

**PREDNISONE- prednisone tablet**  
**NCS HealthCare of KY, LLC dba Vanguard Labs**

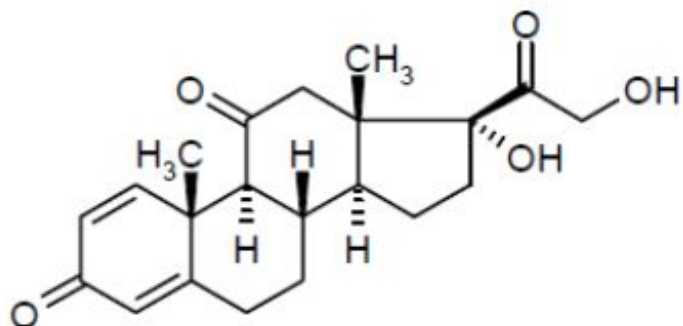
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**PredniSONE Tablets, USP**  
**(10 mg and 20 mg)**  
**Rx only**

**DESCRIPTION**

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

The chemical name for prednisone is 17,21-dihydroxypregna-1,4-diene-3,11,20-trione. Its molecular formula is  $C_{21}H_{26}O_5$  and its molecular weight is 358.4 g/mole.

The structural formula is represented below:



Prednisone tablets, USP are available in 2 strengths: 10 mg and 20 mg.

**Inactive Ingredients:** Lactose monohydrate, magnesium stearate, microcrystalline cellulose, pregelatinized starch and sodium starch glycolate type A.

Meets USP Dissolution Test 2.

**ACTIONS**

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

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

**INDICATIONS**

Prednisone tablets are indicated in the following conditions:

### **1. Endocrine Disorders**

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

Congenital adrenal hyperplasia

Hypercalcemia associated with cancer

Nonsuppurative thyroiditis

### **2. Rheumatic Disorders**

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

Psoriatic arthritis

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

Ankylosing spondylitis

Acute and subacute bursitis

Acute nonspecific tenosynovitis

Acute gouty arthritis

Post-traumatic osteoarthritis

Synovitis of osteoarthritis

Epicondylitis

### **3. Collagen Diseases**

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

Systemic lupus erythematosus

Systemic dermatomyositis (polymyositis)

Acute rheumatic carditis

### **4. Dermatologic Diseases**

Pemphigus

Bullous dermatitis herpetiformis

Severe erythema multiforme (Stevens-Johnson syndrome)

Exfoliative dermatitis

Mycosis fungoides

Severe psoriasis

Severe seborrheic dermatitis

### **5. Allergic States**

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

Seasonal or perennial allergic rhinitis

Bronchial asthma

Contact dermatitis

Atopic dermatitis  
Serum sickness  
Drug hypersensitivity reactions

## **6. Ophthalmic Diseases**

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

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

## **7. Respiratory Diseases**

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

## **8. Hematologic Disorders**

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

## **9. Neoplastic Diseases**

For palliative management of:  
Leukemias and lymphomas in adults  
Acute leukemia of childhood

## **10. Edematous States**

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

## **11. Gastrointestinal Diseases**

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

Ulcerative colitis  
Regional enteritis

## **12. Nervous System**

Acute exacerbations of multiple sclerosis

## **13. Miscellaneous**

Tuberculous meningitis with subarachnoid block or impending block when used concurrently with appropriate antituberculous chemotherapy  
Trichinosis with neurologic or myocardial involvement

## **CONTRAINDICATIONS**

Systemic fungal infections and known hypersensitivity to components.

## **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.

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

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

## **Usage in pregnancy**

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

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

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

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

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

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

## **PRECAUTIONS**

### **General Precautions**

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

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

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

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

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

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

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

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

Although controlled clinical trials have shown corticosteroids to be effective in speeding the resolution of acute exacerbations of multiple sclerosis, they do not show that corticosteroids affect the ultimate outcome or natural history of the disease. The studies

do show that relatively high doses of corticosteroids are necessary to demonstrate a significant effect (see **DOSAGE AND ADMINISTRATION**).

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

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

## **Drug Interactions**

The pharmacokinetic interactions listed below are potentially clinically important. Drugs that induce hepatic enzymes such as phenobarbital, phenytoin and rifampin may increase the clearance of corticosteroids and may require increases in corticosteroid dose to achieve the desired response. Drugs such as troleandomycin and ketoconazole may inhibit the metabolism of corticosteroids and thus decrease their clearance. Therefore, the dose of corticosteroid should be titrated to avoid steroid toxicity. Corticosteroids may increase the clearance of chronic high dose aspirin. This could lead to decreased salicylate serum levels or increase the risk of salicylate toxicity when corticosteroid is withdrawn. Aspirin should be used cautiously in conjunction with corticosteroids in patients suffering from hypoprothrombinemia. The effect of corticosteroids on oral anticoagulants is variable. There are reports of enhanced as well as diminished effects of anticoagulants when given concurrently with corticosteroids. Therefore, coagulation indices should be monitored to maintain the desired anticoagulant effect.

