

DEXAMETHASONE- dexamethasone elixir
Chartwell RX, LLC

DEXAMETHASONE ELIXIR, USP
Rx only

DESCRIPTION

Each red colored, cherry flavored, 5 mL (teaspoonful) contains:

Dexamethasone, USP 0.5 mg

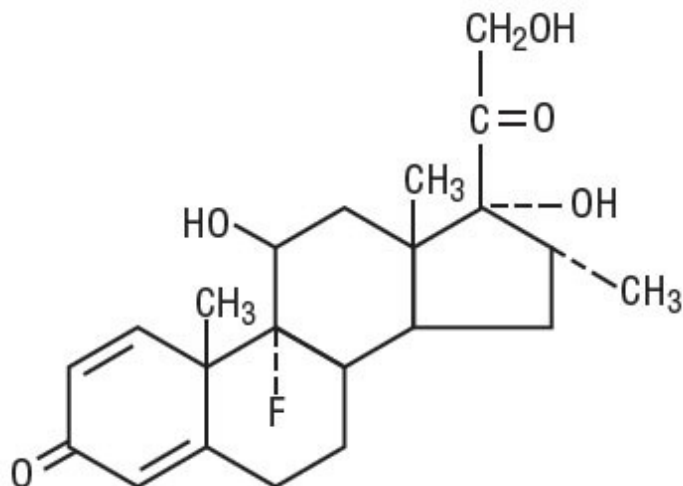
Also contains:

Benzoic Acid, USP 0.1% w/v (as preservative)

Ethyl Alcohol 5.1% v/v

Inactive Ingredients: citric acid, sodium citrate dihydrate, sucrose, ethyl alcohol, benzoic acid, propylene glycol, wild cherry flavor, FD&C Red #40, and purified water.

Dexamethasone, a synthetic adrenocortical steroid, is a white to practically white, odorless, crystalline powder. It is stable in air. It is practically insoluble in water. The molecular weight is 392.47. It is designated chemically as 9-fluoro-11 β ,17,21-trihydroxy-16 α -methylpregna-1, 4-diene-3,20-dione. The molecular formula is C₂₂H₂₉FO₅ and the structural formula is:



CLINICAL PHARMACOLOGY

Naturally occurring glucocorticoids (hydrocortisone and cortisone), which also have salt-retaining properties, are used as replacement therapy in adrenocortical deficiency states. Their synthetic analogs, including dexamethasone, are primarily used for their potent anti-inflammatory effects in disorders of many organ systems. Glucocorticoids cause profound and varied metabolic effects. In addition, they modify the body's immune responses to diverse stimuli. At equipotent anti-inflammatory doses, dexamethasone almost completely lacks the sodium-retaining property of hydrocortisone and closely related derivatives of hydrocortisone.

INDICATIONS AND USAGE

Allergic States

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

- Seasonal or perennial allergic rhinitis
- Bronchial asthma
- Contact dermatitis
- Atopic dermatitis
- Serum sickness
- Drug hypersensitivity reactions

Collagen Diseases

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

- Systemic lupus erythematosus
- Acute rheumatic carditis

Dermatologic Diseases

- Pemphigus
- Bullous dermatitis herpetiformis
- Severe erythema multiforme (Stevens-Johnson syndrome)
- Exfoliative dermatitis
- Mycosis fungoides
- Severe psoriasis
- Severe seborrheic dermatitis

Edematous States

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

Endocrine Disorders

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

- Congenital adrenal hyperplasia
- Nonsuppurative thyroiditis
- Hypercalcemia associated with cancer

Gastrointestinal Diseases

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

- Ulcerative colitis
- Regional enteritis

Hematologic Disorders

- Idiopathic thrombocytopenic purpura in adults
- Secondary thrombocytopenia in adults
- Acquired (autoimmune) hemolytic anemia
- Erythroblastopenia (RBC anemia)
- Congenital (erythroid) hypoplastic anemia

Miscellaneous

Diagnostic testing of adrenocortical hyperfunction

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

Trichinosis with neurologic or myocardial involvement

Neoplastic Diseases

For palliative management of:

