

CLARITHROMYCIN- clarithromycin tablet, film coated, extended release A-S Medication Solutions

HIGHLIGHTS OF PRESCRIBING INFORMATION

These highlights do not include all the information needed to use CLARITHROMYCIN EXTENDED-RELEASE TABLETS safely and effectively. See full prescribing information for CLARITHROMYCIN EXTENDED-RELEASE TABLETS.

CLARITHROMYCIN Extended-release tablets, for oral use

Initial U.S. Approval: 1991

----- RECENT MAJOR CHANGES -----

Warnings and Precautions, Acute Hypersensitivity Reactions (5.1)	06/2017
Warnings and Precautions, All-Cause Mortality in Patients With Coronary Artery Disease Years After Clarithromycin Exposure (5.5)	06/2017

----- INDICATIONS AND USAGE -----

Clarithromycin Extended-release Tablets, USP is a macrolide antimicrobial indicated for mild to moderate infections caused by designated, susceptible bacteria in the following:

- Acute Bacterial Exacerbation of Chronic Bronchitis in Adults (1.1)
- Acute Maxillary Sinusitis (1.2)
- Community-Acquired Pneumonia (1.3)

Limitations of Use

Clarithromycin Extended-release Tablets, USP is indicated only for acute bacterial exacerbation of chronic bronchitis, acute maxillary sinusitis, and community-acquired pneumonia in adults. (1.4)

To reduce the development of drug-resistant bacteria and maintain the effectiveness of Clarithromycin Extended-release Tablets, USP and other antibacterial drugs, Clarithromycin Extended-release Tablets, USP should be used only to treat or prevent infections that are proven or strongly suspected to be caused by bacteria. (1.4)

----- DOSAGE AND ADMINISTRATION -----

- Adults: Clarithromycin Extended-release tablets 1 gram every 24 hours for 7–14 days (2.2)
- Reduce dose in moderate renal impairment with concomitant atazanavir or ritonavir-containing regimens and in severe renal impairment (2.3)

----- DOSAGE FORMS AND STRENGTHS -----

- Extended-release Tablets: 500 mg (3)

----- CONTRAINDICATIONS -----

- Hypersensitivity to clarithromycin or any macrolide drug (4.1)
- Cisapride, pimozide, lovastatin/simvastatin, ergotamine/dihydroergotamine (4.2, 4.5, 4.6)
- History of cholestatic jaundice/hepatic dysfunction with use of clarithromycin (4.3)
- Colchicine in renal or hepatic impairment (4.4)

----- WARNINGS AND PRECAUTIONS -----

- Severe acute hypersensitivity reactions: Discontinue clarithromycin if occurs (5.1)
- QT prolongation: Avoid clarithromycin in patients with known QT prolongation or receiving drugs known to prolong the QT interval, ventricular arrhythmia (torsade de pointes), hypokalemia/hypomagnesemia, significant bradycardia, or taking Class IA or III antiarrhythmics (5.2)
- Hepatotoxicity: Discontinue if signs and symptoms of hepatitis occur (5.3)
- Serious adverse reactions can occur due to drug interactions of clarithromycin with colchicine, some HMG CoA reductase inhibitors, some calcium channel blockers, and other drugs (5.4)
- Risk of all-cause mortality one year or more after the end of treatment in patients with coronary artery disease (5.5)
- *Clostridium difficile* associated diarrhea (CDAD): Evaluate if diarrhea occurs (5.6)
- Embryofetal toxicity: clarithromycin should not be used in pregnant women except in clinical circumstances where no

- alternative therapy is appropriate (5.7)
- Exacerbation of myasthenia gravis (5.8)

----- **ADVERSE REACTIONS** -----

Most frequent adverse reactions for both adult and pediatric populations in clinical trials: abdominal pain, diarrhea, nausea, vomiting, dysgeusia (6.1)

To report SUSPECTED ADVERSE REACTIONS, contact Lannett Company, Inc. at 1-844-834-0530 or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.

----- **DRUG INTERACTIONS** -----

Co-administration of clarithromycin can alter the concentrations of other drugs. The potential for drug-drug interactions must be considered prior to and during therapy. (4, 5.2, 5.4, 7)

----- **USE IN SPECIFIC POPULATIONS** -----

Geriatric: Increased risk of *torsades de pointes*(8.5)

See 17 for PATIENT COUNSELING INFORMATION.

Revised: 1/2019

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FULL PRESCRIBING INFORMATION

1 INDICATIONS AND USAGE

1.1 Acute Bacterial Exacerbation of Chronic Bronchitis

Clarithromycin Extended-release Tablets, USP are indicated in adults for the treatment of mild to moderate infections caused by susceptible isolates due to *Haemophilus influenzae*, *Haemophilus parainfluenzae*, *Moraxella catarrhalis*, or *Streptococcus pneumoniae* [see *Indications and Usage (1.4)*].

1.2 Acute Maxillary Sinusitis

Clarithromycin Extended-release Tablets, USP (in adults) are indicated for the treatment of mild to moderate infections caused by susceptible isolates due to *Haemophilus influenzae*, *Moraxella catarrhalis*, or *Streptococcus pneumoniae* [see *Indications and Usage (1.4)*].

1.3 Community-Acquired Pneumonia

Clarithromycin Extended-release Tablets, USP are indicated [see *Indications and Usage (1.4)*] for the treatment of mild to moderate infections caused by susceptible isolates due to:

- *Haemophilus influenzae* (in adults)
- *Haemophilus parainfluenzae* (in adults)
- *Moraxella catarrhalis* (in adults)
- *Mycoplasma pneumoniae*, *Streptococcus pneumoniae*, *Chlamydia pneumoniae* (in adults)

1.4 Limitations of Use

Clarithromycin Extended-release Tablets, USP are indicated only for acute maxillary sinusitis, acute bacterial exacerbation of chronic bronchitis, and community-acquired pneumonia in adults. The efficacy and safety of Clarithromycin Extended-release Tablets, USP in treating other infections for which other formulations of clarithromycin are approved have not been established.

There is resistance to macrolides in certain bacterial infections caused by *Streptococcus pneumoniae* and *Staphylococcus aureus*. Susceptibility testing should be performed when clinically indicated.

1.5 Usage

To reduce the development of drug-resistant bacteria and maintain the effectiveness of Clarithromycin Extended-release Tablets, USP and other antibacterial drugs, Clarithromycin Extended-release Tablets, USP should be used only to treat or prevent infections that are proven or strongly suspected to be caused by susceptible bacteria. When culture and susceptibility information are available, they should be considered in selecting or modifying antibacterial therapy. In the absence of such data, local epidemiology and susceptibility patterns may contribute to the empiric selection of therapy.

2 DOSAGE AND ADMINISTRATION

2.1 Important Administration Instructions

Clarithromycin Extended-release Tablets, USP should be taken with food. Swallow Clarithromycin Extended-release Tablets, USP whole; do not chew, break or crush Clarithromycin Extended-release Tablets, USP.

2.2 Adult Dosage

The recommended dosages of Clarithromycin Extended-release Tablets, USP for the treatment of mild to moderate infections in adults are listed in Table 1.

Table 1. Adult Dosage Guidelines

Infection	Clarithromycin Extended-release Tablets, USP	
	Dosage (every 24 hours)	Duration (days)
Acute bacterial exacerbation of chronic bronchitis	1 gram	7
Acute maxillary sinusitis	1 gram	14
Community-acquired pneumonia	1 gram	7

2.3 Dosage Adjustment in Patients with Renal Impairment

See Table 2 for dosage adjustment in patients with moderate or severe renal impairment with or without concomitant atazanavir or ritonavir-containing regimens [see *Drug Interactions (7)*].

Table 2. Clarithromycin Dosage Adjustments in Patients with Renal Impairment

	Recommended Clarithromycin Dosage Reduction
Patients with severe renal impairment (CL _{cr} of <30 mL/min)	Reduce the dosage of clarithromycin by 50%
Patients with moderate renal impairment (CL _{cr} of 30 to 60 mL/min) taking concomitant atazanavir or ritonavir-containing regimens	Reduce the dosage of clarithromycin by 50%

Patients with severe renal impairment (CL _{cr} of <30 mL/min) taking concomitant atazanavir or ritonavir-containing regimens	Reduce the dosage of clarithromycin by 75%
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2.4 Dosage Adjustment Due to Drug Interactions

Decrease the dose of clarithromycin by 50 % when co-administered with atazanavir [see *Drug Interactions (7)*]. Dosage adjustments for other drugs when co-administered with clarithromycin may be recommended due to drug interactions [see *Drug Interactions (7)*].

3 DOSAGE FORMS AND STRENGTHS

Clarithromycin Extended-release Tablets, USP are supplied as white or off-white, capsular-shaped film-coated 500 mg tablets debossed “S58” on one side and blank on the other side.

4 CONTRAINDICATIONS

4.1 Hypersensitivity

Clarithromycin is contraindicated in patients with a known hypersensitivity to clarithromycin, erythromycin, or any of the macrolide antibacterial drugs [see *Warnings and Precautions (5.1)*].

4.2 Cardiac Arrhythmias

Concomitant administration of clarithromycin with cisapride and pimozide is contraindicated [see *Drug Interactions (7)*].

There have been postmarketing reports of drug interactions when clarithromycin is co-administered with cisapride or pimozide, resulting in cardiac arrhythmias (QT prolongation, ventricular tachycardia, ventricular fibrillation, and *torsades de pointes*) most likely due to inhibition of metabolism of these drugs by clarithromycin. Fatalities have been reported.

4.3 Cholestatic Jaundice/Hepatic Dysfunction

Clarithromycin is contraindicated in patients with a history of cholestatic jaundice or hepatic dysfunction associated with prior use of clarithromycin.

4.4 Colchicine

Concomitant administration of clarithromycin and colchicine is contraindicated in patients with renal or hepatic impairment.

4.5 HMG-CoA Reductase Inhibitors

Do not use clarithromycin concomitantly with HMG-CoA reductase inhibitors (statins) that are extensively metabolized by CYP3A4 (lovastatin or simvastatin), due to the increased risk of myopathy, including rhabdomyolysis [see *Warnings and Precautions (5.4)* and *Drug Interactions (7)*].

4.6 Ergot Alkaloids

Concomitant administration of clarithromycin and ergotamine or dihydroergotamine is contraindicated [see *Drug Interactions (7)*].

4.7 Contraindications for Co-administered Drugs

For information about contraindications of other drugs indicated in combination with clarithromycin, refer to their full prescribing information (contraindications section).

5 WARNINGS AND PRECAUTIONS

5.1 Acute Hypersensitivity Reactions

In the event of severe acute hypersensitivity reactions, such as anaphylaxis, Stevens-Johnson Syndrome, toxic epidermal necrolysis, drug rash with eosinophilia and systemic symptoms (DRESS), Henoch-Schonlein purpura, and acute generalized exanthematous pustulosis, discontinue clarithromycin therapy immediately and institute appropriate treatment.

