

**DONYFLU**  
**(FLUCONAZOLE TABLETS 200 MG)**



**1. NAME OF THE MEDICINAL PRODUCT**

**DONYFLU**  
**(FLUCONAZOLE TABLETS 200 MG)**

**Strength : 200 mg**

**Pharmaceutical Form : Tablet**

**2. QUALITATIVE AND QUANTITATIVE COMPOSITION**

**DONYFLU (FLUCONAZOLE TABLETS 200 MG)**

Each Uncoated Tablet Contains:

- Fluconazole USP (200 mg)
- Approved Colour Used (-)
- Excipients (0 QS)

Sr. No.	Ingredients	Specification	Quantity/ Tablet (mg)	% overages	Reason for inclusion
<b>Active</b>					
1.	Fluconazole	USP	200.0	0%	Active
<b>Excipients</b>					
2.	Maize Starch*	BP	208.0	8%	Diluent
3.	Lactose	BP	135.450	0%	Diluent
4.	Microcrystalline Cellulose	BP	35.0	0%	Diluent
5.	Sodium Starch Glycollate	BP	10.0	0%	Binding Agent
6.	Maize Starch (For Paste)*	BP	10.0	8%	Binder
7.	Methyl Paraben	BP	0.3	0%	Preservative
8.	Propyl Paraben	BP	0.03	0%	Preservative
9.	Colour Erythrosine Supra	IHS	0.3	0%	Colour
<b>Lubrication</b>					
10.	Purified Talc	BP	7.5	0%	Lubricant
11.	Magnesium Stearate	BP	3.5	0%	Lubricant
12.	Cros Carmellose Sodium	BP	10.0	0%	Disintegrant

\*Loss on drying of Maize starch 8%

BP = British Pharmacopoeia

IHS = In House Specification

**3. PHARMACEUTICAL FORM**

A pink coloured, elongated, biconvex uncoated tablets, having a embossing "FLU 200" on one side and breakline on other side of each tablet.

**4. CLINICAL PARTICULARS**

**4.1 THERAPEUTIC INDICATIONS**

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Fluconazole Tablet, USP is indicated for the treatment of:

1. Vaginal candidiasis (vaginal yeast infections due to *Candida*).
2. Oropharyngeal and esophageal candidiasis. In open noncomparative studies of relatively small numbers of patients, fluconazole was also effective for the treatment of *Candida* urinary tract infections, peritonitis, and systemic *Candida* infections including candidemia, disseminated candidiasis, and pneumonia.
3. Cryptococcal meningitis. Before prescribing fluconazole for AIDS patients with cryptococcal meningitis. Studies comparing fluconazole to amphotericin B in non-HIV infected patients have not been conducted.

Prophylaxis. Fluconazole is also indicated to decrease the incidence of candidiasis in patients undergoing bone marrow transplantation who receive cytotoxic chemotherapy and/or radiation therapy.

Specimens for fungal culture and other relevant laboratory studies (serology, histopathology) should be obtained prior to therapy to isolate and identify causative organisms. Therapy may be instituted before the results of the cultures and other laboratory studies are known; however, once these results become available, anti-infective therapy should be adjusted accordingly.

## **4.2 POSOLOGY AND METHOD OF ADMINISTRATION**

### **Dosage and Administration in Adults**

#### Single Dose

##### *Vaginal candidiasis*

The recommended dosage of fluconazole for vaginal candidiasis is 150 mg as a single oral dose.

#### Multiple Dose

SINCE ORAL ABSORPTION IS RAPID AND ALMOST COMPLETE, THE DAILY DOSE OF FLUCONAZOLE IS THE SAME FOR ORAL (TABLETS AND SUSPENSION) AND INTRAVENOUS ADMINISTRATION. In general, a loading dose of twice the daily dose is recommended on the first day of therapy to result in plasma concentrations close to steady-state by the second day of therapy.

The daily dose of fluconazole for the treatment of infections other than vaginal candidiasis should be based on the infecting organism and the patient's response to therapy. Treatment should be continued until clinical parameters or laboratory tests indicate that active fungal infection has subsided. An inadequate period of treatment may lead to recurrence of active infection. Patients with AIDS and cryptococcal meningitis or recurrent oropharyngeal candidiasis usually require maintenance therapy to prevent relapse.

##### *Oropharyngeal candidiasis*

The recommended dosage of fluconazole for oropharyngeal candidiasis is 200 mg on the first day, followed by 100 mg once daily. Clinical evidence of oropharyngeal candidiasis generally resolves within several days, but treatment should be continued for at least 2 weeks to decrease the likelihood of relapse.