- Leukemia and lymphomas in adults
- Acute leukemia of childhood

Ophthalmic Diseases

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

- Allergic conjunctivitis
- Keratitis
- Allergic corneal marginal ulcers
- Herpes zoster ophthalmicus
- Iritis and iridocyclitis
- Chorioretinitis
- Anterior segment inflammation
- Diffuse posterior uveitis and choroiditis
- Optic neuritis
- Sympathetic ophthalmia

Respiratory Diseases

- Symptomatic sarcoidosis
- Loeffler's syndrome not manageable by other means
- Berylliosis
- Fulminating or disseminated pulmonary tuberculosis when used concurrently with appropriate antituberculous chemotherapy
- Aspiration pneumonitis

Rheumatic Disorders

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

- Psoriatic arthritis
- Rheumatoid arthritis, including juvenile rheumatoid arthritis (selected cases may require low-dose maintenance therapy)
- Ankylosing spondylitis
- Acute and subacute bursitis
- Acute nonspecific tenosynovitis
- Acute gouty arthritis
- Post-traumatic osteoarthritis
- Synovitis of osteoarthritis
- Epicondylitis

CONTRAINDICATIONS

Contraindicated in patients with known systemic fungal infections (See **WARNINGS: Infections: Fungal Infections**) and patients with a known sensitivity to this drug.

WARNINGS

In patients on corticosteroid therapy subjected to unusual stress, increased dosage of rapidly acting corticosteroids before, during, and after the stressful situation is

indicated.

Immunosuppression and Increased Risk of Infection

Corticosteroids, including dexamethasone elixir, suppress the immune system and increase the risk of infection with any pathogen, including viral, bacterial, fungal, protozoan, or helminthic pathogens. Corticosteroids can:

- Reduce resistance to new infections
- Exacerbate existing infections
- Increase the risk of disseminated infections
- Increase the risk of reactivation or exacerbation of latent infections
- Mask some signs of infection

Corticosteroid-associated infections can be mild but can be severe and at times fatal. The rate of infectious complications increases with increasing corticosteroid dosages.

Monitor for the development of infection and consider dexamethasone elixir withdrawal or dosage reduction as needed.

Tuberculosis

If dexamethasone elixir is used to treat a condition in patients with latent tuberculosis or tuberculin reactivity, reactivation of tuberculosis may occur.

Closely monitor such patients for reactivation. During prolonged dexamethasone elixir therapy, patients with latent tuberculosis or tuberculin reactivity should receive chemoprophylaxis.

Varicella Zoster and Measles Viral Infections

Varicella and measles can have a serious or even fatal course in non-immune patients taking corticosteroids, including dexamethasone elixir. In corticosteroid-treated patients who have not had these diseases or are non-immune, particular care should be taken to avoid exposure to varicella and measles:

- If a dexamethasone elixir-treated patient is exposed to varicella, prophylaxis with varicella zoster immune globulin may be indicated. If varicella develops, treatment with antiviral agents may be considered.
- If a dexamethasone elixir-treated patient is exposed to measles, prophylaxis with immunoglobulin may be indicated.

Hepatitis B Virus Reactivation

Hepatitis B virus reactivation can occur in patients who are hepatitis B carriers treated with immunosuppressive dosages of corticosteroids, including dexamethasone elixir. Reactivation can also occur infrequently in corticosteroid-treated patients who appear to have resolved hepatitis B infection.

Screen patients for hepatitis B infection before initiating immunosuppressive (e.g., prolonged) treatment with dexamethasone elixir. For patients who show evidence of hepatitis B infection, recommend-consultation with physicians with expertise in managing hepatitis B regarding monitoring and consideration for hepatitis B antiviral therapy.

Fungal Infections

Corticosteroids, including dexamethasone elixir, may exacerbate systemic fungal infections; therefore, avoid dexamethasone elixir use in the presence of such infections

unless dexamethasone elixir is needed to control drug reactions. For patients on chronic dexamethasone elixir therapy who develop systemic fungal infections, dexamethasone elixir withdrawal or dosage reduction is recommended.