5.2 QT Prolongation

Clarithromycin has been associated with prolongation of the QT interval and infrequent cases of arrhythmia. Cases of *torsades de pointes* have been spontaneously reported during postmarketing surveillance in patients receiving clarithromycin. Fatalities have been reported.

Avoid clarithromycin in the following patients:

- patients with known prolongation of the QT interval, ventricular cardiac arrhythmia, including *torsades de pointes*
- patients receiving drugs known to prolong the QT interval [see also *Contraindications (4.2)*]
- patients with ongoing proarrhythmic conditions such as uncorrected hypokalemia or hypomagnesemia, clinically significant bradycardia and in patients receiving Class IA (quinidine, procainamide) or Class III (dofetilide, amiodarone, sotalol) antiarrhythmic agents.

Elderly patients may be more susceptible to drug-associated effects on the QT interval [see *Use in Specific Populations (8.5)*].

5.3 Hepatotoxicity

Hepatic dysfunction, including increased liver enzymes, and hepatocellular and/or cholestatic hepatitis, with or without jaundice, has been reported with clarithromycin. This hepatic dysfunction may be severe and is usually reversible. In some instances, hepatic failure with fatal outcome has been reported and generally has been associated with serious underlying diseases and/or concomitant medications. Symptoms of hepatitis can include anorexia, jaundice, dark urine, pruritus, or tender abdomen. Discontinue clarithromycin immediately if signs and symptoms of hepatitis occur.

5.4 Serious Adverse Reactions Due to Concomitant Use with Other Drugs

Serious adverse reactions have been reported in patients taking clarithromycin concomitantly with CYP3A4 substrates. These include colchicine toxicity with colchicine; rhabdomyolysis with simvastatin, lovastatin, and atorvastatin; hypotension and with calcium channel blockers metabolized by CYP3A4 (e.g., verapamil, amlodipine, diltiazem,). . Use clarithromycin with caution when administered concurrently with medications that induce the cytochrome CYP3A4 enzyme. The use of clarithromycin with simvastatin, lovastatin, ergotamine, or dihydroergotamine is contraindicated . Drugs metabolized by CYP3A4: Serious adverse reactions have been reported in patients taking clarithromycin concomitantly with CYP3A4 substrates. These include colchicine toxicity with colchicine; rhabdomyolysis with simvastatin, lovastatin, and atorvastatin; hypoglycemia with disopyramide; hypotension and acute kidney injury with calcium channel blockers metabolized by CYP3A4 (e.g., verapamil, amlodipine, diltiazem, nifedipine). Most reports of acute kidney injury with calcium channel blockers metabolized by CYP3A4 involved elderly patients 65 years of age or older. Use clarithromycin with caution when administered concurrently with medications that induce the cytochrome CYP3A4 enzyme. The use of clarithromycin with simvastatin, lovastatin, ergotamine, or dihydroergotamine is contraindicated [see *Contraindications (4.5,4.6) and Drug Interactions (7)*].

Life-threatening and fatal drug interactions have been reported in patients treated with clarithromycin and colchicine. Clarithromycin is a strong CYP3A4 inhibitor and this interaction may occur while using both drugs at their recommended doses. If co-administration of clarithromycin and colchicine is necessary in patients with normal renal and hepatic function, reduce the dose of colchicine. Monitor patients for clinical symptoms of colchicine toxicity. Concomitant administration of clarithromycin and

colchicine is contraindicated in patients with renal or hepatic impairment . Colchicine: Life-threatening and fatal drug interactions have been reported in patients treated with clarithromycin and colchicine. Clarithromycin is a strong CYP3A4 inhibitor and this interaction may occur while using both drugs at their recommended doses. If co-administration of clarithromycin and colchicine is necessary in patients with normal renal and hepatic function, reduce the dose of colchicine. Monitor patients for clinical symptoms of colchicine toxicity. Concomitant administration of clarithromycin and colchicine is contraindicated in patients with renal or hepatic impairment [see *Contraindications (4.4) and Drug Interactions (7)*] .

Concomitant use of clarithromycin with lovastatin or simvastatin is contraindicated as these statins are extensively metabolized by CYP3A4, and concomitant treatment with clarithromycin increases their plasma concentration, which increases the risk of myopathy, including rhabdomyolysis. Cases of rhabdomyolysis have been reported in patients taking clarithromycin concomitantly with these statins. If treatment with clarithromycin cannot be avoided, therapy with lovastatin or simvastatin must be suspended during the course of treatment. HMG-CoA Reductase Inhibitors (statins): Concomitant use of clarithromycin with lovastatin or simvastatin is contraindicated [see *Contraindications (4.5)*] as these statins are extensively metabolized by CYP3A4, and concomitant treatment with clarithromycin increases their plasma concentration, which increases the risk of myopathy, including rhabdomyolysis. Cases of rhabdomyolysis have been reported in patients taking clarithromycin concomitantly with these statins. If treatment with clarithromycin cannot be avoided, therapy with lovastatin or simvastatin must be suspended during the course of treatment.

Exercise caution when prescribing clarithromycin with atorvastatin or pravastatin. In situations where the concomitant use of clarithromycin with atorvastatin or pravastatin cannot be avoided, atorvastatin dose should not exceed 20 mg daily and pravastatin dose should not exceed 40 mg daily. Use of a statin that is not dependent on CYP3A metabolism (e.g. fluvastatin) can be considered. It is recommended to prescribe the lowest registered dose if concomitant use cannot be avoided. Exercise caution when prescribing clarithromycin with atorvastatin or pravastatin. In situations where the concomitant use of clarithromycin with atorvastatin or pravastatin cannot be avoided, atorvastatin dose should not exceed 20 mg daily and pravastatin dose should not exceed 40 mg daily. Use of a statin that is not dependent on CYP3A metabolism (e.g. fluvastatin) can be considered. It is recommended to prescribe the lowest registered dose if concomitant use cannot be avoided.

The concomitant use of clarithromycin and oral hypoglycemic agents and/or insulin can result in significant hypoglycemia. With certain hypoglycemic drugs such as nateglinide, pioglitazone, repaglinide and rosiglitazone, inhibition of CYP3A enzyme by clarithromycin may be involved and could cause hypoglycemia when used concomitantly. Careful monitoring of glucose is recommended . Oral Hypoglycemic Agents/Insulin: The concomitant use of clarithromycin and oral hypoglycemic agents and/or insulin can result in significant hypoglycemia. With certain hypoglycemic drugs such as nateglinide, pioglitazone, repaglinide and rosiglitazone, inhibition of CYP3A enzyme by clarithromycin may be involved and could cause hypoglycemia when used concomitantly. Careful monitoring of glucose is recommended [see *Drug Interactions (7)*] .

Quetiapine: Use quetiapine and clarithromycin concomitantly with caution. Co-administration could result in increased quetiapine exposure and quetiapine related toxicities such as somnolence, orthostatic hypotension, altered state of consciousness, neuroleptic malignant syndrome, and QT prolongation. Refer to quetiapine prescribing information for recommendations on dose reduction if co-administered with CYP3A4 inhibitors such as clarithromycin [see *Drug Interactions (7)*] .

There is a risk of serious hemorrhage and significant elevations in INR and prothrombin time when clarithromycin is co-administered with warfarin. Monitor INR and prothrombin times frequently while patients are receiving clarithromycin and oral anticoagulants concurrently . Oral Anticoagulants: There is a risk of serious hemorrhage and significant elevations in INR and prothrombin time when clarithromycin is co-administered with warfarin. Monitor INR and prothrombin times frequently while patients are receiving clarithromycin and oral anticoagulants concurrently [see *Drug Interactions (7)*] .

Increased sedation and prolongation of sedation have been reported with concomitant administration of clarithromycin and triazolobenzodiazepines, such as triazolam and midazolam. Benzodiazepines: Increased sedation and prolongation of sedation have been reported with concomitant administration of clarithromycin and triazolobenzodiazepines, such as triazolam and midazolam [see *Drug Interactions (7)*].

5.5 All-Cause Mortality in Patients With Coronary Artery Disease 1 to 10 Years After Clarithromycin Exposure

In one clinical trial evaluating treatment with clarithromycin on outcomes in patients with coronary artery disease, an increase in risk of all-cause mortality one year or more after the end of treatment was observed in patients randomized to receive clarithromycin.¹ Clarithromycin for treatment of coronary artery disease is not an approved indication. The cause of the increased risk has not been established. Other epidemiologic studies evaluating this risk have shown variable results [see *Adverse Reactions (6.1)*]. Consider balancing this potential risk with the treatment benefits when prescribing clarithromycin in patients who have suspected or confirmed coronary artery disease.

5.6 *Clostridium difficile* Associated Diarrhea

Clostridium difficile associated diarrhea (CDAD) has been reported with use of nearly all antibacterial agents, including clarithromycin, 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 antibacterial 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 antibacterial use not directed against *C. difficile* may need to be discontinued. Appropriate fluid and electrolyte management, protein supplementation, antibacterial treatment of *C. difficile*, and surgical evaluation should be instituted as clinically indicated.

5.7 Embryofetal Toxicity

Clarithromycin should not be used in pregnant women except in clinical circumstances where no alternative therapy is appropriate. If clarithromycin is used during pregnancy, or if pregnancy occurs while the patient is taking this drug, the patient should be apprised of the potential hazard to the fetus. Clarithromycin has demonstrated adverse effects on pregnancy outcome and/or embryo-fetal development in monkeys, rats, mice, and rabbits at doses that produced plasma levels 2 times to 17 times the serum levels achieved in humans treated at the maximum recommended human doses [see *Use in Specific Populations (8.1)*].

5.8 Exacerbation of Myasthenia Gravis

Exacerbation of symptoms of myasthenia gravis and new onset of symptoms of myasthenic syndrome has been reported in patients receiving clarithromycin therapy.

5.9 Development of Drug Resistant Bacteria

Prescribing clarithromycin 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.

6 ADVERSE REACTIONS

The following serious adverse reactions are described below and elsewhere in the labeling:

- Acute Hypersensitivity Reactions [see Warnings and Precautions (5.1)]
- QT Prolongation [see Warnings and Precautions (5.2)]
- Hepatotoxicity [see Warnings and Precautions (5.3)]
- Serious Adverse Reactions Due to Concomitant Use with Other Drugs [see Warnings and Precautions (5.4)]
- *Clostridium difficile* Associated Diarrhea [see Warnings and Precautions (5.6)]
- Exacerbation of Myasthenia Gravis [see Warnings and Precautions (5.8)]

6.1 Clinical Trials Experience

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

Based on pooled data across all indications, the most frequent adverse reactions for both adult and pediatric populations observed in clinical trials are abdominal pain, diarrhea, nausea, vomiting and dysgeusia. Also reported were dyspepsia, liver function test abnormal, anaphylactic reaction, candidiasis, headache, insomnia, and rash.