## **Information for the Patient**

Patients who are on immunosuppressant doses of corticosteroids should be warned to avoid exposure to chickenpox or measles and, if exposed, to obtain medical advice.

## **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
- Tendon rupture, particularly of the Achilles tendon
- Vertebral compression fractures

Aseptic necrosis of femoral and humeral heads  
Pathologic fracture of long bones

### **Gastrointestinal**

Peptic ulcer with possible perforation and hemorrhage  
Pancreatitis  
Abdominal distention  
Ulcerative esophagitis

### **Dermatologic**

Impaired wound healing  
Thin fragile skin  
Petechiae and ecchymoses  
Facial erythema  
Increased sweating  
May suppress reactions to skin tests

### **Metabolic**

Negative nitrogen balance due to protein catabolism

### **Neurological**

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

### **Endocrine**

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

### **Ophthalmic**

Posterior subcapsular cataracts  
Increased intraocular pressure  
Glaucoma  
Exophthalmos

### **Additional Reactions**

Urticaria and other allergic, anaphylactic or hypersensitivity reactions

**To report SUSPECTED ADVERSE REACTIONS, contact Amneal Pharmaceuticals at 1-877-835-5472 or FDA at 1-800-FDA-1088 or [www.fda.gov/medwatch](http://www.fda.gov/medwatch).**

### **DOSAGE AND ADMINISTRATION**

The initial dosage of prednisone tablets may vary from 5 mg to 60 mg of prednisone per day depending on the specific disease entity being treated. In situations of less severity lower doses will generally suffice while in selected patients higher initial doses may be required. The initial dosage should be maintained or adjusted until a satisfactory response is noted. If after a reasonable period of time there is a lack of satisfactory clinical response, prednisone tablets should be discontinued and the patient transferred to other appropriate therapy. **IT SHOULD BE EMPHASIZED THAT DOSAGE REQUIREMENTS ARE VARIABLE AND MUST BE INDIVIDUALIZED ON THE BASIS OF THE DISEASE UNDER TREATMENT AND THE RESPONSE OF THE PATIENT.**

After a favorable response is noted, the proper maintenance dosage should be determined by decreasing the initial drug dosage in small decrements at appropriate time intervals until the lowest dosage which will maintain an adequate clinical response is reached. It should be kept in mind that constant monitoring is needed in regard to drug dosage. Included in the situations which may make dosage adjustments necessary are changes in clinical status secondary to remissions or exacerbations in the disease process, the patient's individual drug responsiveness, and the effect of patient exposure to stressful situations not directly related to the disease entity under treatment; in this latter situation it may be necessary to increase the dosage of prednisone tablets for a period of time consistent with the patient's condition. If after long-term therapy the drug is to be stopped, it is recommended that it be withdrawn gradually rather than abruptly.

### **Multiple Sclerosis**

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

### **ADT® (Alternate Day Therapy)**

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

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

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

The diurnal rhythm of the HPA axis is lost in Cushing's disease, a syndrome of



adrenocortical hyperfunction characterized by obesity with centripetal fat distribution, thinning of the skin with easy bruisability, muscle wasting with weakness, hypertension, latent diabetes, osteoporosis, electrolyte imbalance, etc. The same clinical findings of hyperadrenocorticism may be noted during long-term pharmacologic dose corticoid therapy administered in conventional daily divided doses. It would appear, then, that a disturbance in the diurnal cycle with maintenance of elevated corticoid values during the night may play a significant role in the development of undesirable corticoid effects. Escape from these constantly elevated plasma levels for even short periods of time may be instrumental in protecting against undesirable pharmacologic effects.

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

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

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

effect on adrenal activity, are not recommended for alternate day therapy (e.g., dexamethasone and betamethasone).

6. The maximal activity of the adrenal cortex is between 2 am and 8 am, and it is minimal between 4 pm and midnight. Exogenous corticosteroids suppress adrenocortical activity the least, when given at the time of maximal activity (am).
7. In using ADT it is important, as in all therapeutic situations to individualize and tailor the therapy to each patient. Complete control of symptoms will not be possible in all patients. An explanation of the benefits of ADT will help the patient to understand and tolerate the possible flare-up in symptoms which may occur in the latter part of the off-steroid day. Other symptomatic therapy may be added or increased at this time if needed.
8. In the event of an acute flare-up of the disease process, it may be necessary to return to a full suppressive daily divided corticoid dose for control. Once control is again established alternate day therapy may be re-instituted.
9. Although many of the undesirable features of corticosteroid therapy can be minimized by ADT, as in any therapeutic situation, the physician must carefully weigh the benefit-risk ratio for each patient in whom corticoid therapy is being considered.