Amebiasis

Corticosteroids, including dexamethasone elixir, may activate latent amebiasis. Therefore, it is recommended that latent amebiasis or active amebiasis be ruled out before initiating dexamethasone elixir in patients who have spent time in the tropics or patients with unexplained diarrhea.

Strongyloides Infestation

Corticosteroids, including dexamethasone elixir, should be used with great care in patients with known or suspected *Strongyloides* (threadworm) infestation. In such patients, corticosteroid-induced immunosuppression may lead to *Strongyloides* hyperinfection and dissemination with widespread larval migration, often accompanied by severe enterocolitis and potentially fatal gram-negative septicemia.

Cerebral Malaria

Avoid corticosteroids, including dexamethasone elixir, in patients with cerebral malaria.

Kaposi's Sarcoma

Kaposi's sarcoma has been reported to occur in patients receiving corticosteroid therapy, most often for chronic conditions. Discontinuation of corticosteroids may result in clinical improvement of Kaposi's sarcoma.

Drug-induced secondary adrenocortical insufficiency may result from too rapid withdrawal of corticosteroids and may be minimized by gradual reduction of dosage. This type of relative insufficiency may persist for months after discontinuation of therapy; therefore, in any situation of stress occurring during that period, hormone therapy should be reinstated. If the patient is receiving steroids already, dosage may have to be increased. Since mineralocorticoid secretion may be impaired, salt and/or a mineralocorticoid should be administered concurrently.

In cerebral malaria, a double-blind trial has shown that the use of corticosteroids is associated with prolongation of coma and a higher incidence of pneumonia and gastrointestinal bleeding.

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

Usage in Pregnancy

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

Corticosteroids appear in breast milk and could suppress growth, interfere with endogenous corticosteroid production, or cause other unwanted effects. Mothers taking pharmacologic doses of corticosteroids should be advised not to nurse.

Average and large doses of hydrocortisone or cortisone can cause elevation of blood

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

Administration of live virus vaccines, including smallpox, is contraindicated in individuals receiving immunosuppressive doses of corticosteroids. If inactivated viral or bacterial vaccines are administered to individuals receiving immunosuppressive doses of corticosteroids, the expected serum antibody response may not be obtained. However, immunization procedures may be undertaken in patients who are receiving corticosteroids as replacement therapy, e.g., for Addison's disease.

Literature reports suggest an apparent association between use of corticosteroids and left ventricular free wall rupture after a recent myocardial infarction; therefore, therapy with corticosteroids should be used with great caution in these patients.

PRECAUTIONS

Following prolonged therapy, withdrawal of corticosteroids may result in symptoms of the corticosteroid withdrawal syndrome including fever, myalgia, arthralgia, and malaise. This may occur in patients even without evidence of adrenal insufficiency.

There is an enhanced effect of corticosteroids in patients with hypothyroidism and in those with cirrhosis.

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

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

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

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

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

When large doses are given, some authorities advise that corticosteroids be taken with meals and antacids taken between meals to help to prevent peptic ulcer.

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

Steroids may increase or decrease motility and number of spermatozoa in some patients.

Phenytoin, phenobarbital, ephedrine, and rifampin may enhance the metabolic clearance of corticosteroids, resulting in decreased blood levels and lessened physiologic activity, thus requiring adjustment in corticosteroid dosage. These interactions may interfere

with dexamethasone suppression tests which should be interpreted with caution during administration of these drugs.

False-negative results in the dexamethasone suppression test (DST) in patients being treated with indomethacin have been reported. Thus, results of the DST should be interpreted with caution in these patients.

The prothrombin time should be checked frequently in patients who are receiving corticosteroids and coumarin anticoagulants at the same time because of reports that corticosteroids have altered the response to these anticoagulants. Studies have shown that the usual effect produced by adding corticosteroids is inhibition of response to coumarins, although there have been some conflicting reports of potentiation not substantiated by studies.

When corticosteroids are administered concomitantly with potassium-depleting diuretics, patients should be observed closely for development of hypokalemia.

