category C. Levofloxacin was not teratogenic in rats at oral doses as high as 810 mg/kg/day which corresponds to 9.4 times the highest recommended human dose based upon relative body surface area, or at intravenous doses as high as 160 mg/kg/day corresponding to 1.9 times the highest recommended human dose based upon relative body surface area. The oral dose of 810 mg/kg/day to rats caused decreased fetal body weight and increased fetal mortality. No teratogenicity was observed when rabbits were dosed orally as high as 50 mg/kg/day which corresponds to 1.1 times the highest recommended human dose based upon relative body surface area, or when dosed intravenously as high as 25 mg/kg/day, corresponding to 0.5 times the highest recommended human dose based upon relative body surface area.

There are, however, no adequate and well-controlled studies in pregnant women. Levofloxacin should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

8.3 Nursing Mothers

Based on data on other fluoroquinolones and very limited data on levofloxacin, it can be presumed that levofloxacin will be excreted in human milk. Because of the potential for serious adverse reactions from levofloxacin in nursing infants, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

8.4 Pediatric Use

Quinolones, including levofloxacin, cause arthropathy and osteochondrosis in juvenile animals of several species. [See Warnings and Precautions (5.12) and Animal Toxicology and/or Pharmacology (13.2)].

Pharmacokinetics following intravenous administration
The pharmacokinetics of levofloxacin following a single intravenous dose were investigated in pediatric patients ranging in age from six months to 16 years. Pediatric patients cleared levofloxacin faster than adults, resulting in lower plasma exposures than adults for a given mg/kg dose [see Clinical Pharmacology (12.3) and Clinical Studies (14.9)].

Inhalational Anthrax (Post-Exposure)

Levofloxacin is indicated in pediatric patients 6 months of age and older, for inhalational anthrax (post-exposure). The risk-benefit assessment indicates that administration of levofloxacin to pediatric patients is appropriate. The safety of levofloxacin in pediatric patients treated for more than 14 days has not been studied [see Indications and Usage (1.7), Dosage and Administration (2.2) and Clinical Studies (14.9)].

Plague

Levofloxacin is indicated in pediatric patients, 6 months of age and older, for treatment of plague, including pneumonic and septicemic plague due to Yersinia pestis (Y. pestis) and prophylaxis for plague. Efficacy studies of levofloxacin could not be conducted in humans with pneumonic plague for ethical and feasibility reasons. Therefore, approval of this indication was based on an efficacy study conducted in animals. The risk-benefit assessment indicates that administration of levofloxacin to pediatric patients is appropriate [see Indications and Usage (1.8), Dosage and Administration (2.2) and Clinical Studies (14.10)].

Safety and effectiveness in pediatric patients below the age of six months have not been established.

Adverse Events

In clinical trials, 1534 children (6 months to 16 years of age) were treated with oral and intravenous levofloxacin. Children 6 months to 5 years of age received levofloxacin 10 mg/kg twice a day and children greater than 5 years of age received 10 mg/kg once a day (maximum 500 mg per day) for approximately 10 days.

A subset of children in the clinical trials (1340 levofloxacin-treated and 893 non-fluoroquinolone-treated) enrolled in a prospective, long-term, surveillance study to assess the incidence of protocol-defined musculoskeletal disorders (arthritis, arthralgia, tendinitis, tendinopathy, gait abnormality) during 60 days and 1 year following the first dose of the study drug. Children treated with levofloxacin had a significantly higher incidence of musculoskeletal disorders when compared to the non-fluoroquinolone-treated children as illustrated in Table 9.

Table 9: Incidence of Musculoskeletal Disorders in Pediatric Clinical Trial

<table>
<thead>
<tr>
<th>Follow-up Period</th>
<th>Levofloxacin N = 1340</th>
<th>Non-Fluoroquinolone* N = 893</th>
<th>p-value†</th>
</tr>
</thead>
<tbody>
<tr>
<td>60 days</td>
<td>28 (2.1%)</td>
<td>8 (0.9%)</td>
<td>p = 0.38</td>
</tr>
<tr>
<td>1 year‡</td>
<td>46 (3.4%)</td>
<td>16 (1.8%)</td>
<td>p = 0.25</td>
</tr>
</tbody>
</table>

*Non-Fluoroquinolone: ceftriaxone, amoxicillin/clavulanic, clarithromycin
†2-sided Fisher’s Exact Test
‡There were 1198 levofloxacin-treated and 804 non-fluoroquinolone-treated children who had a one-year evaluation visit. However, the incidence of musculoskeletal disorders was calculated using all reported events during the specified period for all children enrolled regardless of whether they completed the 1-year evaluation visit.

Arthralgia was the most frequently occurring musculoskeletal disorder in both treatment groups. Most of the musculoskeletal disorders in both groups involved multiple weight-bearing joints. Disorders were moderate in 8/46 (17%) children and mild in 35/46 (76%) levofloxacin-treated children and most were treated with analgesics. The median time to resolution was 7 days for levofloxacin-treated children and 9 for non-fluoroquinolone-treated children (approximately 80% resolved within 2 months in both groups). No child had a severe or serious disorder or all musculoskeletal disorders resolved without sequelae.

Vomiting and diarrhea were the most frequently reported adverse events, occurring in similar frequency in the levofloxacin-treated and non-fluoroquinolone-treated children.

In addition to the events reported in pediatric patients in clinical trials, events reported in adults during clinical trials or post-marketing experience [see Adverse Reactions (6)] may also be expected to occur in pediatric patients.

8.5 Geriatric Use

Geriatric patients are at increased risk for developing severe tendon disorders including tendon rupture when being treated with a fluoroquinolone such as levofloxacin. This risk is further increased in patients receiving concurrent corticosteroid therapy. Tendinitis or tendon rupture can involve the Achilles, hand, shoulder, or other tendon sites and can occur during or after completion of therapy; cases occurring up to several months after fluoroquinolone treatment have been reported. Caution should be used when prescribing levofloxacin to elderly patients especially those on corticosteroids. Patients should be informed of this potential side effect and advised to discontinue levofloxacin and contact their healthcare provider if any symptoms of tendinitis or tendon rupture occur [see Boxed Warning, Warnings and Precautions (5.2) and Adverse Reactions (6.3)].

In Phase 3 clinical trials, 1,945 levofloxacin-treated patients (26%) were ≥ 65 years of age. Of these, 1,081 patients (14%) were between the ages of 65 and 74 and 864 patients (12%) were 75 years or older. No overall differences in safety or effectiveness were observed between these subjects and younger subjects, but greater sensitivity of some older individuals cannot be ruled out.

Severe, and sometimes fatal, cases of hepatotoxicity have been reported post-marketing in association with levofloxacin. The majority of fatal hepatotoxicity reports occurred in patients 65 years of age or older and most were not associated with hypersensitivity. Levofloxacin should be discontinued immediately if the patient develops signs and symptoms of hepatitis [see Warnings and Precautions (5.8)].

Epidemiologic studies report an increased rate of aortic aneurysm and dissection within two months following use of fluoroquinolones, particularly in elderly patients [see Warnings and Precautions (5.9)].

Elderly patients may be more susceptible to drug-associated effects on the QT interval. Therefore, precaution should be taken when using levofloxacin with concomitant drugs that can result in prolongation of the QT interval (e.g., Class IA or Class III antiarrhythmics) or in patients with risk factors for torsade de pointes (e.g., known QT prolongation, uncorrected hypokalemia) [see Warnings and Precautions (5.11)].
The pharmacokinetic properties of levofloxacin in younger adults and elderly adults do not differ significantly when creatinine clearance is taken into consideration. However, since the drug is known to be substantially excreted by the kidney, the risk of toxic reactions to this drug may be greater in patients with impaired renal function. Because elderly patients are more likely to have decreased renal function, care should be taken in dose selection, and it may be useful to monitor renal function [see Clinical Pharmacology (12.5)].

8.6 Renal Impairment

Clearance of levofloxacin is substantially reduced and plasma elimination half-life is substantially prolonged in patients with impaired renal function (creatinine clearance < 50 mL/min), requiring dosage adjustment in such patients to avoid accumulation. Neither hemodialysis nor continuous ambulatory peritoneal dialysis (CAPD) is effective in removal of levofloxacin from the body, indicating that supplemental doses of levofloxacin are not required following hemodialysis or CAPD [see Dosage and Administration (2.3)].

8.7 Hepatic Impairment

Pharmacokinetic studies in hepatically impaired patients have not been conducted. Due to the limited extent of levofloxacin metabolism, the pharmacokinetics of levofloxacin are not expected to be affected by hepatic impairment.

10 OVERDOSAGE

In the event of an acute overdosage, the stomach should be emptied. The patient should be observed and appropriate hydration maintained. Levofloxacin is not efficiently removed by hemodialysis or peritoneal dialysis.

Levofloxacin exhibits a low potential for acute toxicity. Mice, rats, dogs and monkeys exhibited the following clinical signs after receiving a single high dose of levofloxacin ataxia, ptosis, decreased locomotor activity, dyspnea, prostration, tremors, and convulsions. Doses in excess of 1500 mg/kg orally and 250 mg/kg IV produced significant mortality in rodents.