The subsequent subsections list the most common adverse reactions for prophylaxis and treatment of mycobacterial infections and duodenal ulcer associated with *H. pylori* infection. In general, these profiles are consistent with the pooled data described above.

Prophylaxis of Mycobacterial Infections

In AIDS patients treated with clarithromycin over long periods of time for prophylaxis against *M. avium*, it was often difficult to distinguish adverse reactions possibly associated with clarithromycin administration from underlying HIV disease or intercurrent illness. Median duration of treatment was 10.6 months for the clarithromycin group and 8.2 months for the placebo group.

Table 3. Incidence Rates (%) of Selected Adverse Reactions ^a in Immunocompromised Adult Patients Receiving Prophylaxis Against *M. avium* Complex

Body System ^b	Clarithromycin (n=339)	Placebo (n=339)
Adverse Reaction	%	%
Body as a Whole		
Abdominal pain	5%	4%
Headache	3%	1%
Digestive		
Diarrhea	8%	4%
Dyspepsia	4%	3%
Flatulence	2%	1%
Nausea	11%	7%
Vomiting	6%	3%
Skin & Appendages		
Rash	3%	4%
Special Senses		

Taste Perversion	8% ^c	0.3%
a Includes those events possibly or probably related to study drug and excludes concurrent conditions		
b 2% or greater Adverse Reaction Incidence Rates for either treatment group		
c Significant higher incidence compared to the placebo-treated group		

Discontinuation due to adverse reactions occurred in 18% of patients receiving clarithromycin compared to 17% of patients receiving placebo in this trial. Primary reasons for discontinuation in clarithromycin treated patients include headache, nausea, vomiting, depression, and taste perversion.

Changes in Laboratory Values

Selected laboratory adverse experiences that were reported during therapy in greater than 2 % of adult patients treated with clarithromycin in a randomized double-blind clinical trial involving 682 patients are presented in Table 4.

In immunocompromised patients receiving prophylaxis against *M. avium*, evaluations of laboratory values were made by analyzing those values outside the seriously abnormal value (i.e., the extreme high or low limit) for the specified test.

Table 4. Percentage of Patients^a Exceeding Extreme Laboratory Values in Patients Receiving Prophylaxis Against *M. avium* Complex

		Clarithromycin 500 mg twice a day	Placebo
WBC Count	<1 x 10 ⁹ /L	2/103 (4%)	0/95
SGOT	>5 x ULN ^b	7/196 (4%)	5/208 (2%)
SGPT	>5 x ULN ^b	6/217 (3%)	4/232 (2%)
a Includes only patients with baseline values within the normal range or borderline high (hematology variables) and within normal range or borderline low (chemistry variables)			
b ULN= Upper Limit of Normal			

Treatment of Mycobacterial Infections

The adverse reaction profiles for both the 500 mg and 1000 mg twice a day dose regimens were similar.

In AIDS patients and other immunocompromised patients treated with the higher doses of clarithromycin over long periods of time for mycobacterial infections, it was often difficult to distinguish adverse reactions possibly associated with clarithromycin administration from underlying signs of HIV disease or intercurrent illness.

The following analysis summarizes experience during the first 12 weeks of therapy with clarithromycin. Data are reported separately for trial 1 (randomized, double-blind) and trial 2 (open-labeled, compassionate use) and also combined. Adverse reactions were reported less frequently in trial 2, which may be due in part to differences in monitoring between the two studies.

In adult patients receiving clarithromycin 500 mg twice a day, the most frequently reported adverse reactions, considered possibly or possibly related to study drug, with an incidence of 5% or greater, are listed below (Table 5). Approximately 8% of the patients who received 500 mg twice a day and 12% of the patients who received 1000 mg twice a day discontinued therapy due to drug related adverse reactions during the first 12 weeks of therapy; adverse reactions leading to discontinuation in at least 2 patients included nausea, vomiting, abdominal pain, diarrhea, rash, and asthenia.

Table 5. Selected Treatment-Related^a Adverse Reaction Incidence Rates (%) in

Immunocompromised Adult Patients During the First 12 Weeks of Therapy with 500 mg Twice a Day Clarithromycin Dose

Adverse Reaction	Trial 1 (n=53)	Trial 2 (n=255)	Combined (n=308)
Abdominal Pain	8	2	3
Diarrhea	9	2	3
Flatulence	8	0	1
Headache	8	0	2
Nausea	28	9	12
Rash	9	2	3
Taste Perversion	19	0	4
Vomiting	25	4	8

^a Includes those events possibly or probably related to study drug and excludes concurrent conditions

A limited number of pediatric AIDS patients have been treated with clarithromycin suspension for mycobacterial infections. The most frequently reported adverse reactions excluding those due to the patient's concurrent conditions were consistent with those observed in adult patients.

Changes in Laboratory Values

In the first 12 weeks of starting on clarithromycin 500 mg twice a day, 3% of patients has SGOT increases and 2% of patients has SGPT increases > 5 times the upper limit of normal in trial 2 (469 enrolled adult patients) while trial 1 (154 enrolled patients) had no elevation of transaminases. This includes only patients with baseline values within the normal range or borderline low.

Duodenal ulcer associated with *H. pylori* Infection

In clinical trials using combination therapy with clarithromycin plus omeprazole and amoxicillin, no adverse reactions specific to the combination of these drugs have been observed. Adverse reactions that have occurred have been limited to those that have been previously reported with clarithromycin, omeprazole or amoxicillin.

The adverse reaction profiles are shown below (Table 6) for four randomized double-blind clinical trials in which patients received the combination of clarithromycin 500 mg three times a day, and omeprazole 40 mg daily for 14 days, followed by omeprazole 20 mg once a day, (three studies) or 40 mg once a day (one study) for an additional 14 days. Of the 346 patients who received the combination, 3.5% of patients discontinued drug due to adverse reactions.

Table 6. Adverse Reactions with an Incidence of 3% or Greater

Adverse Reaction	Clarithromycin + Omeprazole (n=346) % of Patients	Omeprazole (n=355) % of Patients	Clarithromycin (n=166) % of Patients ^a
Taste Perversion	15	1	16
Nausea	5	1	3
Headache	5	6	9
Diarrhea	4	3	7
Vomiting	4	<1	1
Abdominal Pain	3	2	1

Infection	3	4	2
a Only two of four studies			

Changes in Laboratory Values

Changes in laboratory values with possible clinical significance in patients taking clarithromycin and omeprazole in four randomized double-blind trials in 945 patients are as follows:

Hepatic: elevated direct bilirubin <1%; GGT <1%; SGOT (AST) <1%; SGPT (ALT) <1%, Renal: elevated serum creatinine <1%.

Less Frequent Adverse Reactions Observed During Clinical Trials of Clarithromycin

Based on pooled data across all indications, the following adverse reactions were observed in clinical trials with clarithromycin at a rate less than 1%:

Blood and Lymphatic System Disorders: Leukopenia, neutropenia, thrombocytopenia, eosinophilia

Cardiac Disorders: Electrocardiogram QT prolonged, cardiac arrest, atrial fibrillation, extrasystoles, palpitations

Ear and Labyrinth Disorders: Vertigo, tinnitus, hearing impaired

Gastrointestinal Disorders: Stomatitis, glossitis, esophagitis, gastroesophageal reflux disease, gastritis, proctalgia, abdominal distension, constipation, dry mouth, eructation, flatulence

General Disorders and Administration Site Conditions: Malaise, pyrexia, asthenia, chest pain, chills, fatigue

Hepatobiliary Disorders: Cholestasis, hepatitis

Immune System Disorders: Hypersensitivity

Infections and Infestations: Cellulitis, gastroenteritis, infection, vaginal infection

Investigations: Blood bilirubin increased, blood alkaline phosphatase increased, blood lactate dehydrogenase increased, albumin globulin ratio abnormal

Metabolism and Nutrition Disorders: Anorexia, decreased appetite

Musculoskeletal and Connective Tissue Disorders: Myalgia, muscle spasms, nuchal rigidity

Nervous System Disorders: Dizziness, tremor, loss of consciousness, dyskinesia, somnolence

Psychiatric Disorders: Anxiety, nervousness

Renal and Urinary Disorders: Blood creatinine increased, blood urea increased

Respiratory, Thoracic and Mediastinal Disorders: Asthma, epistaxis, pulmonary embolism

Skin and Subcutaneous Tissue Disorders: Urticaria, dermatitis bullous, pruritus, hyperhidrosis, rash maculo-papular

Gastrointestinal Adverse Reactions

In the acute exacerbation of chronic bronchitis and acute maxillary sinusitis studies overall gastrointestinal adverse reactions were reported by a similar proportion of patients taking either clarithromycin tablets or clarithromycin extended-release tablets; however, patients taking clarithromycin extended-release tablets reported significantly less severe gastrointestinal symptoms compared to patients taking clarithromycin tablets. In addition, patients taking clarithromycin extended-release tablets had significantly fewer premature discontinuations for drug-related gastrointestinal or abnormal taste adverse reactions compared to clarithromycin tablets.

All-Cause Mortality in Patients with Coronary Artery Disease 1 to 10 Years Following Clarithromycin Exposure

In one clinical trial evaluating treatment with clarithromycin on outcomes in patients with coronary artery disease, an increase in risk of all-cause mortality was observed in patients randomized to clarithromycin. Clarithromycin for treatment of coronary artery disease is not an approved indication. Patients were treated with clarithromycin or placebo for 14 days and observed for primary outcome events (e.g., all-cause mortality or non-fatal cardiac events) for several years.¹ A numerically higher number of primary outcome events in patients randomized to receive clarithromycin was observed with a hazard ratio of 1.06 (95% confidence interval 0.98 to 1.14). However, at follow-up 10 years post-treatment, there were 866 (40%) deaths in the clarithromycin group and 815 (37%) deaths in the placebo group that represented a hazard ratio for all-cause mortality of 1.10 (95% confidence interval 1.00 to 1.21). The difference in the number of deaths emerged after one year or more after the end of treatment.

The cause of the difference in all-cause mortality has not been established. Other epidemiologic studies evaluating this risk have shown variable results [see *Warnings and Precautions (5.5)*].

6.2 Postmarketing Experience

The following adverse reactions have been identified during post-approval use of clarithromycin. 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.

Blood and Lymphatic System: Thrombocytopenia, agranulocytosis

Cardiac: Ventricular arrhythmia, ventricular tachycardia, *torsades de pointes*

Ear and Labyrinth: Deafness was reported chiefly in elderly women and was usually reversible.