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*Esophageal candidiasis*

The recommended dosage of fluconazole for esophageal candidiasis is 200 mg on the first day, followed by 100 mg once daily. Doses up to 400 mg/day may be used, based on medical judgment of the patient's response to therapy. Patients with esophageal candidiasis should be treated for a minimum of three weeks and for at least two weeks following resolution of symptoms.

*Systemic Candida infections*

For systemic *Candida* infections including candidemia, disseminated candidiasis, and pneumonia, optimal therapeutic dosage and duration of therapy have not been established. In open, noncomparative studies of small numbers of patients, doses of up to 400 mg daily have been used.

*Urinary tract infections and peritonitis*

For the treatment of *Candida* urinary tract infections and peritonitis, daily doses of 50 to 200 mg have been used in open, noncomparative studies of small numbers of patients.

*Cryptococcal meningitis*

The recommended dosage for treatment of acute cryptococcal meningitis is 400 mg on the first day, followed by 200 mg once daily. A dosage of 400 mg once daily may be used, based on medical judgment of the patient's response to therapy. The recommended duration of treatment for initial therapy of cryptococcal meningitis is 10 to 12 weeks after the cerebrospinal fluid becomes culture negative. The recommended dosage of fluconazole for suppression of relapse of cryptococcal meningitis in patients with AIDS is 200 mg once daily.

*Prophylaxis in patients undergoing bone marrow transplantation*

The recommended fluconazole daily dosage for the prevention of candidiasis in patients undergoing bone marrow transplantation is 400 mg, once daily. Patients who are anticipated to have severe granulocytopenia (less than 500 neutrophils per cu mm) should start fluconazole prophylaxis several days before the anticipated onset of neutropenia, and continue for 7 days after the neutrophil count rises above 1000 cells per cu mm.

**Dosage and Administration in Children**

The following dose equivalency scheme should generally provide equivalent exposure in pediatric and adult patients:

<b>Pediatric Patients</b>	<b>Adults</b>
* Some older children may have clearances similar to that of adults. Absolute doses exceeding 600 mg/day are not recommended.	
3 mg/kg	100 mg
6 mg/kg	200 mg
12* mg/kg	400 mg

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Experience with fluconazole in neonates is limited to pharmacokinetic studies in premature newborns. Based on the prolonged half-life seen in premature newborns (gestational age 26 to 29 weeks), these children, in the first two weeks of life, should receive the same dosage (mg/kg) as in older children, but administered every 72 hours. After the first two weeks, these children should be dosed once daily. No information regarding fluconazole pharmacokinetics in full-term newborns is available.

**Oropharyngeal candidiasis**

The recommended dosage of fluconazole for oropharyngeal candidiasis in children is 6 mg/kg on the first day, followed by 3 mg/kg once daily. Treatment should be administered for at least 2 weeks to decrease the likelihood of relapse.

**Esophageal candidiasis**

For the treatment of esophageal candidiasis, the recommended dosage of fluconazole in children is 6 mg/kg on the first day, followed by 3 mg/kg once daily. Doses up to 12 mg/kg/day may be used, based on medical judgment of the patient's response to therapy. Patients with esophageal candidiasis should be treated for a minimum of three weeks and for at least 2 weeks following the resolution of symptoms.

**Systemic Candida infections**

For the treatment of candidemia and disseminated *Candida* infections, daily doses of 6 to 12 mg/kg/day have been used in an open, noncomparative study of a small number of children.

**Cryptococcal meningitis**

For the treatment of acute cryptococcal meningitis, the recommended dosage is 12 mg/kg on the first day, followed by 6 mg/kg once daily. A dosage of 12 mg/kg once daily may be used, based on medical judgment of the patient's response to therapy. The recommended duration of treatment for initial therapy of cryptococcal meningitis is 10 to 12 weeks after the cerebrospinal fluid becomes culture negative. For suppression of relapse of cryptococcal meningitis in children with AIDS, the recommended dose of fluconazole is 6 mg/kg once daily.

**Dosage In Patients With Impaired Renal Function**

Fluconazole is cleared primarily by renal excretion as unchanged drug. There is no need to adjust single dose therapy for vaginal candidiasis because of impaired renal function. In patients with impaired renal function who will receive multiple doses of fluconazole, an initial loading dose of 50 to 400 mg should be given. After the loading dose, the daily dose (according to indication) should be based on the following table:

<b>Creatinine Clearance (mL/min)</b>	<b>Percent of Recommended Dose</b>

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Creatinine Clearance (mL/min)	Percent of Recommended Dose
>50	100%
≤50 (no dialysis)	50%
Regular dialysis	100% after each dialysis

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These are suggested dose adjustments based on pharmacokinetics following administration of multiple doses. Further adjustment may be needed depending upon clinical condition.