Information for Patients

Persons who are on immunosuppressant doses of corticosteroids should be warned to avoid exposure to chickenpox or measles. Patients should also be advised that if they are exposed, medical advice should be sought without delay.

ADVERSE REACTIONS

Fluid and Electrolyte Disturbances:

- Sodium retention
- Fluid retention
- Congestive heart failure in susceptible patients
- Potassium loss
- Hypokalemic alkalosis
- Hypertension

Musculoskeletal:

- Muscle weakness
- Steroid myopathy
- Loss of muscle mass
- Osteoporosis
- Vertebral compression fractures
- Aseptic necrosis of femoral and humeral heads
- Pathologic fracture of long bones
- Tendon rupture

Gastrointestinal:

- Peptic ulcer with possible perforation and hemorrhage
- Perforation of the small and large bowel, particularly in patients with inflammatory bowel disease
- Pancreatitis
- Abdominal distention
- Ulcerative esophagitis

Dermatologic:

- Impaired wound healing
- Thin fragile skin

Petechiae and ecchymoses
Erythema
Increased sweating
May suppress reactions to skin tests

Other cutaneous reactions, such as allergic dermatitis, urticaria, angioneurotic edema

Neurologic:

Convulsions
Increased intracranial pressure with papilledema (pseudotumor cerebri) usually after treatment
Vertigo
Headache
Psychic Disturbances

Endocrine:

Menstrual irregularities
Development of cushingoid state
Suppression of growth in children
Secondary adrenocortical and pituitary unresponsiveness, particularly in times of stress, as in trauma, surgery, or illness
Decreased carbohydrate tolerance
Manifestations of latent diabetes mellitus
Increased requirements for insulin or oral hypoglycemic agents in diabetes
Hirsutism

Ophthalmic:

Posterior subcapsular cataracts
Increased intraocular pressure
Glaucoma
Exophthalmos

Metabolic:

Negative nitrogen balance due to protein catabolism

Cardiovascular:

Myocardial rupture following recent myocardial infarction (See **WARNINGS**)

Other:

Hypersensitivity
Thromboembolism
Weight gain
Increased appetite
Nausea
Malaise
Hiccups

OVERDOSAGE

Reports of acute toxicity and/or death following overdosage of glucocorticoids are rare. In the event of overdosage, no specific antidote is available; treatment is supportive and symptomatic.

The oral LD₅₀ of dexamethasone in female mice was 6.5 g/kg.

DOSAGE AND ADMINISTRATION

For oral administration:

DOSAGE REQUIREMENTS ARE VARIABLE AND MUST BE INDIVIDUALIZED ON THE BASIS OF THE DISEASE AND THE RESPONSE OF THE PATIENT.

The initial dosage varies from 0.75 to 9 mg a day depending on the disease being treated. In less severe diseases doses lower than 0.75 mg may suffice, while in severe diseases doses higher than 9 mg may be required. The initial dosage should be maintained or adjusted until the patient's response is satisfactory. If satisfactory clinical response does not occur after a reasonable period of time, discontinue dexamethasone elixir and transfer the patient to other therapy.

After a favorable initial response, the proper maintenance dosage should be determined by decreasing the initial dosage in small amounts to the lowest dosage that maintains an adequate clinical response.

Patients should be observed closely for signs that might require dosage adjustment, including changes in clinical status resulting from remissions or exacerbations of the disease, individual drug responsiveness, and the effect of stress (e.g., surgery, infection, trauma). During stress it may be necessary to increase dosage temporarily.

If the drug is to be stopped after more than a few days of treatment, it usually should be withdrawn gradually.

The following milligram equivalents facilitate changing to dexamethasone elixir from other glucocorticoids:

DEXAMETHASONE ELIXIR	METHYLPREDNISOLONE AND TRIAMCINOLONE	PREDNISOLONE AND PREDNISON	HYDROCORTISONE	CORTISONE
0.75 mg =	4 mg =	5 mg =	20 mg =	25 mg

Dexamethasone suppression tests

1. Tests for Cushing's syndrome.

Give 1 mg of dexamethasone orally at 11:00 p.m. Blood is drawn for plasma cortisol determination at 8:00 a.m. the following morning.