11 DESCRIPTION

Levofloxacin is a synthetic broad-spectrum antibacterial agent for intravenous administration. Chemically, levofloxacin, a chiral fluorinated carboxyquinolone, is the pure (-)-(S)-enantiomer of the racemic drug substance ofloxacin. The chemical name is (-)-(S)-9-fluoro-2,3-dihydro-3-methyl-10-(4-methyl-1-piperazinyl)-7-oxo-7H-pyrido[1,2,3-de]-1,4-benoxazine-6-carboxylic acid hemihydrate.

Figure 1: The Chemical Structure of Levofloxacin

![Chemical Structure of Levofloxacin](Image)

The molecular formula is C₁₈H₁₈FN₅O₆·½H₂O and the molecular weight is 370.38. Levofloxacin USP is a pale or bright yellow, crystalline powder. The molecule exists as a zwitterion at the pH conditions in the small intestine.

The data demonstrate that from pH 0.6 to 5.8, the solubility of levofloxacin is essentially constant (approximately 100 mg/mL). Levofloxacin is considered soluble to freely soluble in this pH range, as defined by USP nomenclature. Above pH 5.8, the solubility increases rapidly to its maximum at pH 6.7 (272 mg/mL) and is considered freely soluble in this range. Above pH 6.7, the solubility decreases and reaches a minimum value (about 50 mg/mL) at a pH of approximately 6.9.

Levofloxacin has the potential to form stable coordination compounds with many metal ions. This in vitro chelation potential has the following formation order: Al³⁺ > Cu²⁺ > Zn²⁺ > Mg²⁺ > Ca²⁺.

Excipients and Description of Dosage Forms

The appearance of levofloxacin injection may range from a clear yellow to a clear greenish-yellow solution. This does not adversely affect product potency.

Levofloxacin Injection in Single-Dose Vials is a sterile, preservative-free aqueous solution of levofloxacin in Water for Injection, with pH ranging from 3.8 to 5.8.

12 CLINICAL PHARMACOLOGY

12.1 Mechanism of Action

Levofloxacin is a member of the fluoroquinolone class of antibacterial agents [see Microbiology (12.4)].

12.3 Pharmacokinetics

The mean ± SD pharmacokinetic parameters of levofloxacin determined under single and steady-state conditions following oral tablet, oral solution, or intravenous (IV) doses of levofloxacin are summarized in Table 10.

<table>
<thead>
<tr>
<th>Regimen</th>
<th>Cₘₐₓ (mcg/mL)</th>
<th>Tₘₐₓ (h)</th>
<th>AUC (mcg•h/mL)</th>
<th>CL/F (L/min)</th>
<th>Vd/F (L)</th>
<th>t½ (h)</th>
<th>CLr (mL/min)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single dose</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>250 mg oral tablet³</td>
<td>2.8 ± 0.4</td>
<td>1.6 ± 1.0</td>
<td>27.2 ± 3.9</td>
<td>156 ± 20</td>
<td>ND</td>
<td>7.3 ± 0.9</td>
<td>142 ± 21</td>
</tr>
<tr>
<td>500 mg oral tablet³</td>
<td>5.1 ± 0.8</td>
<td>1.3 ± 0.6</td>
<td>47.0 ± 6.8</td>
<td>178 ± 28</td>
<td>ND</td>
<td>6.3 ± 0.6</td>
<td>103 ± 30</td>
</tr>
<tr>
<td>500 mg oral solution³</td>
<td>5.8 ± 1.8</td>
<td>0.8 ± 0.7</td>
<td>47.0 ± 10.8</td>
<td>183 ± 40</td>
<td>112 ± 37.2</td>
<td>7.0 ± 1.4</td>
<td>ND</td>
</tr>
<tr>
<td>500 mg IV³</td>
<td>6.2 ± 1.0</td>
<td>1.0 ± 0.1</td>
<td>48.3 ± 5.4</td>
<td>175 ± 20</td>
<td>90 ± 11</td>
<td>6.4 ± 0.7</td>
<td>112 ± 25</td>
</tr>
<tr>
<td>750 mg oral tablet³</td>
<td>9.3 ± 1.6</td>
<td>1.6 ± 0.8</td>
<td>101 ± 20</td>
<td>129 ± 24</td>
<td>83 ± 17</td>
<td>7.5 ± 0.9</td>
<td>ND</td>
</tr>
</tbody>
</table>

Table 10: Mean ± SD Levofloxacin PK Parameters
Levofloxacin is rapidly and essentially completely absorbed after oral administration. Peak plasma concentrations are usually attained one to two hours after oral dosing. The absolute bioavailability of levofloxacin from a 500 mg tablet and a 750 mg tablet of levofloxacin are both approximately 99%, demonstrating complete oral absorption of levofloxacin. Following a single intravenous dose of levofloxacin to healthy volunteers, the mean ± SD peak plasma concentration attained was 6.2 ± 1.0 mcg/mL. Following a 500 mg dose infused over 60 minutes and 11.5 ± 4.0 mcg/mL after a 750 mg dose infused over 90 minutes. Levofloxacin oral solution and tablet formulations are bioequivalent.

Levofloxacin pharmacokinetics are linear and predictable after single and multiple oral or IV dosing regimens. Steady-state conditions are reached within 48 hours following a 500 mg or 750 mg once-daily dosage regimen. The mean ± SD peak and trough plasma concentrations attained following multiple once-daily oral dosing regimens were approximately 5.7 ± 1.4 and 0.5 ± 0.2 mcg/mL after the 500 mg doses, and 8.6 ± 1.9 and 1.1 ± 0.4 mcg/mL after the 750 mg doses, respectively. The mean ± SD peak and trough plasma concentrations attained following multiple once-daily IV regimens were approximately 6.9 ± 2.3 and 1.4 ± 1.1 mcg/mL after the 500 mg doses, and 7.1 ± 3.1 and 2.1 ± 1.3 mcg/mL after the 750 mg doses, respectively. Oral administration of a 500 mg dose of levofloxacin with food prolongs the time to peak concentration by approximately 1 hour and decreases the peak concentration by approximately 14%, following tablet and approximately 25% following oral solution administration. Therefore, levofloxacin tablets can be administered without regard to food. It is recommended that levofloxacin oral solution be taken 1 hour before or 2 hours after eating.

The plasma concentration profile of levofloxacin after IV administration is similar and comparable in extent of exposure (AUC) to that observed for levofloxacin tablets when equal doses (mg/mg) are administered. Therefore, the oral and IV routes of administration can be considered interchangeable (see Figure 2 and Figure 3).
Distribution

The mean volume of distribution of levofloxacin generally ranges from 74 to 112 L after single and multiple 500 mg or 750 mg doses, indicating widespread distribution into body tissues. Levofloxacin reaches its peak levels in skin tissues and in blister fluid of healthy subjects at approximately 3 hours after dosing. The skin tissue biopsy to plasma AUC ratio is approximately 2 and the blister fluid to plasma AUC ratio is approximately 1 following multiple once-daily oral administration of 750 mg and 500 mg doses of levofloxacin, respectively, to healthy subjects. Levofloxacin also penetrates well into lung tissues. Lung tissue concentrations were generally 2- to 5-fold higher than plasma concentrations and ranged from approximately 2.4 to 11.3 mcg/g over a 24-hour period after a single 500 mg oral dose.

In vitro, over a clinically relevant range (1 to 10 mcg/mL) of serum/plasma levofloxacin concentrations, levofloxacin is approximately 24 to 38% bound to serum proteins across all species studied, as determined by the equilibrium dialysis method. Levofloxacin is mainly bound to serum albumin in humans. Levofloxacin binding to serum proteins is independent of the drug concentration.

Metabolism

Levofloxacin is stereochemically stable in plasma and urine and does not invert metabolically to its enantiomer, D-ofloxacin. Levofloxacin undergoes limited metabolism in humans and is primarily excreted as unchanged drug in the urine. Following oral administration, approximately 87% of an administered dose was recovered as unchanged drug in urine within 48 hours, whereas less than 4% of the dose was recovered in feces in 72 hours. Less than 5% of an administered dose was recovered in the urine as the desmethyl and N-oxide metabolites, the only metabolites identified in humans. These metabolites have little relevant pharmacological activity.

Excretion

Levofloxacin is excreted largely as unchanged drug in the urine. The mean terminal plasma elimination half-life of levofloxacin ranges from approximately 6 to 8 hours following single or multiple doses of levofloxacin given orally or intravenously. The mean apparent total body clearance and renal clearance range from approximately 144 to 226 mL/min and 96 to 142 mL/min, respectively. Renal clearance in excess of the glomerular filtration rate suggests that tubular secretion of levofloxacin occurs in addition to its glomerular filtration. Concomitant administration of either cimetidine or probenecid results in approximately 24% and 35% reduction in the levofloxacin renal clearance, respectively, indicating that secretion of levofloxacin occurs in the renal proximal tubule. No levofloxacin crystals were found in any of the urine samples freshly collected from subjects receiving levofloxacin.

Geriatric

There are no significant differences in levofloxacin pharmacokinetics between young and elderly subjects when the subjects’ differences in creatinine clearance are taken into consideration. Following a 500 mg oral dose of levofloxacin to healthy elderly subjects (66 to 80 years of age), the mean terminal plasma elimination half-life of levofloxacin was about 7.6 hours, as compared to approximately 6 hours in younger adults. The difference was attributable to the variation in renal function status of the subjects and was not believed to be clinically significant. Drug absorption appears to be unaffected by age. Levofloxacin dose adjustment based on age alone is not necessary [see Use in Specific Populations (8.5)].