Gastrointestinal: Pancreatitis acute, tongue discoloration, tooth discoloration was reported and was usually reversible with professional cleaning upon discontinuation of the drug.

There have been reports of clarithromycin extended-release tablets in the stool, many of which have occurred in patients with anatomic (including ileostomy or colostomy) or functional gastrointestinal disorders with shortened GI transit times. In several reports, tablet residues have occurred in the context of diarrhea. It is recommended that patients who experience tablet residue in the stool and no improvement in their condition should be switched to a different clarithromycin formulation (e.g. suspension) or another antibacterial drug.

Hepatobiliary: Hepatic failure, jaundice hepatocellular. Adverse reactions related to hepatic dysfunction have been reported with clarithromycin [see *Warnings and Precautions (5.2)*].

Infections and Infestations: Pseudomembranous colitis [see *Warnings and Precautions (5.6)*]

Immune System: Anaphylactic reactions, angioedema

Investigations: Prothrombin time prolonged, white blood cell count decreased, international normalized ratio increased. Abnormal urine color has been reported, associated with hepatic failure.

Metabolism and Nutrition: Hypoglycemia has been reported in patients taking oral hypoglycemic agents or insulin.

Musculoskeletal and Connective Tissue: Myopathy rhabdomyolysis was reported and in some of the reports, clarithromycin was administered concomitantly with statins, fibrates, colchicine or allopurinol [see *Contraindications (4.5)* and *Warnings and Precautions (5.4)*].

Nervous System: Parosmia, anosmia, ageusia, paresthesia and convulsions

Psychiatric: Abnormal behavior, confusional state, depersonalization, disorientation, hallucination, depression, manic behavior, abnormal dream, psychotic disorder. These disorders usually resolve upon discontinuation of the drug.

Renal and Urinary: Nephritis interstitial, renal failure

Skin and Subcutaneous Tissue: Stevens-Johnson syndrome, toxic epidermal necrolysis, drug rash with

eosinophilia and systemic symptoms (DRESS), Henoch-Schonlein purpura, acne, acute generalized exanthematous pustulosis

Vascular: Hemorrhage

7 DRUG INTERACTIONS

Co-administration of clarithromycin is known to inhibit CYP3A, and a drug primarily metabolized by CYP3A may be associated with elevations in drug concentrations that could increase or prolong both therapeutic and adverse effects of the concomitant drug.

Clarithromycin should be used with caution in patients receiving treatment with other drugs known to be CYP3A enzyme substrates, especially if the CYP3A substrate has a narrow safety margin (e.g., carbamazepine) and/or the substrate is extensively metabolized by this enzyme. Adjust dosage when appropriate and monitor serum concentrations of drugs primarily metabolized by CYP3A closely in patients concurrently receiving clarithromycin.

Table 7: Clinically Significant Drug Interactions with Clarithromycin

Drugs That Are Affected By Clarithromycin		
Drug(s) with Pharmacokinetics Affected by Clarithromycin	Recommendation	Comments
<p>Antiarrhythmics:</p> <p>Disopyramide Quinidine Dofetilide Amiodarone Sotalol Procainamide</p>	Not Recommended	<p><u>Disopyramide, Quinidine:</u> There have been postmarketing reports of <i>torsades de pointes</i> occurring with concurrent use of clarithromycin and quinidine or disopyramide. Electrocardiograms should be monitored for QTc prolongation during coadministration of clarithromycin with these drugs [see Warnings and Precautions (5.3)] .</p> <p>Serum concentrations of these medications should also be monitored. There have been spontaneous or published reports of CYP3A based interactions of clarithromycin with disopyramide and quinidine.</p> <p>There have been postmarketing reports of hypoglycemia with the concomitant administration of clarithromycin and disopyramide. Therefore, blood glucose levels should be monitored during concomitant administration of clarithromycin and disopyramide.</p>
Digoxin	Use With Caution	<p><u>Digoxin:</u> Digoxin is a substrate for P-glycoprotein (Pgp) and clarithromycin is known to inhibit Pgp. When clarithromycin and digoxin are co-administered, inhibition of Pgp by clarithromycin may lead to increased exposure of digoxin. Elevated digoxin serum concentrations in patients receiving clarithromycin and digoxin concomitantly have been reported in postmarketing surveillance. Some patients have shown clinical signs</p>

		consistent with digoxin toxicity, including potentially fatal arrhythmias. Monitoring of serum digoxin concentrations should be considered, especially for patients with digoxin concentrations in the upper therapeutic range.
Oral Anticoagulants:		
Warfarin	Use With Caution	<u>Oral anticoagulants</u> : Spontaneous reports in the postmarketing period suggest that concomitant administration of clarithromycin and oral anticoagulants may potentiate the effects of the oral anticoagulants. Prothrombin times should be carefully monitored while patients are receiving clarithromycin and oral anticoagulants simultaneously [see <i>Warnings and Precautions (5.4)</i>].
Antiepileptics:		
Carbamazepine	Use With Caution	<u>Carbamazepine</u> : Concomitant administration of single doses of clarithromycin and carbamazepine has been shown to result in increased plasma concentrations of carbamazepine. Blood level monitoring of carbamazepine may be considered. Increased serum concentrations of carbamazepine were observed in clinical trials with clarithromycin. There have been spontaneous or published reports of CYP3A based interactions of clarithromycin with carbamazepine.
Antifungals:		
Itraconazole	Use With Caution	<u>Itraconazole</u> : Both clarithromycin and itraconazole are substrates and inhibitors of CYP3A, potentially leading to a bi-directional drug interaction when administered concomitantly (see also Itraconazole under “Drugs That Affect Clarithromycin” in the table below). Clarithromycin may increase the plasma concentrations of itraconazole. Patients taking itraconazole and clarithromycin concomitantly should be monitored closely for signs or symptoms of increased or prolonged adverse reactions.
Fluconazole	No Dose Adjustment	<u>Fluconazole</u> : [see <i>Pharmacokinetics (12.3)</i>]

<p>Anti-Gout Agents:</p> <p>Colchicine (in patients with renal or hepatic impairment)</p> <p>Colchicine (in patients with normal renal and hepatic function)</p>	<p>Contraindicated</p> <p>Use With Caution</p>	<p><u>Colchicine:</u> Colchicine is a substrate for both CYP3A and the efflux transporter, P-glycoprotein (Pgp). Clarithromycin and other macrolides are known to inhibit CYP3A and Pgp. The dose of colchicine should be reduced when co-administered with clarithromycin in patients with normal renal and hepatic function [see <i>Contraindications (4.4) and Warnings and Precautions (5.4)</i>].</p>
<p>Antipsychotics:</p> <p>Pimozide</p> <p>Quetiapine</p>	<p>Contraindicated</p>	<p><u>Pimozide:</u> [See <i>Contraindications (4.2)</i>]</p> <p><u>Quetiapine:</u> Quetiapine is a substrate for CYP3A4, which is inhibited by clarithromycin. Co-administration with clarithromycin could result in increased quetiapine exposure and possible quetiapine related toxicities. There have been postmarketing reports of somnolence, orthostatic hypotension, altered state of consciousness, neuroleptic malignant syndrome, and QT prolongation during concomitant administration. Refer to quetiapine prescribing information for recommendations on dose reduction if co-administered with CYP3A4 inhibitors such as clarithromycin.</p>
<p>Antispasmodics:</p> <p>Tolterodine (patients deficient in CYP2D6 activity)</p>	<p>Use With Caution</p>	<p><u>Tolterodine:</u> The primary route of metabolism for tolterodine is via CYP2D6. However, in a subset of the population devoid of CYP2D6, the identified pathway of metabolism is via CYP3A. In this population subset, inhibition of CYP3A results in significantly higher serum concentrations of tolterodine. Tolterodine 1 mg twice daily is recommended in patients deficient in CYP2D6 activity (poor metabolizers) when co-administered with clarithromycin.</p>
<p>Antivirals:</p> <p>Atazanavir</p>	<p>Use With Caution</p>	<p><u>Atazanavir:</u> Both clarithromycin and atazanavir are substrates and inhibitors of CYP3A, and there is evidence of a bi-directional drug interaction (see Atazanavir under</p>

<p>Saquinavir (in patients with decreased renal function)</p> <p>Ritonavir Etravirine</p> <p>Maraviroc</p> <p>Boceprevir (in patients with normal renal function)</p> <p>Didanosine</p> <p>Zidovudine</p>	<p>No Dose Adjustment</p>	<p>“Drugs That Affect Clarithromycin” in the table below) [see <i>Pharmacokinetics (12.3)</i>].</p> <p><u>Saquinavir</u>: Both clarithromycin and saquinavir are substrates and inhibitors of CYP3A and there is evidence of a bi-directional drug interaction (see Saquinavir under “Drugs That Affect Clarithromycin” in the table below) [see <i>Pharmacokinetics (12.3)</i>].</p> <p><u>Ritonavir, Etravirine</u>: (see Ritonavir and Etravirine under “Drugs That Affect Clarithromycin” in the table below) [see <i>Pharmacokinetics (12.3)</i>].</p> <p><u>Maraviroc</u>: Clarithromycin may result in increases in maraviroc exposures by inhibition of CYP3A metabolism. See Selzentry[®] prescribing information for dose recommendation when given with strong CYP3A inhibitors such as clarithromycin.</p> <p><u>Boceprevir</u>: Both clarithromycin and boceprevir are substrates and inhibitors of CYP3A, potentially leading to a bi-directional drug interaction when co-administered. No dose adjustments are necessary for patients with normal renal function (see Victrelis[®] prescribing information).</p> <p><u>Zidovudine</u>: Simultaneous oral administration of clarithromycin immediate-release tablets and zidovudine to HIV-infected adult patients may result in decreased steady-state zidovudine concentrations. Administration of clarithromycin and zidovudine should be separated by at least two hours [see <i>Pharmacokinetics (12.3)</i>].</p> <p>The impact of co-administration of clarithromycin extended-release tablets or granules and zidovudine has not been evaluated.</p>
<p>Calcium Channel Blockers:</p> <p>Verapamil</p>	<p>Use With Caution</p>	<p><u>Verapamil</u>: Hypotension, bradyarrhythmias, and lactic acidosis have been observed in patients receiving concurrent verapamil, [see <i>Warnings and Precautions (5.4)</i>].</p>