When serum creatinine is the only measure of renal function available, the following formula (based on sex, weight, and age of the patient) should be used to estimate the creatinine clearance in adults:

Males:  $\text{Weight (kg)} \times (140 - \text{age})$

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$72 \times \text{serum creatinine (mg/100 mL)}$

Females:  $0.85 \times \text{above value}$

Although the pharmacokinetics of fluconazole has not been studied in children with renal insufficiency, dosage reduction in children with renal insufficiency should parallel that recommended for adults. The following formula may be used to estimate creatinine clearance in children:

$K \times \text{linear length or height (cm)}$

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$\text{serum creatinine (mg/100 mL)}$

(Where  $K=0.55$  for children older than 1 year and  $0.45$  for infants.)

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### **Administration**

Fluconazole may be administered either orally or by intravenous infusion. Fluconazole can be taken with or without food.

### **4.3 CONTRAINDICATIONS**

Fluconazole is contraindicated in patients who have shown hypersensitivity to fluconazole or to any of its excipients. There is no information regarding cross-hypersensitivity between fluconazole and other azole antifungal agents. Caution should be used in prescribing fluconazole to patients with hypersensitivity to other azoles. Coadministration of terfenadine is contraindicated in patients receiving fluconazole at multiple doses of 400 mg or higher based upon results of a multiple dose interaction study. Coadministration of other drugs known to prolong the QT interval and which are metabolized via the enzyme CYP3A4 such as cisapride, astemizole, erythromycin, pimozide, and quinidine are contraindicated in patients receiving fluconazole.

### **4.4 SPECIAL WARNINGS AND PRECAUTIONS FOR USE**

#### **WARNINGS**

##### **(1) Hepatic injury**

Fluconazole should be administered with caution to patients with liver dysfunction. Fluconazole has been associated with rare cases of serious hepatic toxicity, including fatalities primarily in patients with serious underlying medical conditions. In cases of fluconazole-associated hepatotoxicity, no obvious relationship to total daily dose, duration of therapy, sex, or age of the patient has been observed. Fluconazole hepatotoxicity has usually, but not always, been reversible on discontinuation of therapy. Patients who develop abnormal liver function tests during fluconazole therapy should be monitored for the development of more severe hepatic injury. Fluconazole should be discontinued if clinical signs and symptoms consistent with liver disease develop that may be attributable to fluconazole.

##### **(2) Anaphylaxis**

In rare cases, anaphylaxis has been reported.

##### **(3) Dermatologic**

Exfoliative skin disorders during treatment with fluconazole have been reported. Fatal outcomes have been reported in patients with serious underlying diseases. Patients with deep seated fungal infections who develop rashes during treatment with fluconazole should be monitored closely and the drug discontinued if lesions progress. Fluconazole should be discontinued in patients treated for superficial fungal infection who develop a rash that may be attributed to fluconazole.

##### **(4) Use in Pregnancy**

There are no adequate and well-controlled studies of fluconazole in pregnant women. Available human data do not suggest an increased risk of congenital anomalies following a single maternal dose of 150 mg. A few published case reports describe a rare pattern of

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distinct congenital anomalies in infants exposed *in utero* to high dose maternal fluconazole (400 to 800 mg/day) during most or all of the first trimester. These reported anomalies are similar to those seen in animal studies. If this drug is used during pregnancy or if the patient becomes pregnant while taking the drug, the patient should be informed of the potential hazard to the fetus.

## **PRECAUTIONS**

### **General**

Some azoles, including fluconazole, have been associated with prolongation of the QT interval on the electrocardiogram. During post-marketing surveillance, there have been rare cases of QT prolongation and torsade de pointes in patients taking fluconazole. Most of these reports involved seriously ill patients with multiple confounding risk factors, such as structural heart disease, electrolyte abnormalities, and concomitant medications that may have been contributory.

Fluconazole should be administered with caution to patients with these potentially proarrhythmic conditions.

Concomitant use of fluconazole and erythromycin has the potential to increase the risk of cardiotoxicity (prolonged QT interval, torsade de pointes) and consequently sudden heart death. This combination should be avoided.

Fluconazole should be administered with caution to patients with renal dysfunction.

Fluconazole is a potent CYP2C9 inhibitor and a moderate CYP3A4 inhibitor. Fluconazole treated patients who are concomitantly treated with drugs with a narrow therapeutic window metabolized through CYP2C9 and CYP3A4 should be monitored.

When driving vehicles or operating machines, it should be taken into account that occasionally dizziness or seizures may occur.

### **Single Dose**

The convenience and efficacy of the single dose oral tablet of fluconazole regimen for the treatment of vaginal yeast infections should be weighed against the acceptability of a higher incidence of drug related adverse events with fluconazole (26%) versus intravaginal agents (16%) in U.S. comparative clinical studies.