Pediatrics

The pharmacokinetics of levofloxacin following a single 7 mg/kg intravenous dose were investigated in pediatric patients ranging in age from 6 months to 16 years. Pediatric patients cleared levofloxacin faster than adult patients, resulting in lower plasma exposures than adults for a given mg/kg dose. Subsequent pharmacokinetic analyses predicted that a dosage regimen of 8 mg/kg every 12 hours (not to exceed 250 mg per dose) for pediatric patients 6 months to 17 years of age would achieve comparable steady state plasma exposures (AUC0-24 and Cmax) to those observed in adult patients administered 500 mg of levofloxacin once every 24 hours.

Gender

There are no significant differences in levofloxacin pharmacokinetics between male and female subjects when subjects’ differences in creatinine clearance are taken into consideration. Following a 500 mg oral dose of levofloxacin to healthy male subjects, the mean terminal plasma elimination half-life of levofloxacin was about 7.5 hours, as compared to approximately 6.1 hours in female subjects. This difference was attributable to the variation in renal function status of the male and female subjects and was not believed to be clinically significant. Drug absorption appears to be unaffected by the gender of the subjects. Dose adjustment based on gender alone is not necessary.

Race

The effect of race on levofloxacin pharmacokinetics was examined through a covariate analysis performed on data from 72 subjects: 48 white and 24 non-white. The apparent total body clearance and apparent volume of distribution were not affected by the race of the subjects.

Renal Impairment
Clearance of levofloxacin is substantially reduced and plasma elimination half-life is substantially prolonged in adult patients with impaired renal function (creatinine clearance < 50 mL/min), requiring dosage adjustment in such patients to avoid accumulation. Neither hemodialysis nor continuous ambulatory peritoneal dialysis (CAPD) is effective in removal of levofloxacin from the body, indicating that supplemental doses of levofloxacin are not required following hemodialysis or CAPD [see Dosage and Administration (2.3), Use in Specific Populations (8.6)].

Hepatic Impairment

Pharmacokinetic studies in hepatically impaired patients have not been conducted. Due to the limited extent of levofloxacin metabolism, the pharmacokinetics of levofloxacin are not expected to be affected by hepatic impairment [see Use in Specific Populations (8.7)].

Bacterial Infection

The pharmacokinetics of levofloxacin in patients with serious community-acquired bacterial infections are comparable to those observed in healthy subjects.

Drug-Drug Interactions

The potential for pharmacokinetic drug interactions between levofloxacin and antacids, warfarin, theophylline, cyclosporine, digoxin, probenecid, and cimetidine has been evaluated [see Drug Interactions (7)].

12.4 Microbiology

Mechanism of Action

Levofloxacin is the L-isomer of the racemate, ofloxacin, a quinolone antimicrobial agent. The antibacterial activity of ofloxacin resides primarily in the L-isomer. The mechanism of action of levofloxacin and other fluoroquinolone antimicrobials involves inhibition of bacterial topoisomerase IV and DNA gyrase (both of which are type II topoisomerases), enzymes required for DNA replication, transcription, repair and recombination.

Mechanism of Resistance

Fluoroquinolone resistance can arise through mutations in defined regions of DNA gyrase or topoisomerase IV, termed the Quinolone-Resistance Determining Region (QRDRs), or through altered efflux.

Fluoroquinolones, including levofloxacin, differ in chemical structure and mode of action from aminoglycosides, macrolides and β-lactam antibiotics, including penicillin. Fluoroquinolones may, therefore, be active against bacteria resistant to these antimicrobials.

Resistance to levofloxacin due to spontaneous mutation in vitro is a rare occurrence (range: 10^{-12} to 10^{-15}). Cross-resistance has been observed between levofloxacin and some other fluoroquinolones, some microorganisms resistant to other fluoroquinolones may be susceptible to levofloxacin.

Activity in vitro and in vivo

Levofloxacin has in vitro activity against Gram-negative and Gram-positive bacteria.

Levofloxacin has been shown to be active against most isolates of the following bacteria both in vitro and in clinical infections as described in Indications and Usage (1):

**Gram-Positive Bacteria**

- Enterococcus faecalis
- Staphylococcus aureus (methicillin-susceptible isolates)
- Staphylococcus epidermidis (methicillin-susceptible isolates)
- Staphylococcus saprophyticus
- Streptococcus pneumoniae (including multi-drug resistant isolates [MDRSP])
- Streptococcus pyogenes

**Gram-Negative Bacteria**

- Enterobacter cloacae
- Escherichia coli
- Haemophilus influenzae
- Haemophilus parainfluenzae
- Klebsiella pneumoniae
- Legionella pneumophila
- Moraxella catarrhalis
- Proteus mirabilis
- Pseudomonas aeruginosa
- Serratia marcescens

**Other Bacteria**

- Chlamydophila pneumoniae
- Mycoplasma pneumoniae

The following in vitro data are available, but their clinical significance is unknown: Levofloxacin exhibits in vitro minimum inhibitory concentrations (MIC values) of 2 mcg/mL or less against most (≥90%) isolates of the following microorganisms; however, the safety and effectiveness of levofloxacin in treating clinical infections due to these bacteria have not been established in adequate and well-controlled clinical trials.

**Gram-Positive Bacteria**

- Staphylococcus haemolyticus
- β-hemolytic Streptococcus (Group A)
- β-hemolytic Streptococcus (Group G)
- Streptococcus pyogenes
- Viridans group streptococci
- Bacillus anthracis

1 MDRSP (Multi-drug resistant Streptococcus pneumoniae) isolates are isolates resistant to two or more of the following antibiotics: penicillin (MIC ≥2 mcg/mL), 2nd generation cephalosporins, e.g., cefuroxime; macrolides, tetracyclines and trimethoprim/sulfamethoxazole.
with documented levofloxacin arm and 7 days in the comparator. In clinically and microbiologically evaluable patients (56.4%) patients in the comparator arm. The average duration of adjunctive therapy was 7 days in the empirically initiated at study entry in 56 of 93 (60.2%) patients in the levofloxacin arm and 53 of 94 overall, in the clinically and microbiologically evaluable population, adjunctive therapy was days of intravenous therapy (range: 1 to 19 days).

In vitro interactions with other drugs or agents are anticipated. In dogs, levofloxacin administered at 6 mg/kg or higher by rapid intravenous injection produced hypotensive effects. These effects were considered to be related to histamine release. In mice, the CNS stimulatory effect of quinolones is enhanced by concomitant administration of non-steroidal anti-inflammatory drugs.

In vivo in vitro studies in animals indicate that levofloxacin is neither an enzyme inducer nor inhibitor in the human therapeutic plasma concentration range; therefore, no drug metabolizing enzyme-related interactions with other drugs or agents are anticipated.

13 NONCLINICAL TOXICOLOGY

13.1 Carcinogenesis, Mutagenesis, Impairment of Fertility

In a lifetime bioassay in rats, levofloxacin exhibited no carcinogenic potential following daily dietary administration for 2 years; the highest dose (100 mg/kg/day) was 1.4 times the highest recommended human dose (750 mg) based upon relative body surface area. Levofloxacin did not shorten the time to tumor development of UV-induced skin tumors in hairless albino (SahB-1) mice at any levofloxacin dose level and was therefore not photo-carcinogenic under conditions of this study. Dermal levofloxacin concentrations in the hairless mice ranged from 25 to 42 mcg/g at the highest levofloxacin dose level (300 mg/kg/day) used in the photo-carcinogenicity study. By comparison, dermal levofloxacin concentrations in human subjects receiving 750 mg of levofloxacin averaged approximately 11.8 mcg/g at Cmax.

Levofloxacin was not mutagenic in the following assays: Ames bacterial mutation assay (S. typhimurium and E. coli), CHO/HGPRT forward mutation assay, mouse micronucleus test, mouse dominant lethal test, rat uncharged DNA synthesis assay, and the mouse sister chromatid exchange assay. It was positive in the in vitro chromosomal aberration (CHL cell line) and sister chromatid exchange (CHL/ U cell line) assays.

Levofloxacin caused no impairment of fertility or reproductive performance in rats at oral doses as high as 360 mg/kg/day, corresponding to 4.2 times the highest recommended human dose based upon relative body surface area and intravenous doses as high as 100 mg/kg/day, corresponding to 1.2 times the highest recommended human dose based upon relative body surface area.