For greater accuracy, give 0.5 mg of dexamethasone orally every 6 hours for 48 hours. Twenty-four hour urine collections are made for determination of 17-hydroxycorticosteroid excretion.

2. Test to distinguish Cushing's syndrome due to pituitary ACTH excess from Cushing's syndrome due to other causes.

Give 2 mg of dexamethasone orally every 6 hours for 48 hours. Twenty-four hour urine collections are made for determination of 17-hydroxycorticosteroid excretion.

HOW SUPPLIED

Dexamethasone Elixir, USP, 0.5 mg/5 mL is supplied as a red colored, cherry-flavored liquid in the following size:

Bottles of 8 fl oz (237 mL) NDC 62135-114-37

STORAGE

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

KEEP TIGHTLY CLOSED

AVOID FREEZING

Dispense in a tight container as defined in the USP.

Manufactured for:

Chartwell RX, LLC.

Congers, NY 10920

L71175

Rev 02/2024

PACKAGE LABEL.PRINCIPAL DISPLAY PANEL

Dexamethasone Elixir, USP, 0.5 mg/5 mL - NDC 62135-114-37 - 8 fl oz (237 mL) Bottle Label

NDC 62135-114-37

Dexamethasone Elixir, USP

0.5 mg/5 mL

Rx Only
8 fl oz (237 mL)

Chartwell Rx

EACH 5 mL (TEASPOONFUL) CONTAINS:
Dexamethasone, USP.....0.5 mg
Also contains:
Benzoic Acid, USP (as preservative).....0.1% w/v
Ethyl Alcohol.....5.1% w/v

USUAL ADULT DOSAGE: See accompanying package insert.

WARNINGS: KEEP THIS AND ALL MEDICATIONS OUT OF THE REACH OF CHILDREN. In case of accidental overdose, seek professional assistance or contact a Poison Control Center immediately.

Store at 20° to 25°C (68° to 77°F) excursion permitted to 15° to 30°C (59° to 86°F) [See USP Controlled Room Temperature].

KEEP TIGHTLY CLOSED
AVOID FREEZING

DISPENSE in a tight container as defined in the USP.
Manufactured For: Chartwell RX, LLC.
Congers, NY 10920

GTIN 00362135114374 L71174 REV. 01 01/23

No Varnish

DEXAMETHASONE

dexamethasone elixir

Product Information

Product Type	HUMAN PRESCRIPTION DRUG	Item Code (Source)	NDC:62135-114
Route of Administration	ORAL		

Active Ingredient/Active Moiety

Ingredient Name	Basis of Strength	Strength
DEXAMETHASONE (UNII: 7S517G3JQL) (DEXAMETHASONE - UNII:7S517G3JQL)	DEXAMETHASONE	0.5 mg in 5 mL

Inactive Ingredients

Ingredient Name	Strength
ANHYDROUS CITRIC ACID (UNII: XF417D3PSL)	

TRISODIUM CITRATE DIHYDRATE (UNII: B22547B95K)

SUCROSE (UNII: C151H8M554)

ALCOHOL (UNII: 3K9958V90M)

BENZOIC ACID (UNII: 8SKN0B0MIM)

PROPYLENE GLYCOL (UNII: 6DC9Q167V3)

FD&C RED NO. 40 (UNII: WZB9127XOA)

WATER (UNII: 059QF0K00R)

Product Characteristics

Color	red	Score	
Shape		Size	
Flavor	CHERRY	Imprint Code	
Contains			

Packaging

#	Item Code	Package Description	Marketing Start Date	Marketing End Date
1	NDC:62135-114-37	237 mL in 1 BOTTLE; Type 0: Not a Combination Product	01/13/2023	

Marketing Information

Marketing Category	Application Number or Monograph Citation	Marketing Start Date	Marketing End Date
ANDA	ANDA091188	05/11/2011	

Labeler - Chartwell RX, LLC (079394054)

Registrant - Chartwell Pharmaceuticals Carmel, LLC (118673485)

Revised: 3/2024

Chartwell RX, LLC