## **4.5 INTERACTION WITH OTHER MEDICINAL PRODUCTS AND OTHER FORMS OF INTERACTION**

Fluconazole is a potent inhibitor of cytochrome P450 (CYP) isoenzyme 2C9 and a moderate inhibitor of CYP3A4. In addition to the observed /documented interactions mentioned below, there is a risk of increased plasma concentration of other compounds metabolized by CYP2C9 and CYP3A4 coadministered with fluconazole. Therefore, caution should be exercised when using these combinations and the patients should be carefully monitored. The enzyme inhibiting effect of fluconazole persists 4 to 5 days after discontinuation of fluconazole treatment due to the long half-life of fluconazole. Clinically or potentially significant drug interactions between fluconazole and the following agents/classes have been observed. These are described in greater detail below:

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Oral hypoglycemics  
Coumarin-type anticoagulants  
Phenytoin  
Cyclosporine  
Rifampin  
Theophylline  
Terfenadine  
Cisapride  
Astemizole  
Rifabutin  
Voriconazole  
Tacrolimus  
Short-acting benzodiazepines  
Tofacitinib  
Triazolam  
Oral Contraceptives  
Pimozide  
Quinidine  
Hydrochlorothiazide  
Alfentanil  
Amitriptyline, nortriptyline  
Amphotericin B  
Azithromycin  
Carbamazepine  
Calcium Channel Blockers  
Celecoxib  
Cyclophosphamide  
Fentanyl  
Halofantrine  
HMG-CoA reductase inhibitors  
Losartan  
Methadone  
Non-steroidal anti-inflammatory drugs  
Prednisone  
Saquinavir  
Sirolimus  
Vinca Alkaloids  
Vitamin A  
Zidovudine

Oral hypoglycemics

Clinically significant hypoglycemia may be precipitated by the use of fluconazole with oral hypoglycemic agents; one fatality has been reported from hypoglycemia in association with combined fluconazole and glyburide use. Fluconazole reduces the metabolism of tolbutamide, glyburide, and glipizide and increases the plasma concentration of these agents. When fluconazole is used concomitantly with these or other sulfonylurea oral hypoglycemic



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agents, blood glucose concentrations should be carefully monitored and the dose of the sulfonylurea should be adjusted as necessary.

**Coumarin-type anticoagulants**

Prothrombin time may be increased in patients receiving concomitant fluconazole and coumarin-type anticoagulants. In post-marketing experience, as with other azole antifungals, bleeding events (bruising, epistaxis, gastrointestinal bleeding, hematuria, and melena) have been reported in association with increases in prothrombin time in patients receiving fluconazole concurrently with warfarin. Careful monitoring of prothrombin time in patients receiving fluconazole and coumarin-type anticoagulants is recommended. Dose adjustment of warfarin may be necessary.

**Phenytoin**

Fluconazole increases the plasma concentrations of phenytoin. Careful monitoring of phenytoin concentrations in patients receiving fluconazole and phenytoin is recommended.

**Cyclosporine**

Fluconazole significantly increases cyclosporine levels in renal transplant patients with or without renal impairment. Careful monitoring of cyclosporine concentrations and serum creatinine is recommended in patients receiving fluconazole and cyclosporine. This combination may be used by reducing the dosage of cyclosporine depending on cyclosporine concentration.

**Rifampin**

Rifampin enhances the metabolism of concurrently administered fluconazole. Depending on clinical circumstances, consideration should be given to increasing the dose of fluconazole when it is administered with rifampin.

**Theophylline**

Fluconazole increases the serum concentrations of theophylline. Careful monitoring of serum theophylline concentrations in patients receiving fluconazole and theophylline is recommended.

**Terfenadine**

Because of the occurrence of serious cardiac dysrhythmias secondary to prolongation of the QTc interval in patients receiving azole antifungals in conjunction with terfenadine, interaction studies have been performed. One study at a 200 mg daily dose of fluconazole failed to demonstrate a prolongation in QTc interval. Another study at a 400 mg and 800 mg daily dose of fluconazole demonstrated that fluconazole taken in doses of 400 mg per day or greater significantly increases plasma levels of terfenadine when taken concomitantly. The combined use of fluconazole at doses of 400 mg or greater with terfenadine is contraindicated. The coadministration of fluconazole at doses lower than 400 mg/day with terfenadine should be carefully monitored.

**Cisapride**

There have been reports of cardiac events, including torsade de pointes, in patients to whom fluconazole and cisapride were coadministered. A controlled study found that concomitant

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fluconazole 200 mg once daily and cisapride 20 mg four times a day yielded a significant increase in cisapride plasma levels and prolongation of QTc interval. The combined use of fluconazole with cisapride is contraindicated.

**Astemizole**

Concomitant administration of fluconazole with astemizole may decrease the clearance of astemizole. Resulting increased plasma concentrations of astemizole can lead to QT prolongation and rare occurrences of torsade de pointes. Coadministration of fluconazole and astemizole is contraindicated.