13.2 Animal Toxicology and Pharmacology

Levofloxacin and other quinolones have been shown to cause arthropathy in immature animals of most species tested (see Warnings and Precautions (5.12)). In immature dogs (4 to 5 months old), oral doses of 10 mg/kg/day for 7 days and intravenous doses of 4 mg/kg/day for 14 days of levofloxacin resulted in arthropathic lesions. Administration at oral doses of 300 mg/kg/day for 7 days and intravenous doses of 60 mg/kg/day for 4 weeks produced arthropathy in juvenile rats. Three-month old beagle dogs dosed orally with levofloxacin at 40 mg/kg/day exhibited clinically severe arthrototoxicity resulting in the termination of dosing at Day 8 of a 14-day dosing routine. Slight musculoskeletal clinical effects, in the absence of gross pathological or histopathological effects, resulted from the lowest dose level of 2.5 mg/kg/day (approximately 0.2-fold the pediatric dose based upon AUC comparisons). Synovitis and articular cartilage lesions were observed at the 10 and 40 mg/kg/dose levels (approximately 0.7-fold and 2.4-fold the pediatric dose, respectively, based on AUC comparisons). Articular cartilage gross pathology and histopathology persisted to the end of the 18-week recovery period for those dogs from the 10 and 40 mg/kg/day dose levels.

When tested in a mouse ear swelling bioassay, levofloxacin exhibited phototoxicity similar in magnitude to ofloxacin, but less phototoxicity than other quinolones.

While crystalluria has been observed in some intravenous rat studies, urinary crystals are not formed in the bladder, being present only after micturition and are not associated with nephrotoxicity.

In mice, the CNS stimulatory effect of quinolones is enhanced by concomitant administration of non-steroidal anti-inflammatory drugs.

In dogs, levofloxacin administered at 6 mg/kg or higher by rapid intravenous injection produced hemolytic effects. These effects were considered to be related to histamine release.

In vitro and in vivo studies in animals indicate that levofloxacin is neither an enzyme inducer nor inhibitor in the human therapeutic plasma concentration range; therefore, no drug metabolizing enzyme-related interactions with other drugs or agents are anticipated.

14 CLINICAL STUDIES

14.1 Nosocomial Pneumonia

Adult patients with clinically and radiologically documented nosocomial pneumonia were enrolled in a multicenter, randomized, open-label study comparing intravenous levofloxacin (750 mg once daily) followed by oral levofloxacin (750 mg once daily) for a total of 7 to 15 days to intravenous imipenem/cilastatin (500 to 1000 mg every 6 to 8 hours daily) followed by oral ciprofloxacin (750 mg every 12 hours daily) for a total of 7 to 15 days. Levofloxacin-treated patients received an average of 7 days of intravenous therapy (range: 1 to 16 days); comparator-treated patients received an average of 8 days of intravenous therapy (range: 1 to 19 days).

Overall, in the clinically and microbiologically evaluable population, adjunctive therapy was empirically initiated at study entry in 56 of 93 (60.2%) patients in the levofloxacin arm and 53 of 94 (56.4%) patients in the comparator arm. The average duration of adjunctive therapy was 7 days in the levofloxacin arm and 7 days in the comparator. The average duration of adjunctive therapy was 7 days in the levofloxacin arm and 7 days in the comparator treatment arm. The average duration of adjunctive therapy was 7 days in the levofloxacin arm and 7 days in the comparator.
Bacteremia with MDRSP resistant to 5 antibacterials

Not all isolates were resistant to all antimicrobial classes tested. Success and eradication rates are microbiologically evaluable patients in the designated resistance group.

Tetracycline-resistant
Trimethoprim/Sulfamethoxazole resistant
Macrolide-resistant

Screening Susceptibility Clinical Success Bacteriologic Success
nN % nN %

Penicillin-resistant 16/17 94.1 16/17 94.1

2nd generation Cephalosporin resistant 31/32 96.9 31/32 96.9

Macrolide-resistant 26/28 96.6 26/28 96.6

Trimethoprim/Sulfamethoxazole resistant 17/19 89.5 17/19 89.5

Tetracycline-resistant 12/12 100 12/12 100

* One patient had a respiratory isolate that was resistant to tetracycline, ceftaxime, macrolides and TMP/SMX and intermediate to penicillin and a blood isolate that was intermediate to penicillin and ceftaxime and resistant to the other classes. The patient is included in the database based on respiratory isolate.

† n = the number of microbiologically evaluable patients who were clinical successes; N = number of microbiologically evaluable patients in the designated resistance group.

‡ a = the number of MDRSP isolates eradicated or presumed eradicated in microbiologically evaluable patients; N = number of MDRSP isolates in a designated resistance group.

Not all isolates were resistant to all antimicrobial classes tested. Success and eradication rates are summarized in Table 14.

Clinical Success and Bacteriologic Eradication Rates for Resistant Streptococcus pneumoniae (Community Acquired Pneumonia)

Type of Resistance Clinical Success Bacteriologic Eradication

17/18 (94.4%) 17/18 (94.4%)

14/15 (93.3%) 14/15 (93.3%)

7/7 (100%) 7/7 (100%)

0 0

0/9 (0%) 0/9 (0%)
14.3 Community-Acquired Pneumonia: 5-day Treatment Regimen

To evaluate the safety and efficacy of the higher dose and shorter course of levofloxacin, 528 outpatient and hospitalized adults with clinically and radiologically determined mild to severe community-acquired pneumonia were enrolled in a double-blind, randomized, prospective, multicenter study comparing levofloxacin 750 mg, IV or orally, every day for five days or levofloxacin 500 mg IV or orally, every day for 10 days.

Clinical success rates (cure plus improvement) in the clinically evaluable population were 90.9% in the levofloxacin 750 mg group and 91.1% in the levofloxacin 500 mg group. The 95% CI for the difference of response rates (levofloxacin 750 minus levofloxacin 500) was [-5.9, 5.4]. In the clinically evaluable population (31 to 38 days after enrollment) pneumonia was observed in 7 out of 151 patients in the levofloxacin 750 mg group and 2 out of 147 patients in the levofloxacin 500 mg group. Given the small numbers observed, the significance of this finding cannot be determined statistically. The microbiological efficacy of the 5-day regimen was documented for infections listed in Table 15.

**Pneumonia**

<table>
<thead>
<tr>
<th>Pathogen</th>
<th>Levofloxacin 750 mg x 5 days</th>
<th>Levofloxacin 500 mg x 10 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>S. pneumoniae</td>
<td>25/27 (92.6%)</td>
<td>26/27 (96.3%)</td>
</tr>
<tr>
<td>H. influenzae</td>
<td>19/21 (90.5%)</td>
<td>25/27 (92.6%)</td>
</tr>
<tr>
<td>H. parainfluenzae</td>
<td>10/11 (90.9%)</td>
<td>13/13 (100%)</td>
</tr>
<tr>
<td>M. catarrhalis</td>
<td>25/27 (92.6%)</td>
<td>13/13 (100%)</td>
</tr>
</tbody>
</table>

* Note: Forty percent of the subjects in this trial had specimens obtained by sinus endoscopy. The efficacy data for subjects whose specimen was obtained endoscopically were comparable to those presented in the above table.

14.4 Acute Bacterial Sinusitis: 5-day and 10 to 14 day Treatment Regimen

Levofloxacin is approved for the treatment of acute bacterial sinusitis (ABS) using either 750 mg by mouth x 5 days or 500 mg by mouth once daily x 10 to 14 days. To evaluate the safety and efficacy of a high dose short course of levofloxacin, 780 outpatients adults with clinically and radiologically determined acute bacterial sinusitis were evaluated in a double-blind, randomized, prospective, multicenter study comparing levofloxacin 750 mg by mouth once daily for five days to levofloxacin 500 mg by mouth once daily for 10 days.

Clinical success rates (defined as complete or partial resolution of the pre-treatment signs and symptoms of ABS to such an extent that no further antibiotic treatment was deemed necessary) in the microbiologically evaluable population were 91.4% (139/152) in the levofloxacin 750 mg group and 88.6% (132/149) in the levofloxacin 500 mg group at the test-of-cure (TOC) visit (95% CI [-4.2, 10.0] for levofloxacin 750 mg minus levofloxacin 500 mg).

Rates of clinical success by pathogen in the microbiologically evaluable population who had specimens obtained by antral tap at study entry showed comparable results for the five- and ten-day regimens at the test-of-cure visit 22 days post treatment (see Table 16).

**Table 16: Clinical Success Rate by Pathogen at the TOC in Microbiologically Evaluable Subjects Who Underwent Antral Puncture (Acute Bacterial Sinusitis)**

<table>
<thead>
<tr>
<th>Pathogen</th>
<th>Levofloxacin 750 mg x 5 days</th>
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<tr>
<td>S. pneumoniae</td>
<td>10/10 (100%)</td>
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</tr>
<tr>
<td>H. influenzae</td>
<td>12/12 (100%)</td>
<td>12/12 (100%)</td>
</tr>
<tr>
<td>H. parainfluenzae</td>
<td>10/10 (100%)</td>
<td>10/10 (100%)</td>
</tr>
<tr>
<td>M. catarrhalis</td>
<td>25/27 (92.6%)</td>
<td>13/13 (100%)</td>
</tr>
</tbody>
</table>

Success rates varied with the type of diagnosis ranging from 68% in patients with infected ulcers to 90% in patients with infected wounds and abscesses. These rates were equivalent to those seen with high dose short course of levofloxacin, 780 outpatient adults with clinically and radiologically determined acute bacterial sinusitis were evaluated in a double-blind, randomized, prospective, multicenter study comparing levofloxacin 750 mg by mouth once daily for five days to levofloxacin 500 mg by mouth once daily for 10 days.