## HOW SUPPLIED

Prednisone Tablets USP, **10 mg** are supplied as white to off-white, round, biconvex, uncoated tablets, scored on one side and debossed with "A48" on the other side.

They are available as follows:

Blistercards of 30:	NDC 0615-8440-39
Blistercards of 15:	NDC 0615-8440-05

Prednisone Tablets USP, **20 mg** are supplied as white to off-white, round, biconvex, uncoated tablets, scored on one side and debossed with "AC72" on the other side.

They are available as follows:

Blistercards of 30:	NDC 0615-8441-39
Blistercards of 10:	NDC 0615-8441-10

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

Dispense in a tight, child-resistant container as defined in the USP.

Manufactured by:

**Amneal Pharmaceuticals Pvt. Ltd.**

**Oral Solid Dosage Unit**

Ahmedabad 382213, INDIA

Distributed by:

**Amneal Pharmaceuticals LLC**

Bridgewater, NJ 08807

Rev. 08-2021-02

## PRINCIPAL DISPLAY PANEL

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PREDNISONE

prednisone tablet

Product Information			
Product Type	HUMAN PRESCRIPTION DRUG	Item Code (Source)	NDC:0615-8440(NDC:60219-1707)
Route of Administration	ORAL		

Active Ingredient/Active Moiety		
Ingredient Name	Basis of Strength	Strength
PREDNISONE (UNII: VB0R961HZT) (PREDNISONE - UNII:VB0R961HZT)	PREDNISONE	10 mg

Inactive Ingredients	
Ingredient Name	Strength
LACTOSE MONOHYDRATE (UNII: EWQ57Q8I5X)	
MAGNESIUM STEARATE (UNII: 70O97M6I3O)	

MICROCRYSTALLINE CELLULOSE 102 (UNII: PNR0YF693Y)				
SODIUM STARCH GLYCOLATE TYPE A POTATO (UNII: 5856J3G2A2)				
STARCH, CORN (UNII: O8232NY3SJ)				
Product Characteristics				
Color	white (white to off-white)		Score	2 pieces
Shape	ROUND		Size	6mm
Flavor			Imprint Code	A48
Contains				
Packaging				
#	Item Code	Package Description	Marketing Start Date	Marketing End Date
1	NDC:0615-8440-39	30 in 1 BLISTER PACK; Type 0: Not a Combination Product	10/27/2022	
2	NDC:0615-8440-05	15 in 1 BLISTER PACK; Type 0: Not a Combination Product	10/27/2022	
Marketing Information				
Marketing Category	Application Number or Monograph Citation		Marketing Start Date	Marketing End Date
ANDA	ANDA213386		06/24/2020	

## PREDNISONE

prednisone tablet

Product Information			
Product Type	HUMAN PRESCRIPTION DRUG	Item Code (Source)	NDC:0615-8441(NDC:60219-1708)
Route of Administration	ORAL		
Active Ingredient/Active Moiety			
Ingredient Name		Basis of Strength	Strength
PREDNISONE (UNII: VB0R961HZT) (PREDNISONE - UNII:VB0R961HZT)		PREDNISONE	20 mg
Inactive Ingredients			
Ingredient Name			Strength
LACTOSE MONOHYDRATE (UNII: EWQ57Q8I5X)			
MAGNESIUM STEARATE (UNII: 70097M6I30)			
MICROCRYSTALLINE CELLULOSE 102 (UNII: PNR0YF693Y)			
SODIUM STARCH GLYCOLATE TYPE A POTATO (UNII: 5856J3G2A2)			
STARCH, CORN (UNII: O8232NY3SJ)			

## Product Characteristics

<b>Color</b>	white (white to off-white)	<b>Score</b>	2 pieces
<b>Shape</b>	ROUND	<b>Size</b>	9mm
<b>Flavor</b>		<b>Imprint Code</b>	AC72
<b>Contains</b>			

## Packaging

#	Item Code	Package Description	Marketing Start Date	Marketing End Date
1	NDC:0615-8441-39	30 in 1 BLISTER PACK; Type 0: Not a Combination Product	11/10/2022	
2	NDC:0615-8441-10	10 in 1 BLISTER PACK; Type 0: Not a Combination Product	08/07/2023	

## Marketing Information

Marketing Category	Application Number or Monograph Citation	Marketing Start Date	Marketing End Date
ANDA	ANDA213386	06/24/2020	

**Labeler -** NCS HealthCare of KY, LLC dba Vanguard Labs (050052943)

## Establishment

Name	Address	ID/FEI	Business Operations
NCS HealthCare of KY, LLC dba Vanguard Labs		050052943	repack(0615-8440, 0615-8441)

Revised: 8/2023

NCS HealthCare of KY, LLC dba Vanguard Labs