Amlodipine Diltiazem		<u>Amlodipine, Diltiazem:</u> <i>[See Warnings and Precautions (5.4)]</i>
Nifedipine		<u>Nifedipine:</u> Nifedipine is a substrate for CYP3A. Clarithromycin and other macrolides are known to inhibit CYP3A. There is potential of CYP3A-mediated interaction between nifedipine and clarithromycin. Hypotension and peripheral edema were observed when clarithromycin was taken concomitantly with nifedipine <i>[see Warnings and Precautions (5.4)]</i> .
Ergot Alkaloids:		
Ergotamine Dihydroergotamine	Contraindicated	<u>Ergotamine, Dihydroergotamine:</u> Postmarketing reports indicate that coadministration of clarithromycin with ergotamine or dihydroergotamine has been associated with acute ergot toxicity characterized by vasospasm and ischemia of the extremities and other tissues including the central nervous system <i>[see Contraindications (4.6)]</i> .
Gastroprokinetic Agents:		
Cisapride	Contraindicated	<u>Cisapride:</u> <i>[See Contraindications (4.2)]</i>
HMG-CoA Reductase Inhibitors:		
Lovastatin Simvastatin	Contraindicated	<u>Lovastatin, Simvastatin, Atorvastatin, Pravastatin, Fluvastatin:</u> <i>[See Contraindications (4.5)and Warnings and Precautions (5.4)]</i>
Atorvastatin Pravastatin	Use With Caution	
Fluvastatin	No Dose Adjustment	
Hypoglycemic Agents:		
Nateglinide	Use With Caution	<u>Nateglinide, Pioglitazone, Repaglinide,</u>

Pioglitazone Repaglinide Rosiglitazone		<u>Rosiglitazone:</u> [See Warnings and Precautions (5.4) and Adverse Reactions (6.2)]
Insulin		<u>Insulin:</u> [See Warnings and Precautions (5.4) and Adverse Reactions (6.2)]
Immunosuppressants:		
Cyclosporine	Use With Caution	<u>Cyclosporine:</u> There have been spontaneous or published reports of CYP3A based interactions of clarithromycin with cyclosporine.
Tacrolimus		<u>Tacrolimus:</u> There have been spontaneous or published reports of CYP3A based interactions of clarithromycin with tacrolimus.
Phosphodiesterase inhibitors:		
Sildenafil Tadalafil Vardenafil	Use With Caution	<u>Sildenafil, Tadalafil, Vardenafil:</u> Each of these phosphodiesterase inhibitors is primarily metabolized by CYP3A, and CYP3A will be inhibited by concomitant administration of clarithromycin. Co-administration of clarithromycin with sildenafil, tadalafil, or vardenafil will result in increased exposure of these phosphodiesterase inhibitors. Co-administration of these phosphodiesterase inhibitors with clarithromycin is not recommended. Increased systemic exposure of these drugs may occur with clarithromycin; reduction of dosage for phosphodiesterase inhibitors should be considered (see their respective prescribing information).
Proton Pump Inhibitors:		
Omeprazole	No Dose Adjustment	<u>Omeprazole:</u> The mean 24-hour gastric pH value was 5.2 when omeprazole was administered alone and 5.7 when coadministered with clarithromycin as a result of increased omeprazole exposures [see Pharmacokinetics (12.3)] (see also Omeprazole under “Drugs That Affect Clarithromycin” in the table below).
Xanthine Derivatives:		

Theophylline	Use With Caution	<u>Theophylline</u> : Clarithromycin use in patients who are receiving theophylline may be associated with an increase of serum theophylline concentrations [see <i>Pharmacokinetics (12.3)</i>]. Monitoring of serum theophylline concentrations should be considered for patients receiving high doses of theophylline or with baseline concentrations in the upper therapeutic range.
Triazolobenzodiazepines and Other Related Benzodiazepines: Midazolam Alprazolam Triazolam	Use With Caution	<u>Midazolam</u> : When oral midazolam is co-administered with clarithromycin, dose adjustments may be necessary and possible prolongation and intensity of effect should be anticipated [see <i>Warnings and Precautions (5.4)</i> and <i>Pharmacokinetics (12.3)</i>]. <u>Triazolam, Alprazolam</u> : Caution and appropriate dose adjustments should be considered when triazolam or alprazolam is co-administered with clarithromycin. There have been postmarketing reports of drug interactions and central nervous system (CNS) effects (e.g., somnolence and confusion) with the concomitant use of clarithromycin and triazolam. Monitoring the patient for increased CNS pharmacological effects is suggested. In postmarketing experience, erythromycin has been reported to decrease the clearance of triazolam and midazolam, and thus, may increase the pharmacologic effect of these benzodiazepines.
Temazepam Nitrazepam Lorazepam	No Dose Adjustment	<u>Temazepam, Nitrazepam, Lorazepam</u> : For benzodiazepines which are not metabolized by CYP3A (e.g., temazepam, nitrazepam, lorazepam), a clinically important interaction with clarithromycin is unlikely.
Cytochrome P450 Inducers: Rifabutin	Use With Caution	<u>Rifabutin</u> : Concomitant administration of rifabutin and clarithromycin resulted in an increase in rifabutin, and decrease in clarithromycin serum levels together with an increased risk of uveitis (see Rifabutin under “Drugs That

		Affect Clarithromycin” in the table below).
Other Drugs Metabolized by CYP3A:		
Alfentanil Bromocriptine Cilostazol Methylprednisolone Vinblastine Phenobarbital St. John’s Wort	Use With Caution	There have been spontaneous or published reports of CYP3A based interactions of clarithromycin with alfentanil, methylprednisolone, cilostazol, bromocriptine, vinblastine, phenobarbital, and St. John’s Wort.
Other Drugs Metabolized by CYP450 Isoforms Other than CYP3A:		
Hexobarbital Phenytoin Valproate	Use With Caution	There have been postmarketing reports of interactions of clarithromycin with drugs not thought to be metabolized by CYP3A, including hexobarbital, phenytoin, and valproate.
Drugs that Affect Clarithromycin		
Drug(s) that Affect the Pharmacokinetics of Clarithromycin	Recommendation	Comments
Antifungals:		
Itraconazole	Use With Caution	<u>Itraconazole</u> : Itraconazole may increase the plasma concentrations of clarithromycin. Patients taking itraconazole and clarithromycin concomitantly should be monitored closely for signs or symptoms of increased or prolonged adverse reactions (see also Itraconazole under “Drugs That Are Affected By Clarithromycin” in the table above).
Antivirals:		
Atazanavir	Use With Caution	<u>Atazanavir</u> : When clarithromycin is co-administered with atazanavir, the dose of clarithromycin should be decreased by 50% [see <i>Clinical Pharmacology (12.3)</i>] . Since concentrations of 14-OH clarithromycin are

<p>Ritonavir (in patients with decreased renal function)</p> <p>Saquinavir (in patients with decreased renal function)</p> <p>Etravirine</p> <p>Saquinavir (in patients with normal renal function) Ritonavir (in patients with normal renal function)</p>	<p>No Dose Adjustment</p>	<p>significantly reduced when clarithromycin is co-administered with atazanavir, alternative antibacterial therapy should be considered for indications other than infections due to <i>Mycobacterium avium</i> complex. Doses of clarithromycin greater than 1000 mg per day should not be co-administered with protease inhibitors.</p> <p><u>Ritonavir:</u> Since concentrations of 14-OH clarithromycin are significantly reduced when clarithromycin is co-administered with ritonavir, alternative antibacterial therapy should be considered for indications other than infections due to <i>Mycobacterium avium</i>[see <i>Pharmacokinetics (12.3)</i>].</p> <p>Doses of clarithromycin greater than 1000 mg per day should not be co-administered with protease inhibitors.</p> <p><u>Saquinavir:</u> When saquinavir is co-administered with ritonavir, consideration should be given to the potential effects of ritonavir on clarithromycin (refer to ritonavir above) [see <i>Pharmacokinetics (12.3)</i>].</p> <p><u>Etravirine:</u> Clarithromycin exposure was decreased by etravirine; however, concentrations of the active metabolite, 14-OH-clarithromycin, were increased. Because 14-OH-clarithromycin has reduced activity against <i>Mycobacterium avium</i> complex (MAC), overall activity against this pathogen may be altered; therefore alternatives to clarithromycin should be considered for the treatment of MAC.</p>
<p>Proton Pump Inhibitors:</p> <p>Omeprazole</p>	<p>Use With Caution</p>	<p><u>Omeprazole:</u> Clarithromycin concentrations in the gastric tissue and mucus were also increased by concomitant administration of omeprazole [see <i>Pharmacokinetics (12.3)</i>].</p>

Miscellaneous Cytochrome P450 Inducers: Efavirenz Nevirapine Rifampicin Rifabutin Rifapentine	Use With Caution	Inducers of CYP3A enzymes, such as efavirenz, nevirapine, rifampicin, rifabutin, and rifapentine will increase the metabolism of clarithromycin, thus decreasing plasma concentrations of clarithromycin, while increasing those of 14-OH-clarithromycin. Since the microbiological activities of clarithromycin and 14-OH-clarithromycin are different for different bacteria, the intended therapeutic effect could be impaired during concomitant administration of clarithromycin and enzyme inducers. Alternative antibacterial treatment should be considered when treating patients receiving inducers of CYP3A. There have been spontaneous or published reports of CYP3A based interactions of clarithromycin with rifabutin (see Rifabutin under “Drugs That Are Affected By Clarithromycin” in the table above).
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8 USE IN SPECIFIC POPULATIONS

8.1 Pregnancy

Teratogenic Effects

Pregnancy Category C

Clarithromycin should not be used in pregnant women except in clinical circumstances where no alternative therapy is appropriate. If pregnancy occurs while taking this drug, the patient should be apprised of the potential hazard to the fetus [see *Warnings and Precautions (5.7)*].

Four teratogenicity studies in rats (three with oral doses and one with intravenous doses up to 160 mg/kg/day administered during the period of major organogenesis) and two in rabbits at oral doses up to 125 mg/kg/day (approximately twice the recommended maximum human dose based on mg/m²) or intravenous doses of 30 mg/kg/day administered during gestation days 6 to 18 failed to demonstrate any teratogenicity from clarithromycin. Two additional oral studies in a different rat strain at similar doses and similar conditions demonstrated a low incidence of cardiovascular anomalies at doses of 150 mg/kg/day administered during gestation days 6 to 15. Plasma levels after 150 mg/kg/day were twice the human serum levels. Four studies in mice revealed a variable incidence of cleft palate following oral doses of 1000 mg/kg/day (2 and 4 times the recommended maximum human dose based on mg/m², respectively) during gestation days 6 to 15. Cleft palate was also seen at 500 mg/kg/day. The 1000 mg/kg/day exposure resulted in plasma levels 17 times the human serum levels. In monkeys, an oral dose of 70 mg/kg/day produced fetal growth retardation at plasma levels that were twice the human serum levels.