Clinical success rates (defined as complete or partial resolution of the pre-treatment signs and symptoms of ABS to such an extent that no further antibiotic treatment was deemed necessary) in the microbiologically evaluable population were 91.4% (139/152) in the levofloxacin 750 mg group and 88.6% (132/149) in the levofloxacin 500 mg group at the test-of-cure (TOC) visit (95% CI [-4.2, 10.0] for levofloxacin 750 mg minus levofloxacin 500 mg).

Rates of clinical success by pathogen in the microbiologically evaluable population who had specimens obtained by antral tap at study entry showed comparable results for the five- and ten-day regimens at the test-of-cure visit 22 days post treatment (see Table 16).

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<td>25/27 (92.6%)</td>
<td>13/13 (100%)</td>
</tr>
</tbody>
</table>

Note: Forty percent of the subjects in this trial had specimens obtained by sinus endoscopy. The efficacy data for subjects whose specimen was obtained endoscopically were comparable to those presented in the above table.

14.5 Complicated Skin and Skin Structure Infections

Three hundred ninety-nine patients were enrolled in an open-label, randomized, comparative study for complicated skin and skin structure infections. The patients were randomized to receive either levofloxacin 750 mg once daily (IV followed by oral), or an approved comparator for a median of 10 ± 4.7 days. As is expected in complicated skin and skin structure infections, surgical procedures were performed in the levofloxacin and comparator groups. Surgery (incision and drainage or debridement) was performed on 45% of the levofloxacin-treated patients and 44% of the comparator-treated patients, either shortly before or during antibiotic treatment and formed an integral part of therapy for this indication.

Among those who could be evaluated clinically 2 to 5 days after completion of study drug, overall success rates (improved or cured) were 116/136 (84.1%) for patients treated with levofloxacin and 106/132 (80.3%) for patients treated with the comparator.

Success rates varied with the type of diagnosis ranging from 68% in patients with infected ulcers to 90% in patients with infected wounds and abscesses. These rates were equivalent to those seen with comparator drugs.

14.6 Chronic Bacterial Prostatitis

Adult patients with a clinical diagnosis of prostatitis and microbiological culture results from urine sample collected after prostatic massage (VBs) or expressed prostatic secretion (EPS) specimens obtained via the Mears-Stammy procedure were enrolled in a multicenter, randomized, double-blind study comparing oral levofloxacin 500 mg, once daily for a total of 28 days to oral ciprofloxacin 500 mg, twice daily for a total of 28 days. The primary efficacy endpoint was microbiologic efficacy in microbiologically evaluable patients. A total of 136 and 125 microbiologically evaluable patients were enrolled in the levofloxacin and ciprofloxacin groups, respectively. The microbiologic eradication rate by pathogen infection at 5 to 18 days after completion of therapy was 75.0% in the levofloxacin group and 76.8% in the ciprofloxacin group (95% CI [-12.58, 8.98] for levofloxacin minus ciprofloxacin). The overall eradication rates for pathogen of interest are presented in Table 17.

**Table 17: Bacteriological Eradication Rates (Chronic Bacterial Prostatitis)**

<table>
<thead>
<tr>
<th>Pathogen</th>
<th>Levofloxacin (N = 136)</th>
<th>Ciprofloxacin (N = 125)</th>
</tr>
</thead>
<tbody>
<tr>
<td>E. coli</td>
<td>15/15 (93.3%)</td>
<td>14/14 (93.3%)</td>
</tr>
<tr>
<td>E. faecalis</td>
<td>11/11 (100%)</td>
<td>11/11 (100%)</td>
</tr>
<tr>
<td>S. epidermidis</td>
<td>11/11 (100%)</td>
<td>11/11 (100%)</td>
</tr>
</tbody>
</table>

* Eradication rates shown are for patients who had a sole pathogen only; mixed cultures were excluded.
Eradication rates for S. epidermidis when found with other co-pathogens are consistent with rates seen in pure isolates.

Clinical success (cure + improvement with no need for further antibiotic therapy) rates in microbiologically evaluable population 5 to 18 days after completion of therapy were 75.0% for levofloxacin-treated patients and 72.8% for ciprofloxacin-treated patients (95% CI [-1.87, 13.27] for levofloxacin minus ciprofloxacin). Clinical long-term success (24 to 45 days after completion of therapy) rates were 66.7% for the levofloxacin-treated patients and 76.9% for the ciprofloxacin-treated patients (95% CI [-21.40, 2.89] for levofloxacin minus ciprofloxacin).

14.7 Complicated Urinary Tract Infections and Acute Pyelonephritis: 5-day Treatment Regimen

To evaluate the safety and efficacy of the higher dose and shorter course of levofloxacin, 1109 patients with cUTI and AP were enrolled in a randomized, double-blind, multicenter clinical trial conducted in the U.S. from November 2004 to April 2006 comparing levofloxacin 750 mg IV or orally once daily for 5 days (346 patients) with ciprofloxacin 400 mg IV or 500 mg orally twice daily for 10 days (563 patients). Patients with AP complicated by underlying renal diseases or conditions such as complete obstruction, surgery, transplantation, concurrent infection or congenital malformation were excluded. Efficacy was measured by bacteriologic eradication of the baseline organism(s) at the post-therapy visit in patients with a pathogen identified at baseline. The post-therapy (test-of-cure) visit occurred 10 to 14 days after the last active dose of levofloxacin and 5 to 9 days after the last dose of active ciprofloxacin.

The bacteriologic cure rates overall for levofloxacin and control at the test-of-cure (TOC) visit for the group of all patients with a documented pathogen at baseline (modified intent to treat or mITT) and the group of patients in the mITT population who closely followed the protocol (Microbiologically Evaluable) are summarized in Table 18.

Microbiologic eradication rates in the Microbiologically Evaluable population at TOC for individual pathogens recovered from patients randomized to levofloxacin treatment are presented in Table 19.

14.8 Complicated Urinary Tract Infections and Acute Pyelonephritis: 10-day Treatment Regimen

To evaluate the safety and efficacy of the 250 mg dose, 10 day regimen of levofloxacin, 567 patients with uncomplicated UTI, mild-to-moderate cUTI and mild-to-moderate AP were enrolled in a randomized, double-blind, multicenter clinical trial conducted in the U.S. from June 1993 to January 1995 comparing levofloxacin 250 mg orally once daily for 10 days (285 patients) with ciprofloxacin 500 mg orally twice daily for 10 days (282 patients). Patients with a resistant pathogen, recurrent UTI, women over age 55 years, and with an indwelling catheter were initially excluded, prior to protocol amendment which took place after 30% of enrollment. Microbiological efficacy was measured by bacteriologic eradication of the baseline organism(s) at 1 to 12 days post-therapy in patients with a pathogen identified at baseline.

The bacteriologic cure rates overall for levofloxacin and control at the test-of-cure (TOC) visit for the group of all patients with a documented pathogen at baseline (modified intent to treat or mITT) and the group of patients in the mITT population who closely followed the protocol (Microbiologically Evaluable) are summarized in Table 20.

Table 18: Bacteriological Eradication at Test-of-Cure

<table>
<thead>
<tr>
<th>Pathogen</th>
<th>Ciprofloxacin 250 mg orally once daily for 5 days</th>
<th>Levofloxacin 500 mg orally twice daily for 10 days</th>
<th>Overall Difference [95% CI]</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n/N %</td>
<td>n/N %</td>
<td>Levofloxacin-Ciprofloxacin</td>
</tr>
<tr>
<td>Overall (cUTI or AP)</td>
<td>252/333                                         75.7                                          239/318                       75.2                                         0.5 [-6.1, 7.1]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>cUTI</td>
<td>168/220                                         73.0                                          157/213                       73.7                                          0.3 [-6.4, 7.0]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>AP</td>
<td>84/103                                          81.6                                         82/105                        78.1                                          -3.5 [-10.1, 3.1]</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Microbiologically Evaluable Population†

<table>
<thead>
<tr>
<th>Pathogen</th>
<th>Ciprofloxacin 250 mg orally once daily for 5 days</th>
<th>Levofloxacin 500 mg orally twice daily for 10 days</th>
<th>Overall Difference [95% CI]</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n/N %</td>
<td>n/N %</td>
<td>Levofloxacin-Ciprofloxacin</td>
</tr>
<tr>
<td>Overall (cUTI or AP)</td>
<td>228/265                                         86.0                                          215/244                       89.2                                         -3.2 [-8.9, 2.5]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>cUTI</td>
<td>154/185                                         83.3                                          144/165                       87.3                                         -4.0 [-9.7, 1.7]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>AP</td>
<td>74/90                                          92.5                                          71/76                         93.4                                         -0.9 [-5.6, 3.8]</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

† The mITT population included patients who received study medication and who had a positive (≥10^5 CFU/mL) urine culture with no more than 2 uropathogens at baseline. Patients with missing response were counted as failures in this analysis.

‡ The Microbiologically Evaluable population included patients with a confirmed diagnosis of cUTI or AP, a causative organism(s) at baseline present at ≥10^5 CFU/mL, a valid test-of-cure urine culture, no pathogens isolated from blood resistant to study drug, no premature discontinuation or loss to follow-up, and compliance with treatment (among other criteria).