**Rifabutin**

There have been reports that an interaction exists when fluconazole is administered concomitantly with rifabutin, leading to increased serum levels of rifabutin up to 80%. There have been reports of uveitis in patients to whom fluconazole and rifabutin were coadministered. Patients receiving rifabutin and fluconazole concomitantly should be carefully monitored.

**Voriconazole**

Avoid concomitant administration of voriconazole and fluconazole. Monitoring for adverse events and toxicity related to voriconazole is recommended; especially, if voriconazole is started within 24 h after the last dose of fluconazole.

**Tacrolimus**

Fluconazole may increase the serum concentrations of orally administered tacrolimus up to 5 times due to inhibition of tacrolimus metabolism through CYP3A4 in the intestines. No significant pharmacokinetic changes have been observed when tacrolimus is given intravenously. Increased tacrolimus levels have been associated with nephrotoxicity. Dosage of orally administered tacrolimus should be decreased depending on tacrolimus concentration.

**Short-acting Benzodiazepines**

Following oral administration of midazolam, fluconazole resulted in substantial increases in midazolam concentrations and psychomotor effects. This effect on midazolam appears to be more pronounced following oral administration of fluconazole than with fluconazole administered intravenously. If short-acting benzodiazepines, which are metabolized by the cytochrome P450 system, are concomitantly administered with fluconazole, consideration should be given to decreasing the benzodiazepine dosage, and the patients should be appropriately monitored.

**Tofacitinib**

Systemic exposure to tofacitinib is increased when tofacitinib is coadministered with fluconazole, a combined moderate CYP3A4 and potent CYP2C19 inhibitor. Reduce the dose of tofacitinib when given concomitantly with fluconazole (i.e., from 5 mg twice daily to 5 mg once daily as instructed in the XELJANZ® [tofacitinib] label).

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**Triazolam**

Fluconazole increases the AUC of triazolam (single dose) by approximately 50%,  $C_{max}$  by 20 to 32%, and increases  $t_{1/2}$  by 25 to 50% due to the inhibition of metabolism of triazolam. Dosage adjustments of triazolam may be necessary.

**Oral Contraceptives**

Two pharmacokinetic studies with a combined oral contraceptive have been performed using multiple doses of fluconazole. There were no relevant effects on hormone level in the 50 mg fluconazole study, while at 200 mg daily, the AUCs of ethinyl estradiol and levonorgestrel were increased 40% and 24%, respectively. Thus, multiple dose use of fluconazole at these doses is unlikely to have an effect on the efficacy of the combined oral contraceptive.

**Pimozide**

Although not studied *in vitro* or *in vivo*, concomitant administration of fluconazole with pimozide may result in inhibition of pimozide metabolism. Increased pimozide plasma concentrations can lead to QT prolongation and rare occurrences of torsade de pointes. Coadministration of fluconazole and pimozide is contraindicated.

**Quinidine**

Although not studied *in vitro* or *in vivo*, concomitant administration of fluconazole with quinidine may result in inhibition of quinidine metabolism. Use of quinidine has been associated with QT prolongation and rare occurrences of torsades de pointes. Coadministration of fluconazole and quinidine is contraindicated.

**Hydrochlorothiazide**

In a pharmacokinetic interaction study, coadministration of multiple dose hydrochlorothiazide to healthy volunteers receiving fluconazole increased plasma concentrations of fluconazole by 40%. An effect of this magnitude should not necessitate a change in the fluconazole dose regimen in subjects receiving concomitant diuretics.

**Alfentanil**

A study observed a reduction in clearance and distribution volume as well as prolongation of  $T_{1/2}$  of alfentanil following concomitant treatment with fluconazole. A possible mechanism of action is fluconazole's inhibition of CYP3A4. Dosage adjustment of alfentanil may be necessary.

**Amitriptyline, nortriptyline**

Fluconazole increases the effect of amitriptyline and nortriptyline. 5-nortriptyline and/or S-amitriptyline may be measured at initiation of the combination therapy and after one week. Dosage of amitriptyline/nortriptyline should be adjusted, if necessary.

**Amphotericin B**

Concurrent administration of fluconazole and amphotericin B in infected normal and immunosuppressed mice showed the following results: a small additive antifungal effect in systemic infection with *C. albicans*, no interaction in intracranial infection with *Cryptococcus*

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*neoformans*, and antagonism of the two drugs in systemic infection with *A. fumigatus*. The clinical significance of results obtained in these studies is unknown.

#### Azithromycin

An open-label, randomized, three-way crossover study in 18 healthy subjects assessed the effect of a single 1200 mg oral dose of azithromycin on the pharmacokinetics of a single 800 mg oral dose of fluconazole as well as the effects of fluconazole on the pharmacokinetics of azithromycin. There was no significant pharmacokinetic interaction between fluconazole and azithromycin.