8.3 Nursing Mothers

Caution should be exercised when clarithromycin is administered to nursing women. The development and health benefits of human milk feeding should be considered along with the mother’s clinical need for clarithromycin and any potential adverse effects on the human milk fed child from the drug or from the underlying maternal condition.

Clarithromycin and its active metabolite 14-hydroxy clarithromycin are excreted in human milk. Serum and milk samples were obtained after 3 days of treatment, at steady state, from one published study of 12

lactating women who were taking clarithromycin 250 mg orally twice daily. Based on the limited data from this study, and assuming milk consumption of 150 mL/kg/day, an exclusively human milk fed infant would receive an estimated average of 136 mcg/kg/day of clarithromycin and its active metabolite, with this maternal dosage regimen. This is less than 2% of the maternal weight-adjusted dose (7.8 mg/kg/day, based on the average maternal weight of 64 kg), and less than 1% of the pediatric dose (15 mg/kg/day) for children greater than 6 months of age.

A prospective observational study of 55 breastfed infants of mothers taking a macrolide antibacterial (6 were exposed to clarithromycin) were compared to 36 breastfed infants of mothers taking amoxicillin. Adverse reactions were comparable in both groups. Adverse reactions occurred in 12.7% of infants exposed to macrolides and included rash, diarrhea, loss of appetite, and somnolence.

8.4 Pediatric Use

The safety and effectiveness of clarithromycin extended-release tablets in the treatment of pediatric patients has not been established.

Safety and effectiveness of clarithromycin in pediatric patients under 6 months of age have not been established. The safety of clarithromycin has not been studied in MAC patients under the age of 20 months.

8.5 Geriatric Use

In a steady-state study in which healthy elderly subjects (65 years to 81 years of age) were given 500 mg of clarithromycin every 12 hours, the maximum serum concentrations and area under the curves of clarithromycin and 14-OH clarithromycin were increased compared to those achieved in healthy young adults. These changes in pharmacokinetics parallel known age-related decreases in renal function. In clinical trials, elderly patients did not have an increased incidence of adverse reactions when compared to younger patients. Consider dosage adjustment in elderly patients with severe renal impairment. Elderly patients may be more susceptible to development of *torsades de pointes* arrhythmias than younger patients [see *Warnings and Precautions (5.3)*].

Most reports of acute kidney injury with calcium channel blockers metabolized by CYP3A4 (e.g., verapamil, amlodipine, diltiazem, nifedipine) involved elderly patients 65 years of age or older [see *Warnings and Precautions (5.4)*].

Especially in elderly patients, there have been reports of colchicine toxicity with concomitant use of clarithromycin and colchicine, some of which occurred in patients with renal insufficiency. Deaths have been reported in some patients [see *Contraindications (4.4)* and *Warnings and Precautions (5.4)*].

8.6 Renal and Hepatic Impairment

Clarithromycin is principally excreted via the liver and kidney. Clarithromycin may be administered without dosage adjustment to patients with hepatic impairment and normal renal function. However, in the presence of severe renal impairment with or without coexisting hepatic impairment, decreased dosage or prolonged dosing intervals may be appropriate [see *Dosage and Administration (2.5)*].

10 OVERDOSAGE

Overdosage of clarithromycin can cause gastrointestinal symptoms such as abdominal pain, vomiting, nausea, and diarrhea.

Treat adverse reactions accompanying overdosage by the prompt elimination of unabsorbed drug and supportive measures. As with other macrolides, clarithromycin serum concentrations are not expected to be appreciably affected by hemodialysis or peritoneal dialysis.

11 DESCRIPTION

Clarithromycin is a semi-synthetic macrolide antimicrobial for oral use. Chemically, it is 6-*O*-methylerythromycin. The molecular formula is C₃₈H₆₉NO₁₃, and the molecular weight is 747.96. The structural formula is:

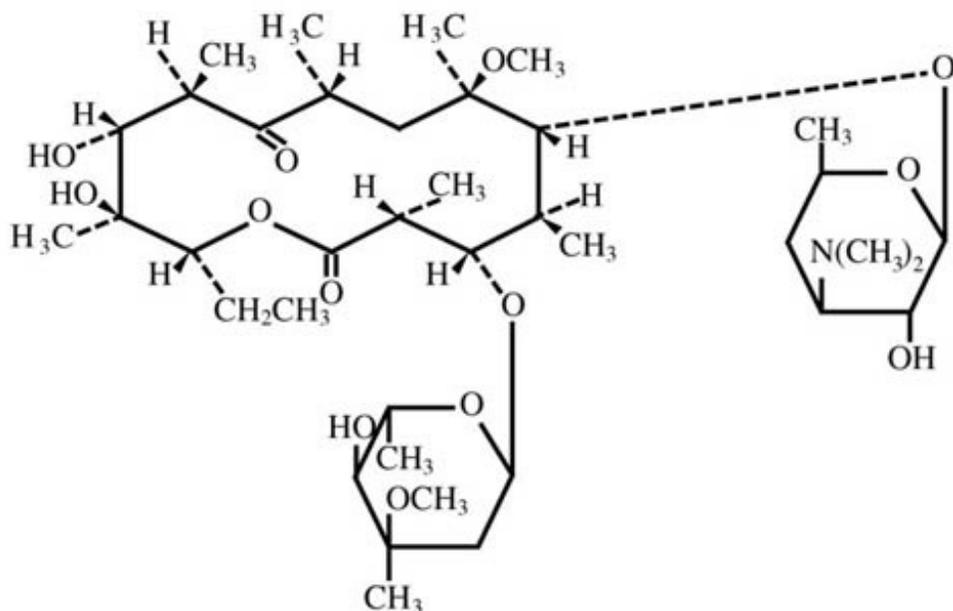


Figure 1: Structure of Clarithromycin

Clarithromycin is a white to off-white crystalline powder. It is soluble in acetone, slightly soluble in methanol, ethanol, and acetonitrile, and practically insoluble in water.

Clarithromycin is available as extended-release tablets.

Each white or off-white, capsular-shaped film-coated Clarithromycin Extended-release Tablets, USP contains 500 mg of clarithromycin and the following inactive ingredients: glyceryl dibehenate, hypromellose, lactose monohydrate, magnesium stearate, polyethylene glycol, and titanium dioxide.

Clarithromycin Extended-release Tablets, USP meets the dissolution specifications which were established according to the USP monograph-Clarithromycin Extended-release Tablets Test 2.

12 CLINICAL PHARMACOLOGY

12.1 Mechanism of Action

Clarithromycin is a macrolide antimicrobial drug [see *Microbiology (12.4)*].

12.3 Pharmacokinetics

Absorption

Clarithromycin Immediate-Release Tablets

The absolute bioavailability of 250 mg clarithromycin tablets was approximately 50%. For a single 500 mg dose of clarithromycin, food slightly delays the onset of clarithromycin absorption, increasing the peak time from approximately 2 to 2.5 hours. Food also increases the clarithromycin peak plasma concentration by about 24%, but does not affect the extent of clarithromycin bioavailability. Food does not affect the onset of formation of the active metabolite, 14-OH clarithromycin or its peak plasma concentration but does slightly decrease the extent of metabolite formation, indicated by an 11% decrease in area under the plasma concentration-time curve (AUC). Therefore, clarithromycin tablets

may be given without regard to food. In non-fasting healthy human subjects (males and females), peak plasma concentrations were attained within 2 to 3 hours after oral dosing.

Clarithromycin Extended-Release Tablets

Clarithromycin extended-release tablets provide extended absorption of clarithromycin from the gastrointestinal tract after oral administration. Relative to an equal total daily dose of immediate-release clarithromycin tablets, clarithromycin extended-release tablets provide lower and later steady-state peak plasma concentrations but equivalent 24-hour AUCs for both clarithromycin and its microbiologically-active metabolite, 14-OH clarithromycin. While the extent of formation of 14-OH clarithromycin following administration of clarithromycin extended-release tablets (2 x 500 mg tablets once daily) is not affected by food, administration under fasting conditions is associated with approximately 30% lower clarithromycin AUC relative to administration with food. Therefore, clarithromycin extended-release tablets should be taken with food.

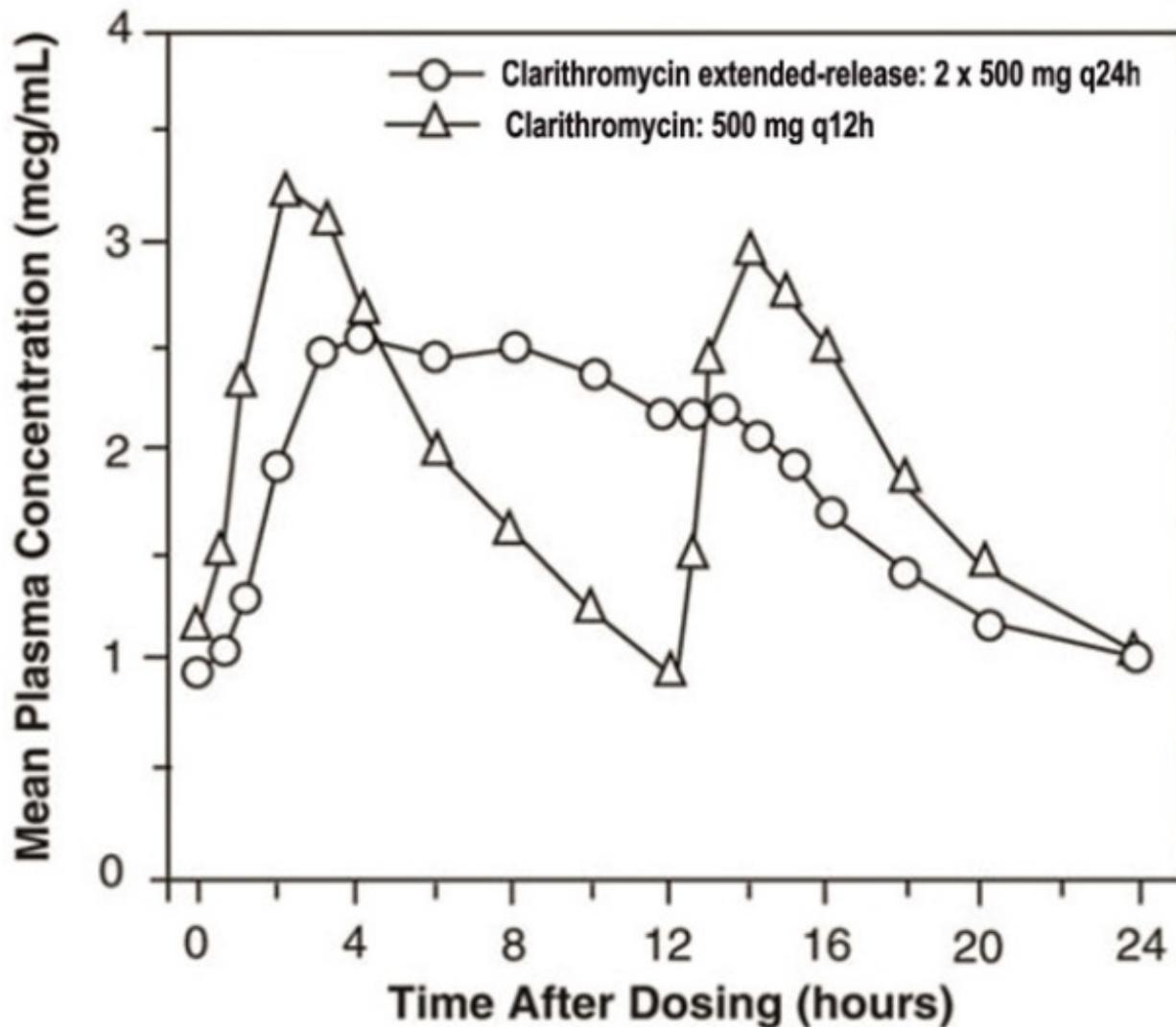


Figure 2: Steady-State Clarithromycin Plasma Concentration-Time Profiles

Clarithromycin Granules For Oral Suspension

When 250 mg doses of clarithromycin as an oral suspension were administered to fasting healthy adult subjects, peak plasma concentrations were attained around 3 hours after dosing.