Table 19: Bacteriological Eradication Rates for Individual Pathogens Recovered From Patients Randomized to Levofloxacin 750 mg QD for 5 Days Treatment

<table>
<thead>
<tr>
<th>Pathogen</th>
<th>Bacteriological Eradication Rate (n/N)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Escherichia coli</td>
<td>155/172                               90</td>
<td></td>
</tr>
<tr>
<td>Klebsiella pneumonia</td>
<td>20/23                               87</td>
<td></td>
</tr>
<tr>
<td>Proteus mirabilis</td>
<td>12/12                               100</td>
<td></td>
</tr>
</tbody>
</table>

* The predominant organism isolated from patients with AP was E. coli: 91% (63/69) eradication in AP and 89% (92/103) in patients with cUTI.

Table 20: Bacteriological Eradication Overall (cUTI or AP) at Test-Of-Cure†

<table>
<thead>
<tr>
<th>Pathogen</th>
<th>Ciprofloxacin 250 mg orally once daily for 5 days</th>
<th>Levofloxacin 500 mg orally twice daily for 10 days</th>
<th>Overall Difference [95% CI]</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n/N %</td>
<td>n/N %</td>
<td>Levofloxacin-Ciprofloxacin</td>
</tr>
<tr>
<td>mITT Population†</td>
<td>174/209                                         83.3                                          184/219                       84.0                                         0.5 [-6.1, 7.1]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Microbiologically Evaluable Population‡</td>
<td>164/177                                         92.7                                          159/171                       93.0                                         -0.3 [-9.0, 8.4]</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

† 1 to 9 days posttherapy for 30% of subjects enrolled prior to a protocol amendment; 5 to 12 days posttherapy for 70% of subjects.

‡ The mITT population included patients who had a pathogen isolated at baseline. Patients with missing response were counted as failures in this analysis.
ADVISE THE PATIENT TO READ THE FDA-APPROVED PATIENT LABELING (MEDICATION GUIDE).

KEEP OUT OF REACH OF CHILDREN.

RETAIN IN CARTON UNTIL TIME OF USE.

750 mg of levofloxacin in 30 mL vials.
greenish yellow concentrated solution with the equivalent of 500 mg of levofloxacin in 20 mL vials and

Levofloxacin injection is supplied in single-dose vials. Each vial contains a clear yellow to a clear

16.3 Levofloxacin Injection, Single-Dose Vials

Levofloxacin injection is supplied in single-dose vials. Each vial contains a clear yellow to a clear
greenish yellow concentrated solution with the equivalent of 500 mg of levofloxacin in 20 mL vials and
750 mg of levofloxacin in 30 mL vials.

- 500 mg (25 mg/mL), 20 mL vials in a carton of 1 NDC: 55150-156-20
- 750 mg (25 mg/mL), 30 mL vials in a carton of 1 NDC: 55150-157-30

Levofloxacin injection in single-dose vials should be stored at 20° - 25°C (68° - 77°F) [see USP
Controlled Room Temperature].

Retain in Carton until time of use.

Keep out of reach of children.

17 PATIENT COUNSELING INFORMATION

Advise the patient to read the FDA-approved patient labeling (Medication Guide).
Serious Adverse Reactions

Advise patients to stop taking levofloxacin if they experience an adverse reaction and to call their healthcare provider for advice on completing the full course of treatment with another antibacterial drug.

Inform patients of the following serious adverse reactions that have been associated with levofloxacin or other fluoroquinolone use:

- **Disabling and Potentially Irreversible Serious Adverse Reactions That May Occur Together:** Inform patients that disabling and potentially irreversible serious adverse reactions, including tendinitis and tendon rupture, peripheral neuropathies, and central nervous system effects, have been associated with use of levofloxacin and may occur together in the same patient. Inform patients to stop taking levofloxacin immediately if they experience an adverse reaction and to call their healthcare provider.

- **Tendinitis and Tendon Rupture:** Inform patients to contact their healthcare provider if they experience pain, swelling, or inflammation of a tendon, or weakness or inability to use one of their joints; rest and refrain from exercise; and discontinue levofloxacin treatment. Symptoms may be irreversible. The risk of severe tendon disorder with fluoroquinolones is higher in older patients usually over 60 years of age, in patients taking corticosteroid drugs, and in patients with kidney, heart or lung transplants.

- **Peripheral Neuropathies:** Inform patients that peripheral neuropathies have been associated with levofloxacin use; symptoms may occur soon after initiation of therapy and may be irreversible. If symptoms of peripheral neuropathy including pain, tingling, numbness and/or weakness develop, immediately discontinue levofloxacin and tell them to contact their physician.

- **Central Nervous System Effects** (for example, convulsions, dizziness, lightheadedness, increased intracranial pressure) Inform patients that convulsions have been reported in patients receiving fluoroquinolones, including levofloxacin. Instruct patients to notify their physician before taking this drug if they have a history of convulsions. Inform patients that they should know how they react to levofloxacin before they operate an automobile or machinery or engage in other activities requiring mental alertness and coordination. Instruct patients to notify their physician if persistent headache with or without blurred vision occurs.

- **Exacerbation of Myasthenia Gravis:** Instruct patients to inform their physician of any history of myasthenia gravis. Instruct patients to notify their physician if they experience any symptoms of muscle weakness, including respiratory difficulties.

- **Hypersensitivity Reactions:** Inform patients that levofloxacin can cause hypersensitivity reactions, even following a single dose, and to discontinue the drug at the first sign of a skin rash, hives or other skin reactions, a rapid heartbeat, difficulty in swallowing or breathing, any swelling suggesting angioedema (for example, swelling of the lips, tongue, face, tightness of the throat, hoarseness), or other symptoms of an allergic reaction.

- **Hepatotoxicity:** Inform patients that severe hepatotoxicity (including acute hepatitis and fatal events) has been reported in patients taking levofloxacin. Instruct patients to inform their physician if they experience any signs or symptoms of liver injury including: loss of appetite, nausea, vomiting, fever, weakness, tiredness, right upper quadrant tenderness, itching, yellowing of the skin and eyes, light-colored bowel movements or dark colored urine.

- **Aortic aneurysm and dissection:** Inform patients to seek emergency medical care if they experience sudden chest, stomach, or back pain.

- **Diabetes:** Diarrhea is a common problem caused by antibiotics which usually ends when the antibiotic is discontinued. Sometimes after starting treatment with antibiotics, patients can develop watery and bloody stools (with or without stomach cramps and fever) even as late as two or more months after having taken the last dose of the antibiotic. If this occurs, instruct patients to contact their physician as soon as possible.

- **Prolongation of the QT Interval:** Instruct patients to inform their physician of any personal or family history of QT prolongation or proarrhythmic conditions such as hypokalemia, bradycardia, or recent myocardial ischemia; if they are taking any Class IA (quinidine, procainamide), or Class III (amiodarone, sotalol) antiarrhythmic agents. Instruct patients to notify their physician if they have any symptoms of prolongation of the QT interval, including prolonged heart palpitations or a loss of consciousness.

- **Musculoskeletal Disorders in Pediatric Patients:** Instruct parents to inform their child’s physician if the child has a history of joint-related problems before taking this drug. Inform parents of pediatric patients to notify their child’s physician of any joint-related problems that occur during or following levofloxacin therapy (see Warnings and Precautions (5.12) and Use in Specific Populations (8.4)).

- **Photosensitivity/Photoxicity:** Inform patients that photosensitivity/photoxicity has been reported in patients receiving fluoroquinolones. Inform patients to minimize or avoid exposure to natural or artificial sunlight (tanning beds or UVA/UVB treatment) while taking fluoroquinolones. If patients need to be outdoors while using fluoroquinolones, instruct them to wear loose-fitting clothes that protect skin from sun exposure and discuss other sun protection measures with their physician. If a sunburn-like reaction or skin eruption occurs, instruct patients to contact their physician.

**Antibacterial Resistance**

Antibacterial drugs including levofloxacin should only be used to treat bacterial infections. They do not treat viral infections (e.g., the common cold). When levofloxacin is prescribed to treat a bacterial infection, patients should be told that although it is common to feel better early in the course of therapy, the medication should be taken exactly as directed. Skipping doses or not completing the full course of therapy may (1) decrease the effectiveness of the immediate treatment and (2) increase the likelihood that bacteria will develop resistance and will not be treatable by levofloxacin or other antibacterial drugs in the future.

**Administration with Food, Fluids, and Concomitant Medications**

Patients should drink fluids liberally while taking levofloxacin injection to avoid formation of a highly concentrated urine and crystal formation in the urine.

**Drug Interactions with Insulin, Oral Hypoglycemic Agents, and Warfarin**

Patients should be informed that if they are diabetic and are being treated with insulin or an oral hypoglycemic agent and a hypoglycemic reaction occurs, they should discontinue levofloxacin and consult a physician.

Patients should be informed that concurrent administration of warfarin and levofloxacin has been associated with increases of the International Normalized Ratio (INR) or prothrombin time and clinical episodes of bleeding. Patients should notify their physician if they are taking warfarin, be monitored for evidence of bleeding, and also have their anticoagulation tests closely monitored while taking warfarin concomitantly.

**Plague and Anthrax Studies**

Patients given levofloxacin for these conditions should be informed that efficacy studies could not be conducted in humans for ethical and feasibility reasons. Therefore, approval for these conditions was
Levofloxacin, a fluoroquinolone antibiotic, can cause serious side effects. Some of these serious side effects can happen at the same time and could result in death.