#### Carbamazepine

Fluconazole inhibits the metabolism of carbamazepine and an increase in serum carbamazepine of 30% has been observed. There is a risk of developing carbamazepine toxicity. Dosage adjustment of carbamazepine may be necessary depending on concentration measurements/effect.

#### Calcium Channel Blockers

Certain dihydropyridine calcium channel antagonists (nifedipine, isradipine, amlodipine, and felodipine) are metabolized by CYP3A4. Fluconazole has the potential to increase the systemic exposure of the calcium channel antagonists. Frequent monitoring for adverse events is recommended.

#### Celecoxib

During concomitant treatment with fluconazole (200 mg daily) and celecoxib (200 mg), the celecoxib  $C_{max}$  and AUC increased by 68% and 134%, respectively. Half of the celecoxib dose may be necessary when combined with fluconazole.

#### Cyclophosphamide

Combination therapy with cyclophosphamide and fluconazole results in an increase in serum bilirubin and serum creatinine. The combination may be used while taking increased consideration to the risk of increased serum bilirubin and serum creatinine.

#### Fentanyl

One fatal case of possible fentanyl fluconazole interaction was reported. The author judged that the patient died from fentanyl intoxication. Furthermore, in a randomized crossover study with 12 healthy volunteers it was shown that fluconazole delayed the elimination of fentanyl significantly. Elevated fentanyl concentration may lead to respiratory depression.

#### Halofantrine

Fluconazole can increase halofantrine plasma concentration due to an inhibitory effect on CYP3A4.

#### HMG-CoA reductase inhibitors

The risk of myopathy and rhabdomyolysis increases when fluconazole is coadministered with HMG-CoA reductase inhibitors metabolized through CYP3A4, such as atorvastatin and simvastatin, or through CYP2C9, such as fluvastatin. If concomitant therapy is necessary, the

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patient should be observed for symptoms of myopathy and rhabdomyolysis and creatinine kinase should be monitored. HMG-CoA reductase inhibitors should be discontinued if a marked increase in creatinine kinase is observed or myopathy/rhabdomyolysis is diagnosed or suspected.

**Losartan**

Fluconazole inhibits the metabolism of losartan to its active metabolite (E-31 74) which is responsible for most of the angiotensin II-receptor antagonism which occurs during treatment with losartan. Patients should have their blood pressure monitored continuously.

**Methadone**

Fluconazole may enhance the serum concentration of methadone. Dosage adjustment of methadone may be necessary.

**Non-steroidal anti-inflammatory drugs**

The  $C_{max}$  and AUC of flurbiprofen were increased by 23% and 81%, respectively, when coadministered with fluconazole compared to administration of flurbiprofen alone. Similarly, the  $C_{max}$  and AUC of the pharmacologically active isomer [S-(+)-ibuprofen] were increased by 15% and 82%, respectively, when fluconazole was coadministered with racemic ibuprofen (400 mg) compared to administration of racemic ibuprofen alone.

Although not specifically studied, fluconazole has the potential to increase the systemic exposure of other NSAIDs that are metabolized by CYP2C9 (e.g., naproxen, lornoxicam, meloxicam, diclofenac). Frequent monitoring for adverse events and toxicity related to NSAIDs is recommended. Adjustment of dosage of NSAIDs may be needed.

**Prednisone**

There was a case report that a liver-transplanted patient treated with prednisone developed acute adrenal cortex insufficiency when a three month therapy with fluconazole was discontinued. The discontinuation of fluconazole presumably caused an enhanced CYP3A4 activity which led to increased metabolism of prednisone. Patients on long-term treatment with fluconazole and prednisone should be carefully monitored for adrenal cortex insufficiency when fluconazole is discontinued.

**Saquinavir**

Fluconazole increases the AUC of saquinavir by approximately 50%,  $C_{max}$  by approximately 55%, and decreases clearance of saquinavir by approximately 50% due to inhibition of saquinavir's hepatic metabolism by CYP3A4 and inhibition of P-glycoprotein. Dosage adjustment of saquinavir may be necessary.

**Sirolimus**

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Fluconazole increases plasma concentrations of sirolimus presumably by inhibiting the metabolism of sirolimus via CYP3A4 and P-glycoprotein. This combination may be used with a dosage adjustment of sirolimus depending on the effect/concentration measurements.

**Vinca Alkaloids**

Although not studied, fluconazole may increase the plasma levels of the vinca alkaloids (e.g., vincristine and vinblastine) and lead to neurotoxicity, which is possibly due to an inhibitory effect on CYP3A4.