For adult patients, the bioavailability of 10 mL of the 125 mg/5 mL suspension or 10 mL of the 250 mg/5 mL suspension is similar to a 250 mg or 500 mg tablet, respectively.

In adults given 250 mg clarithromycin as suspension (n = 22), food appeared to decrease mean peak plasma clarithromycin concentrations from 1.2 (\pm 0.4) mcg/mL to 1.0 (\pm 0.4) mcg/mL and the extent of absorption from 7.2 (\pm 2.5) hr•mcg/mL to 6.5 (\pm 3.7) hr•mcg/mL.

Distribution

Clarithromycin and the 14-OH clarithromycin metabolite distribute readily into body tissues and fluids. There are no data available on cerebrospinal fluid penetration. Because of high intracellular concentrations, tissue concentrations are higher than serum concentrations. Examples of tissue and serum concentrations are presented below.

Table 8. Tissue and Serum Concentrations of Clarithromycin

CONCENTRATION (after 250 mg every 12 hours)		
Tissue Type	Tissue (mcg/g)	Serum (mcg/mL)
Tonsil	1.6	0.8
Lung	8.8	1.7

Metabolism and Elimination

Clarithromycin Immediate-Release Tablets

Steady-state peak plasma clarithromycin concentrations were attained within 3 days and were approximately 1 mcg/mL to 2 mcg/mL with a 250 mg dose administered every 12 hours and 3 mcg/mL to 4 mcg/mL with a 500 mg dose administered every 8 hours to 12 hours. The elimination half-life of clarithromycin was about 3 hours to 4 hours with 250 mg administered every 12 hours but increased to 5 hours to 7 hours with 500 mg administered every 8 hours to 12 hours. The nonlinearity of clarithromycin pharmacokinetics is slight at the recommended doses of 250 mg and 500 mg administered every 8 hours to 12 hours. With a 250 mg every 12 hours dosing, the principal metabolite, 14-OH clarithromycin, attains a peak steady-state concentration of about 0.6 mcg/mL and has an elimination half-life of 5 hours to 6 hours. With a 500 mg every 8 hours to 12 hours dosing, the peak steady-state concentration of 14-OH clarithromycin is slightly higher (up to 1 mcg/mL), and its elimination half-life is about 7 hours to 9 hours. With any of these dosing regimens, the steady-state concentration of this metabolite is generally attained within 3 days to 4 days.

After a 250 mg tablet every 12 hours, approximately 20% of the dose is excreted in the urine as clarithromycin, while after a 500 mg tablet every 12 hours, the urinary excretion of clarithromycin is somewhat greater, approximately 30%. In comparison, after an oral dose of 250 mg (125 mg/5 mL) suspension every 12 hours, approximately 40% is excreted in urine as clarithromycin. The renal clearance of clarithromycin is, however, relatively independent of the dose size and approximates the normal glomerular filtration rate. The major metabolite found in urine is 14-OH clarithromycin, which accounts for an additional 10% to 15% of the dose with either a 250 mg or a 500 mg tablet administered every 12 hours.

Clarithromycin Extended-Release Tablets

In healthy human subjects, steady-state peak plasma clarithromycin concentrations of approximately 2 mcg/mL to 3 mcg/mL were achieved about 5 hours to 8 hours after oral administration of 1000 mg clarithromycin extended-release tablets once daily; for 14-OH clarithromycin, steady-state peak plasma concentrations of approximately 0.8 mcg/mL were attained about 6 hours to 9 hours after dosing. Steady-state peak plasma clarithromycin concentrations of approximately 1 mcg/mL to 2 mcg/mL were achieved about 5 hours to 6 hours after oral administration of a single 500 mg clarithromycin extended-release tablets once daily; for 14-OH clarithromycin, steady-state peak plasma concentrations of approximately 0.6 mcg/mL were attained about 6 hours after dosing.

Steady-state peak plasma concentrations were attained in 2 days to 3 days and were approximately 2

mcg/mL for clarithromycin and 0.7 mcg/mL for 14-OH clarithromycin when 250-mg doses of the clarithromycin suspension were administered every 12 hours. Elimination half-life of clarithromycin (3 hours to 4 hours) and that of 14-OH clarithromycin (5 hours to 7 hours) were similar to those observed at steady state following administration of equivalent doses of clarithromycin immediate-release tablets.

Specific Populations for Clarithromycin Immediate-release Tablets, Clarithromycin Extended-release Tablets, and Clarithromycin Granules Formulations

Clarithromycin Granules For Oral Suspension in Pediatric Patients

Clarithromycin penetrates into the middle ear fluid of pediatric patients with secretory otitis media.

Table 9. Middle Ear Fluid and Serum Concentrations of Clarithromycin and 14-OH-Clarithromycin in Pediatric Patients

CONCENTRATION (after 7.5 mg/kg every 12 hours for 5 doses)		
Analyte	Middle Ear Fluid (mcg/mL)	Serum (mcg/mL)
Clarithromycin	2.5	1.7
14-OH Clarithromycin	1.3	0.8

When pediatric patients (n = 10) were administered a single oral dose of 7.5 mg/kg clarithromycin as an oral suspension, food increased mean peak plasma clarithromycin concentrations from 3.6 (± 1.5) mcg/mL to 4.6 (± 2.8) mcg/mL and the extent of absorption from 10.0 (± 5.5) hr•mcg/mL to 14.2 (± 9.4) hr•mcg/mL.

In pediatric patients requiring antibacterial therapy, administration of 7.5 mg/kg every 12 hours of clarithromycin as an oral suspension generally resulted in steady-state peak plasma concentrations of 3 mcg/mL to 7 mcg/mL for clarithromycin and 1 mcg/mL to 2 mcg/mL for 14-OH clarithromycin.

In HIV-infected pediatric patients taking 15 mg/kg of clarithromycin as an oral suspension every 12 hours, steady-state clarithromycin peak concentrations generally ranged from 6 mcg/mL to 15 mcg/mL.

HIV Infection

Steady-state concentrations of clarithromycin and 14-OH clarithromycin observed following administration of 500 mg doses of clarithromycin every 12 hours to adult patients with HIV infection were similar to those observed in healthy volunteers. In adult HIV-infected patients taking 500-mg or 1000-mg doses of clarithromycin every 12 hours, steady-state clarithromycin C_{max} values ranged from 2 mcg/mL to 4 mcg/mL and 5 mcg/mL to 10 mcg/mL, respectively.

Hepatic Impairment

The steady-state concentrations of clarithromycin in subjects with impaired hepatic function did not differ from those in normal subjects; however, the 14-OH clarithromycin concentrations were lower in the hepatically impaired subjects. The decreased formation of 14-OH clarithromycin was at least partially offset by an increase in renal clearance of clarithromycin in the subjects with impaired hepatic function when compared to healthy subjects.

Renal Impairment

The pharmacokinetics of clarithromycin was also altered in subjects with impaired renal function [see *Use in Specific Populations (8.6) and Dosage and Administration (2.5)*].

Drug Interactions

Fluconazole

Following administration of fluconazole 200 mg daily and clarithromycin 500 mg twice daily to 21 healthy volunteers, the steady-state clarithromycin C_{min} and AUC increased 33% and 18%,

respectively. Clarithromycin exposures were increased and steady-state concentrations of 14-OH clarithromycin were not significantly affected by concomitant administration of fluconazole.

Colchicine

When a single dose of colchicine 0.6 mg was administered with clarithromycin 250 mg BID for 7 days, the colchicine C_{max} increased 197% and the $AUC_{0-\infty}$ increased 239% compared to administration of colchicine alone.

Atazanavir

Following administration of clarithromycin (500 mg twice daily) with atazanavir (400 mg once daily), the clarithromycin AUC increased 94%, the 14-OH clarithromycin AUC decreased 70% and the atazanavir AUC increased 28%.

Ritonavir

Concomitant administration of clarithromycin and ritonavir (n = 22) resulted in a 77% increase in clarithromycin AUC and a 100% decrease in the AUC of 14-OH clarithromycin.

Saquinavir

Following administration of clarithromycin (500 mg bid) and saquinavir (soft gelatin capsules, 1200 mg tid) to 12 healthy volunteers, the steady-state saquinavir AUC and C_{max} increased 177% and 187% respectively compared to administration of saquinavir alone. Clarithromycin AUC and C_{max} increased 45% and 39% respectively, whereas the 14-OH clarithromycin AUC and C_{max} decreased 24% and 34% respectively, compared to administration with clarithromycin alone.

Didanosine

Simultaneous administration of clarithromycin tablets and didanosine to 12 HIV-infected adult patients resulted in no statistically significant change in didanosine pharmacokinetics.

Zidovudine

Following administration of clarithromycin 500 mg tablets twice daily with zidovudine 100 mg every 4 hours, the steady-state zidovudine AUC decreased 12% compared to administration of zidovudine alone (n=4). Individual values ranged from a decrease of 34% to an increase of 14%. When clarithromycin tablets were administered two to four hours prior to zidovudine, the steady-state zidovudine C_{max} increased 100% whereas the AUC was unaffected (n=24).

Omeprazole

Clarithromycin 500 mg every 8 hours was given in combination with omeprazole 40 mg daily to healthy adult subjects. The steady-state plasma concentrations of omeprazole were increased (C_{max} , AUC_{0-24} , and $t_{1/2}$ increases of 30%, 89%, and 34%, respectively), by the concomitant administration of clarithromycin.