If you have any of the following serious side effects while you take levofloxacin, you should stop taking levofloxacin immediately and get medical help right away.

1. Tendon rupture or swelling of the tendon (tendinitis).
   - Tendon problems can happen in people of all ages who take levofloxacin. Tendons are tough cords of tissue that connect muscles to bones.
   - The risk of getting tendon problems while you take levofloxacin is higher if you:
     - are over 60 years of age
     - are taking steroids (corticosteroids)
     - have had a kidney, heart or lung transplant.
   - Tendon problems can happen in people who do not have the above risk factors when they take levofloxacin.
   - Other reasons that can increase your risk of tendon problems can include:
     - physical activity or exercise
     - kidney failure
     - tendon problems in the past, such as in people with rheumatoid arthritis (RA)
   - Stop taking levofloxacin immediately and get medical help right away at the first sign of tendon pain, swelling or inflammation. Avoid exercise and using the affected area.

   The most common area of pain and swelling is the Achilles tendon at the back of your ankle. This can also happen with other tendons. You may need a different antibiotic that is not a fluoroquinolone to treat your infection.

   - Tendon rupture can happen while you are taking or after you have finished taking levofloxacin.
   - Tendon ruptures can happen within hours or days of taking levofloxacin and have happened up to several months after people have finished taking their fluoroquinolone.
   - Stop taking levofloxacin immediately and get medical help right away if you get any of the following signs or symptoms of a tendon rupture:
     - hear or feel a snap or pop in a tendon area
     - bruising right after an injury in a tendon area
     - unable to move the affected area or bear weight

2. Changes in sensation and possible nerve damage (Peripheral Neuropathy). Damage to the nerves in arms, hands, legs, or feet can happen in people who take fluoroquinolones, including levofloxacin. Stop taking levofloxacin immediately and talk to your healthcare provider right away if you get any of the following symptoms of peripheral neuropathy in your arms, hands, legs, or feet:
   - pain
   - burning
   - tingling
   - numbness
   - weakness

   The nerve damage may be permanent.

3. Central Nervous System (CNS) effects. Seizures have been reported in people who take fluoroquinolone antibacterial medicines, including levofloxacin. Tell your healthcare provider if you have a history of seizures before you start taking levofloxacin. CNS side effects may happen as soon as after taking the first dose of levofloxacin. Stop taking levofloxacin immediately and talk to your healthcare provider right away if you get any of these side effects, or other changes in mood or behavior:
   - seizures
   - hear voices, see things, or sense things that are not there (hallucinations)
   - feel restless
   - tremors
   - feel anxious or nervous
   - confusion
   - depression
   - trouble sleeping
   - nightmares
   - feel lightheaded or dizzy
   - feel more suspicious (paranoia)
   - suicidal thoughts or acts
   - headaches that will not go away, with or without blurred vision

4. Worsening of myasthenia gravis (a problem that causes muscle weakness). Fluoroquinolones like levofloxacin may cause worsening of myasthenia gravis symptoms, including muscle weakness and breathing problems. Tell your healthcare provider if you have a history of myasthenia gravis before you start taking levofloxacin. Call your healthcare provider right away if you have any worsening muscle weakness or breathing problem.
What is levofloxacin?

Levofloxacin is a fluoroquinolone antibiotic medicine used in adults age 18 years or older to treat certain infections caused by certain germs called bacteria. These bacterial infections include:

- nosocomial pneumonia
- community acquired pneumonia
- acute sinus infection
- acute worsening of chronic bronchitis
- skin infections, complicated and uncomplicated
- chronic prostatic infection
- urinary tract infections, complicated and uncomplicated
- acute kidney infection (pyelonephritis)
- inhalation anthrax
- plague

Studies of levofloxacin for use in the treatment of plague and anthrax were done in animals only, because plague and anthrax could not be studied in people.

Levofloxacin should not be used in patients with uncomplicated urinary tract infections, acute bacterial exacerbation of chronic bronchitis, or acute bacterial sinusitis if there are other treatment options available.

Levofloxacin is also used to treat children who are 6 months of age or older and may have breathed in anthrax germs, have plague, or been exposed to plague germs.

It is not known if levofloxacin is safe and effective in children under 6 months of age.

Who should not take levofloxacin?

Do not take levofloxacin if you have ever had a severe allergic reaction to an antibiotic known as a fluoroquinolone, or if you are allergic to levofloxacin or any of the ingredients in levofloxacin injection. See the end of this leaflet for a complete list of ingredients in levofloxacin injection.

What should I tell my healthcare provider before taking levofloxacin?

Before you take levofloxacin, tell your healthcare provider if you:
- have tendon problems; levofloxacin should not be used in patients who have a history of tendon problem
- have a problem that causes muscle weakness (myasthenia gravis); levofloxacin should not be used in patients who have a known history of myasthenia gravis
- have central nervous system problems such as seizures (epilepsy)
- have nerve problem; levofloxacin should not be used in patients who have a history of a nerve problem called peripheral neuropathy
- have or anyone in your family has an irregular heartbeat, especially a condition called “QT prolongation”
- have low blood potassium (hypokalemia)
- have bone problems
- have joint problems including rheumatoid arthritis (RA)
- have kidney problems. You may need a lower dose of levofloxacin if your kidneys do not work well.
- have liver problems
- have diabetes or problems with low blood sugar (hypoglycemia)
- are pregnant or plan to become pregnant. It is not known if levofloxacin will harm your unborn child.
- are breastfeeding or plan to breastfeed. It is not known if levofloxacin passes into your breast milk.

Tell your healthcare provider about all the medicines you take, including prescription and non-prescription medicines, vitamins, and herbal supplements.

Especially tell your healthcare provider if you take:
- a steroid medicine.
- an anti-psychotic medicine
- a tricyclic antidepressant
- a water pill (diuretic)
- a blood thinner (warfarin, Coumadin, Jantoven)
- an oral anti-diabetes medicine or insulin
- an NSAID (Non-Steroidal Anti-Inflammatory Drug). Many common medicines for pain relief are NSAIDs. Taking an NSAID while you take levofloxacin or other fluoroquinolones may increase your risk of central nervous system effects and seizures.
- theophylline (Theo-24®, Elixophyllin®, Theochron®, Uniphyl®, Theolair®)
- a medicine to control your heart rate or rhythm (antiarrhythmics)

Ask your healthcare provider if you are not sure if any of your medicines are listed above.

Know the medicines you take. Keep a list of your medicines and show it to your healthcare provider and pharmacist when you get a new medicine.

How should I take levofloxacin?

Take levofloxacin exactly as your healthcare provider tells you to take it.

Take levofloxacin at about the same time each day.

Drink plenty of fluids while you take levofloxacin.

If you miss a dose of levofloxacin, take it as soon as you remember. Do not take more than 1 dose in 1 day.

Levofloxacin Injection is given by slow intravenous (I.V.) infusion into your vein over 60 or 90 minutes as prescribed by your healthcare provider.

Do not skip any doses of levofloxacin or stop taking it, even if you begin to feel better, until you finish your prescribed treatment, unless:
- you have tendon problems. See “What is the most important information I should know about levofloxacin?”
- you have a nerve problem. See “What are the possible side effects of levofloxacin?”
- you have a central nervous system problem. See “What are the possible side effects of levofloxacin?”
- you have a serious allergic reaction. See “What are the possible side effects of levofloxacin?”
your healthcare provider tells you to stop taking levofloxacin.

Taking all of your levofloxacin doses will help make sure that all of the bacteria are killed. Taking all of your levofloxacin doses will help you lower the chance that the bacteria will become resistant to levofloxacin. If your infection does not get better while you take levofloxacin, it may mean that the bacteria causing your infection may be resistant to levofloxacin. If your infection does not get better, call your healthcare provider. If your infection does not get better, levofloxacin and other similar antibiotic medicines may not work for you in the future.

If you take too much levofloxacin, call your healthcare provider or get medical help right away.

What should I avoid while taking levofloxacin?

Levofloxacin can make you feel dizzy and lightheaded. Do not drive, operate machinery, or do other activities that require mental alertness or coordination until you know how levofloxacin affects you.

Avoid sunlamps, tanning beds, and try to limit your time in the sun. Levofloxacin can make your skin sensitive to the sun (photosensitivity) and the light from sunlamps and tanning beds. You could get severe sunburn, blisters or swelling of your skin. If you get any of these symptoms while you take levofloxacin, call your healthcare provider right away. You should use a sunscreen and wear a hat and clothes that cover your skin if you have to be in sunlight.

What are the possible side effects of levofloxacin?

Levofloxacin can cause serious side effects, including:

See “What is the most important information I should know about levofloxacin?”

Serious allergic reactions.

Allergic reactions can happen in people taking fluoroquinolones, including levofloxacin, even after only 1 dose. Stop taking levofloxacin and get emergency medical help right away if you have any of the following symptoms of a severe allergic reaction:

- hives
- trouble breathing or swallowing
- swelling of the lips, tongue, face
- throat tightness, hoarseness
- rapid heartbeat
- faint
- skin rash

Skin rash may happen in people taking levofloxacin, even after only 1 dose. Stop taking levofloxacin at the first sign of a skin rash and immediately call your healthcare provider. Skin rash may be a sign of a more serious reaction to levofloxacin.