**Vitamin A**

Based on a case report in one patient receiving combination therapy with all-transretinoid acid (an acid form of vitamin A) and fluconazole, CNS related undesirable effects have developed in the form of pseudotumour cerebri, which disappeared after discontinuation of fluconazole treatment. This combination may be used but the incidence of CNS related undesirable effects should be borne in mind.

**Zidovudine**

Fluconazole increases  $C_{max}$  and AUC of zidovudine by 84% and 74%, respectively, due to an approximately 45% decrease in oral zidovudine clearance. The half-life of zidovudine was likewise prolonged by approximately 128% following combination therapy with fluconazole. Patients receiving this combination should be monitored for the development of zidovudine-related adverse reactions. Dosage reduction of zidovudine may be considered.

**4.6 PREGNANCY AND LACTATION**

Pregnancy:

**Teratogenic Effects**

*Pregnancy Category C*

Single 150 mg tablet use for Vaginal Candidiasis

There are no adequate and well-controlled studies of fluconazole in pregnant women. Available human data do not suggest an increased risk of congenital anomalies following a single maternal dose of 150 mg.

*Pregnancy Category D*

**All other indications**

A few published case reports describe a rare pattern of distinct congenital anomalies in infants exposed *in utero* to high dose maternal fluconazole (400 to 800 mg/day) during most or all of the first trimester. These reported anomalies are similar to those seen in animal studies. If this drug is used during pregnancy, or if the patient becomes pregnant while taking the drug, the patient should be informed of the potential hazard to the fetus.

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*Human Data*

Several published epidemiologic studies do not suggest an increased risk of congenital anomalies associated with low dose exposure to fluconazole in pregnancy (most subjects received a single oral dose of 150 mg). A few published case reports describe a distinctive and rare pattern of birth defects among infants whose mothers received high-dose (400 to 800 mg/day) fluconazole during most or all of the first trimester of pregnancy. The features seen in these infants include: brachycephaly, abnormal facies, abnormal calvarial development, cleft palate, femoral bowing, thin ribs and long bones, arthrogyrosis, and congenital heart disease. These effects are similar to those seen in animal studies.

*Animal Data*

Fluconazole was administered orally to pregnant rabbits during organogenesis in two studies at doses of 5, 10, and 20 mg/kg and at 5, 25, and 75 mg/kg, respectively. Maternal weight gain was impaired at all dose levels (approximately 0.25 to 4 times the 400 mg clinical dose based on BSA), and abortions occurred at 75 mg/kg (approximately 4 times the 400 mg clinical dose based on BSA); no adverse fetal effects were observed.

In several studies in which pregnant rats received fluconazole orally during organogenesis, maternal weight gain was impaired and placental weights were increased at 25 mg/kg. There were no fetal effects at 5 or 10 mg/kg; increases in fetal anatomical variants (supernumerary ribs, renal pelvis dilation) and delays in ossification were observed at 25 and 50 mg/kg and higher doses. At doses ranging from 80 to 320 mg/kg (approximately 2 to 8 times the 400 mg clinical dose based on BSA), embryoletality in rats was increased and fetal abnormalities included wavy ribs, cleft palate, and abnormal cranio-facial ossification. These effects are consistent with the inhibition of estrogen synthesis in rats and may be a result of known effects of lowered estrogen on pregnancy, organogenesis, and parturition.

Breast-feeding:

Fluconazole is secreted in human milk at concentrations similar to maternal plasma concentrations. Caution should be exercised when fluconazole is administered to a nursing woman.

Fertility:

Fluconazole showed no evidence of carcinogenic potential in mice and rats treated orally for 24 months at doses of 2.5, 5, or 10 mg/kg/day (approximately 2 to 7 times the recommended human dose). Male rats treated with 5 and 10 mg/kg/day had an increased incidence of hepatocellular adenomas.

Fluconazole, with or without metabolic activation, was negative in tests for mutagenicity in 4 strains of *S. typhimurium*, and in the mouse lymphoma L5178Y system. Cytogenetic studies *in vivo* (murine bone marrow cells, following oral administration of fluconazole) and *in vitro* (human lymphocytes exposed to fluconazole at 1000 µg/mL) showed no evidence of chromosomal mutations.

Fluconazole did not affect the fertility of male or female rats treated orally with daily doses of 5, 10, or 20 mg/kg or with parenteral doses of 5, 25, or 75 mg/kg, although the onset of



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parturition was slightly delayed at 20 mg/kg PO. In an intravenous perinatal study in rats at 5, 20, and 40 mg/kg, dystocia and prolongation of parturition were observed in a few dams at 20 mg/kg (approximately 5 to 15 times the recommended human dose) and 40 mg/kg, but not at 5 mg/kg. The disturbances in parturition were reflected by a slight increase in the number of still-born pups and decrease of neonatal survival at these dose levels. The effects on parturition in rats are consistent with the species specific estrogen-lowering property produced by high doses of fluconazole. Such a hormone change has not been observed in women treated with fluconazole.