The plasma levels of clarithromycin and 14-OH clarithromycin were increased by the concomitant administration of omeprazole. For clarithromycin, the mean C_{max} was 10% greater, the mean C_{min} was 27% greater, and the mean AUC_{0-8} was 15% greater when clarithromycin was administered with omeprazole than when clarithromycin was administered alone. Similar results were seen for 14-OH clarithromycin, the mean C_{max} was 45% greater, the mean C_{min} was 57% greater, and the mean AUC_{0-8} was 45% greater. Clarithromycin concentrations in the gastric tissue and mucus were also increased by concomitant administration of omeprazole.

Clarithromycin Tissue Concentrations 2 hours after Dose (mcg/mL)/(mcg/g)					
Treatment	N	antrum	fundus	N	Mucus
Clarithromycin	5	10.48 ± 2.01	20.81 ± 7.64	4	4.15 ± 7.74
Clarithromycin + Omeprazole	5	19.96 ± 4.71	24.25 ± 6.37	4	39.29 ± 32.79

Theophylline

In two studies in which theophylline was administered with clarithromycin (a theophylline sustained-release formulation was dosed at either 6.5 mg/kg or 12 mg/kg together with 250 or 500 mg q12h clarithromycin), the steady-state levels of C_{max} , C_{min} , and the area under the serum concentration time curve (AUC) of theophylline increased about 20%.

Midazolam

When a single dose of midazolam was co-administered with clarithromycin tablets (500 mg twice daily for 7 days), midazolam AUC increased 174% after intravenous administration of midazolam and 600% after oral administration.

For information about other drugs indicated in combination with clarithromycin, refer to their full prescribing information, CLINICAL PHARMACOLOGY section.

12.4 Microbiology

Mechanism of Action

Clarithromycin exerts its antibacterial action by binding to the 50S ribosomal subunit of susceptible bacteria resulting in inhibition of protein synthesis.

Resistance

The major routes of resistance are modification of the 23S rRNA in the 50S ribosomal subunit to insensitivity or drug efflux pumps. Beta-lactamase production should have no effect on clarithromycin activity.

Most isolates of methicillin-resistant and oxacillin-resistant staphylococci are resistant to clarithromycin.

Antimicrobial Activity

Clarithromycin has been shown to be active against most of the isolates of the following microorganisms both *in vitro* and in clinical infections [see *Indications and Usage (1)*].

Gram-Positive Bacteria

- *Staphylococcus aureus*
- *Streptococcus pneumoniae*
- *Streptococcus pyogenes*

Gram-Negative Bacteria

- *Haemophilus influenzae*
- *Haemophilus parainfluenzae*
- *Moraxella catarrhalis*

Other Microorganisms

- *Chlamydomyxa pneumoniae*
- *Mycoplasma pneumoniae*

At least 90 percent of the microorganisms listed below exhibit *in vitro* minimum inhibitory concentrations (MICs) less than or equal to the clarithromycin susceptible MIC breakpoint for organisms of similar type to those shown in Table 11. However, the efficacy of clarithromycin in treating clinical infections due to these microorganisms has not been established in adequate and well-controlled clinical trials.

Gram-Positive Bacteria

- *Streptococcus agalactiae*

- Streptococci (Groups C, F, G)
- Viridans group streptococci

Gram-Negative Bacteria

- *Legionella pneumophila*
- *Pasteurella multocida*

Anaerobic Bacteria

- *Clostridium perfringens*
- *Peptococcus niger*
- *Prevotella melaninogenica*
- *Propionibacterium acnes*

Susceptibility Testing Methods (Excluding Mycobacteria and Helicobacter)

For specific information regarding susceptibility test interpretive criteria and associated test methods and quality control standards recognized by FDA for this drug, please see: <https://www.fda.gov/STIC>.

13 NONCLINICAL TOXICOLOGY

13.1 Carcinogenesis, Mutagenesis, Impairment of Fertility

The following *in vitro* mutagenicity tests have been conducted with clarithromycin:

- *Salmonella*/Mammalian Microsomes Test
- Bacterial Induced Mutation Frequency Test
- *In Vitro* Chromosome Aberration Test
- Rat Hepatocyte DNA Synthesis Assay
- Mouse Lymphoma Assay
- Mouse Dominant Lethal Study
- Mouse Micronucleus Test

All tests had negative results except the *in vitro* chromosome aberration test which was positive in one test and negative in another. In addition, a bacterial reverse-mutation test (Ames test) has been performed on clarithromycin metabolites with negative results.

Impairment of Fertility

Fertility and reproduction studies have shown that daily doses of up to 160 mg/kg/ to male and female rats caused no adverse effects on the estrous cycle, fertility, parturition, or number and viability of offspring. Plasma levels in rats after 150 mg/kg/day were twice the human serum levels.

Testicular atrophy occurred in rats at doses 7 times, in dogs at doses 3 times, and in monkeys at doses 8 times greater than the maximum human daily dose (on a body surface area basis).

13.2 Animal Toxicology and/or Pharmacology

Corneal opacity occurred in dogs at doses 12 times and in monkeys at doses 8 times greater than the maximum human daily dose (on a body surface area basis). Lymphoid depletion occurred in dogs at doses 3 times greater than and in monkeys at doses 2 times greater than the maximum human daily dose (on a body surface area basis).

15 REFERENCES

1. Winkel P, Hilden J, Hansen JF, Kastrup J, Kolmos HJ, Kjølner E, et al. Clarithromycin for stable coronary heart disease increases all-cause and cardiovascular mortality and cerebrovascular morbidity over 10 years in the CLARICOR randomised, blinded clinical trial. *Int J Cardiol*

2015;182:459-65.

2. Kemper CA, et al. Treatment of *Mycobacterium avium* Complex Bacteremia in AIDS with a Four-Drug Oral Regimen. *Ann Intern Med.* 1992;116:466-472.

16 HOW SUPPLIED/STORAGE AND HANDLING

Product: 50090-4059

NDC: 50090-4059-0 14 TABLET, FILM COATED, EXTENDED RELEASE in a BOTTLE

17 PATIENT COUNSELING INFORMATION

Provide the following instructions or information about clarithromycin extended-release tablets to patients:

- Counsel patients that antibacterial drugs including clarithromycin extended-release tablets should only be used to treat bacterial infections. They do not treat viral infections (e.g., the common cold). When clarithromycin extended-release tablets 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 clarithromycin or other antibacterial drugs in the future.
- Advise patients that diarrhea is a common problem caused by antibacterials including clarithromycin which usually ends when the antibacterial is discontinued. Sometimes after starting treatment with antibacterials, 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 antibacterial. If this occurs, instruct patients to contact their healthcare provider as soon as possible.
- Advise patients that clarithromycin may interact with some drugs; therefore, advise patients to report to their healthcare provider the use of any other medications.
- Advise patients that clarithromycin extended-release tablets should be taken with food. Do not refrigerate the suspension.
- There are no data on the effect of clarithromycin on the ability to drive or use machines. However, counsel patients regarding the potential for dizziness, vertigo, confusion and disorientation, which may occur with the medication. The potential for these adverse reactions should be taken into account before patients drive or use machines.
- Advise patients that if pregnancy occurs while taking this drug, there is a potential hazard to the fetus [*see Warnings and Precautions (5.7) and Use in Specific Populations (8.1)*].
- Advise patients who have coronary artery disease to continue medications and lifestyle modifications for their coronary artery disease because clarithromycin may be associated with increased risk for mortality years after the end of clarithromycin treatment.

Clarithromycin Extended-release Tablets, USP

* All trademark names are the property of their respective owners.

Manufactured by:

 **Sunshine Lake Pharma Co., Ltd.**

Northern Industry Road 1#,
Song Shan Lake, DongGuan,
GuangDong Province, 523808,
P.R. China

Manufactured for:

Lannett Company Inc.
Philadelphia, PA 19154

Clarithromycin

CAUTION: Federal law prohibits the transfer of this drug to any person other than the patient for whom it was prescribed.

Patient First[®]

WARNING: KEEP OUT OF CHILDREN'S REACH DISPENSE IN THIS LIGHT RESISTANT CONTAINER

STORE AT 68-77 DEGREES F



GTIN: 00350090405903
LOT:
EXP:
S/N:

Packaged Exclusively By:
A-S MEDICATION SOLUTIONS LLC™
Libertyville, IL 60048

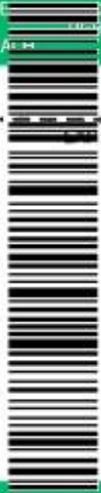
CLARITHROMYCIN
500 MG

14 EXTENDED-RELEASE TABLETS
NDC 50090-4059-0
PRODUCT # 8313-0

EACH FILM-COATED TABLET CONTAINS
500 MG CLARITHROMYCIN

MFR: LANNETT COMPANY, INC
PHILADELPHIA, PA 19136
SRC NDC: 0527-1930-06

LOT#



RX ONLY

CLARITHROMYCIN

clarithromycin tablet, film coated, extended release

Product Information

Product Type	HUMAN PRESCRIPTION DRUG	Item Code (Source)	NDC:50090-4059(NDC:0527-1930)
Route of Administration	ORAL		

Active Ingredient/Active Moiety

Ingredient Name	Basis of Strength	Strength
CLARITHROMYCIN (UNII: H1250JIK0A) (CLARITHROMYCIN - UNII:H1250JIK0A)	CLARITHROMYCIN	500 mg

Inactive Ingredients

Ingredient Name	Strength
GLYCERYL DIBEHENATE (UNII: R8WTH25YS2)	
HYPROMELLOSE, UNSPECIFIED (UNII: 3NXW29V3WO)	
LACTOSE MONOHYDRATE (UNII: EWQ57Q8I5X)	
MAGNESIUM STEARATE (UNII: 70097M6I30)	
POLYETHYLENE GLYCOL, UNSPECIFIED (UNII: 3WJQ0SDW1A)	
TITANIUM DIOXIDE (UNII: 15FIX9V2JP)	

Product Characteristics

Color		Score	no score
Shape	CAPSULE	Size	19mm

Flavor		Imprint Code	S58	
Contains				
Packaging				
#	Item Code	Package Description	Marketing Start Date	Marketing End Date
1	NDC:50090-4059-0	14 in 1 BOTTLE; Type 0: Not a Combination Product	01/16/2019	
Marketing Information				
Marketing Category	Application Number or Monograph Citation	Marketing Start Date	Marketing End Date	
ANDA	ANDA208987	07/23/2018		

Labeler - A-S Medication Solutions (830016429)

Establishment

Name	Address	ID/FEI	Business Operations
A-S Medication Solutions		830016429	RELABEL(50090-4059) , REPACK(50090-4059)

Revised: 1/2019

A-S Medication Solutions