- Liver damage (hepatotoxicity): Hepatotoxicity can happen in people who take levofloxacin. Call your healthcare provider right away if you have unexplained symptoms such as:
  - nausea or vomiting
  - stomach pain
  - fever
  - weakness
  - abdominal pain or tenderness
  - itching
  - unusual tiredness
  - loss of appetite
  - light colored bowel movements
  - dark colored urine
  - yellowing of your skin or the whites of your eyes

Stop taking levofloxacin and tell your healthcare provider right away if you have yellowing of your skin or white part of your eyes, or if you have dark urine. These can be signs of a serious reaction to levofloxacin (a liver problem).

- Aortic aneurysm and dissection

Tell your healthcare provider if you have ever been told that you have an aortic aneurysm, a swelling of the large artery that carries blood from the heart to the body. Get emergency medical help right away if you have sudden chest, stomach, or back pain.

- Intestine infection (Pseudomembranous colitis)

Pseudomembranous colitis can happen with many antibiotics, including levofloxacin. Call your healthcare provider right away if you get watery diarrhea, diarrhea that does not go away, or bloody stools. You may have stomach cramps and a fever. Pseudomembranous colitis can happen 2 or more months after you have finished your antibiotic.

- Serious heart rhythm changes (QT prolongation and torsades de pointes)

Tell your healthcare provider right away if you have a change in your heart beat (a fast or irregular heartbeat), or if you faint. Levofloxacin may cause a rare heart problem known as prolongation of the QT interval. This condition can cause an abnormal heartbeat and can be very dangerous. The chances of this happening are higher in people:
  - who are elderly
  - with a family history of prolonged QT interval
  - with low blood potassium (hypokalemia)
  - who take certain medicines to control heart rhythm (antiarrhythmics)

- Joint Problems

Increased chance of problems with joints and tissues around joints in children can happen. Tell your child's healthcare provider if your child has any joint problems during or after treatment with levofloxacin.

- Changes in blood sugar

People who take levofloxacin and other fluoroquinolone medicines with oral anti-diabetes medicines or with insulin can get low blood sugar (hypoglycemia) and high blood sugar (hyperglycemia). Follow your healthcare provider's instructions for how often to check your blood sugar. If you have diabetes and you get low blood sugar while taking levofloxacin, stop taking levofloxacin and call your healthcare provider right away. Your antibiotic medicine may need to be changed.

- Sensitivity to sunlight (photosensitivity)

See “What should I avoid while taking levofloxacin?”
The most common side effects of levofloxacin include:

- nausea
- headache
- diarrhea
- insomnia
- constipation
- dizziness

In children 6 months and older who take levofloxacin to treat anthrax disease or plague, vomiting is also common.

Low blood pressure can happen when levofloxacin is given too fast by IV injection. Tell your healthcare provider if you feel dizzy or faint during a treatment with levofloxacin injection.

Levofloxacin may cause false-positive urine screening results for opiates when testing is done with some commercially available kits. A positive result should be confirmed using a more specific test.

These are not all the possible side effects of levofloxacin. Tell your healthcare provider about any side effect that bothers you or that does not go away.

Call your doctor for medical advice about side effects. You may report side effects to FDA at 1-800-FDA-1088.

**How should I store levofloxacin?**

Levofloxacin injection should be stored at 20° - 25°C (68° - 77°F) [See USP Controlled Room Temperature].

**Keep levofloxacin and all medicines out of the reach of children.**

**General information about the safe and effective use of levofloxacin**

Medicines are sometimes prescribed for purposes other than those listed in a Medication Guide. Do not use levofloxacin for a condition for which it is not prescribed. Do not give levofloxacin to other people, even if they have the same symptoms that you have. It may harm them.

This Medication Guide summarizes the most important information about levofloxacin. If you would like more information about levofloxacin, talk with your healthcare provider. You can ask your healthcare provider or pharmacist for information about levofloxacin that is written for healthcare professionals.

For more information call 1-866-850-2876.

**What are the ingredients in levofloxacin injection?**

Active ingredient: levofloxacin.

Inactive ingredients: water for injection. Levofloxacin injection single-dose vials do not contain any preservatives.

All brands listed are the trademarks of their respective owners and are not trademarks of Aurobindo Pharma Limited.

This Medication Guide has been approved by the U.S. Food and Drug Administration.

Distributed by:
AuroMedics Pharma LLC
279 Princeton-Hightstown Rd.
E. Windsor, NJ 08520

Manufactured by:
Aurobindo Pharma Limited
Hyderabad - 500038
India

Revised: March 2019
LEVOFOLOXACIN
levofloxacin injection, solution, concentrate

Product Information
Product Type: HUMAN PRESCRIPTION DRUG
Item Code (Source): NDC:55150-156
Route of Administration: INTRAVENOUS

Active Ingredient/Active Moiety
<table>
<thead>
<tr>
<th>Ingredient Name</th>
<th>Basis of Strength</th>
<th>Strength</th>
</tr>
</thead>
<tbody>
<tr>
<td>LEVOFOLOXACIN (UNII: S0NO3Y5G5M)</td>
<td>LEVOFOLOXACIN ANHYDROUS</td>
<td>350 mg in 20 mL</td>
</tr>
</tbody>
</table>

Inactive Ingredients
<table>
<thead>
<tr>
<th>Ingredient Name</th>
<th>Strength</th>
</tr>
</thead>
<tbody>
<tr>
<td>WATER (UNII: 059QF0K00R)</td>
<td></td>
</tr>
<tr>
<td>HYDROCHLORIC ACID (UNII: QTT17582CB)</td>
<td></td>
</tr>
<tr>
<td>SODIUM HYDROXIDE (UNII: 55X04QC32I)</td>
<td></td>
</tr>
</tbody>
</table>

Product Characteristics
Color: YELLOW (Clear Yellow to Clear Greenish Yellow)
Shape: Score
Size: Imprint Code

Packaging
<table>
<thead>
<tr>
<th>Item Code</th>
<th>Package Description</th>
<th>Marketing Start Date</th>
<th>Marketing End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 55150-156-30</td>
<td>1 in 1 CARTRON</td>
<td>01/24/2013</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>20 mL in 1 VIAL, SINGLE-USE; Type 0; Not a Combination Product</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Marketing Information
Marketing Category: ANDA
Application Number or Monograph Citation: ANDA021238
Marketing Start Date: 01/24/2013
Marketing End Date: 

LEVOFOLOXACIN
### Product Information

**Product Type**: HUMAN PRESCRIPTION DRUG  
**NDC**: 55150-157

**Route of Administration**: INTRAVENOUS

### Active Ingredient/Active Moiety

<table>
<thead>
<tr>
<th>Ingredient Name</th>
<th>Basis of Strength</th>
<th>Strength</th>
</tr>
</thead>
<tbody>
<tr>
<td>LEVOFLOXACIN (UNII: 6GNT3Y5LMF)</td>
<td>LEVOFLOXACIN ANHYDROUS</td>
<td>750 mg in 30 mL</td>
</tr>
</tbody>
</table>

### Inactive Ingredients

<table>
<thead>
<tr>
<th>Ingredient Name</th>
<th>Strength</th>
</tr>
</thead>
<tbody>
<tr>
<td>WATER (UNII: 059QF0K00R)</td>
<td></td>
</tr>
<tr>
<td>HYDROCHLORIC ACID (UNII: QTT17582CB)</td>
<td></td>
</tr>
<tr>
<td>SODIUM HYDROXIDE (UNII: 55X04QC32I)</td>
<td></td>
</tr>
</tbody>
</table>

### Product Characteristics

- **Color**: YELLOW (Clear Yellow to Clear Greenish Yellow)  
- **Shape**:  
- **Size**:  
- **Flavor**:  
- **Imprint Code**: Contains

### Packaging

<table>
<thead>
<tr>
<th>#</th>
<th>Item Code</th>
<th>Package Description</th>
<th>Marketing Start Date</th>
<th>Marketing End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>NDC:55150-157-30</td>
<td>1 in 1 CARTON</td>
<td>01/24/2013</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td></td>
<td>30 mL in 1 VIAL, SINGLE-USE; Type 0; Not a Combination Product</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Marketing Information

**Marketing Category**: ANDA  
**Application Number or Monograph Citation**: ANDA202328  
**Marketing Start Date**: 01/24/2013  
**Marketing End Date**:  

**Labeler**: AuroMedics Pharma LLC (968561354)

**Establishment**

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
<th>ID/FEI</th>
<th>Business Operations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aurobindo Pharma Limited</td>
<td>918917626</td>
<td>API MANUFACTURE(55150-156, 55150-157)</td>
<td></td>
</tr>
</tbody>
</table>

**Establishment**

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<thead>
<tr>
<th>Name</th>
<th>Address</th>
<th>ID/FEI</th>
<th>Business Operations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aurobindo Pharma Limited</td>
<td>650498244</td>
<td>ANALYSIS(55150-156, 55150-157) , MANUFACTURE(55150-156, 55150-157)</td>
<td></td>
</tr>
</tbody>
</table>

Revised: 3/2019