#### **4.7 EFFECTS ON ABILITY TO DRIVE AND USE MACHINES**

When driving vehicles or operating machines, it should be taken into account that occasionally dizziness or seizures may occur.

#### **4.8 UNDESIRABLE EFFECTS**

Fluconazole is generally well tolerated.

In some patients, particularly those with serious underlying diseases such as AIDS and cancer, changes in renal and hematological function test results and hepatic abnormalities have been observed during treatment with fluconazole and comparative agents, but the clinical significance and relationship to treatment is uncertain.

##### **In Patients Receiving a Single Dose for Vaginal Candidiasis**

During comparative clinical studies conducted in the United States, 448 patients with vaginal candidiasis were treated with fluconazole, 150 mg single dose. The overall incidence of side effects possibly related to fluconazole was 26%. In 422 patients receiving active comparative agents, the incidence was 16%. The most common treatment-related adverse events reported in the patients who received 150 mg single dose fluconazole for vaginitis were headache (13%), nausea (7%), and abdominal pain (6%). Other side effects reported with an incidence equal to or greater than 1% included diarrhea (3%), dyspepsia (1%), dizziness (1%), and taste perversion (1%). Most of the reported side effects were mild to moderate in severity. Rarely, angioedema and anaphylactic reaction have been reported in marketing experience.

##### **In Patients Receiving Multiple Doses for Other Infections**

Sixteen percent of over 4000 patients treated with fluconazole in clinical trials of 7 days or more experienced adverse events. Treatment was discontinued in 1.5% of patients due to adverse clinical events and in 1.3% of patients due to laboratory test abnormalities.

Clinical adverse events were reported more frequently in HIV infected patients (21%) than in non-HIV infected patients (13%); however, the patterns in HIV infected and non-HIV infected patients were similar. The proportions of patients discontinuing therapy due to clinical adverse events were similar in the two groups (1.5%).

The following treatment-related clinical adverse events occurred at an incidence of 1% or greater in 4048 patients receiving fluconazole for 7 or more days in clinical trials: nausea 3.7%, headache 1.9%, skin rash 1.8%, vomiting 1.7%, abdominal pain 1.7%, and diarrhea 1.5%.

Hepatobiliary



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In combined clinical trials and marketing experience, there have been rare cases of serious hepatic reactions during treatment with fluconazole. The spectrum of these hepatic reactions has ranged from mild transient elevations in transaminases to clinical hepatitis, cholestasis and fulminant hepatic failure, including fatalities. Instances of fatal hepatic reactions were noted to occur primarily in patients with serious underlying medical conditions (predominantly AIDS or malignancy) and often while taking multiple concomitant medications. Transient hepatic reactions, including hepatitis and jaundice, have occurred among patients with no other identifiable risk factors. In each of these cases, liver function returned to baseline on discontinuation of fluconazole.

In two comparative trials evaluating the efficacy of fluconazole for the suppression of relapse of cryptococcal meningitis, a statistically significant increase was observed in median AST (SGOT) levels from a baseline value of 30 IU/L to 41 IU/L in one trial and 34 IU/L to 66 IU/L in the other. The overall rate of serum transaminase elevations of more than 8 times the upper limit of normal was approximately 1% in fluconazole-treated patients in clinical trials. These elevations occurred in patients with severe underlying disease, predominantly AIDS or malignancies, most of whom were receiving multiple concomitant medications, including many known to be hepatotoxic. The incidence of abnormally elevated serum transaminases was greater in patients taking fluconazole concomitantly with one or more of the following medications: rifampin, phenytoin, isoniazid, valproic acid, or oral sulfonylurea hypoglycemic agents.

**Post-Marketing Experience**

In addition, the following adverse events have occurred during post-marketing experience.

*Immunologic:* In rare cases, anaphylaxis (including angioedema, face edema and pruritus) has been reported.

*Body as a Whole:* Asthenia, fatigue, fever, malaise.

*Cardiovascular:* QT prolongation, torsade de pointes.

*Central Nervous System:* Seizures, dizziness.

*Hematopoietic and Lymphatic:* Leukopenia, including neutropenia and agranulocytosis, thrombocytopenia.

*Metabolic:* Hypercholesterolemia, hypertriglyceridemia, hypokalemia.

*Gastrointestinal:* Cholestasis, dry mouth, hepatocellular damage, dyspepsia, vomiting.

*Other Senses:* Taste perversion.

*Musculoskeletal System:* myalgia.

*Nervous System:* Insomnia, paresthesia, somnolence, tremor, vertigo.

*Skin and Appendages:* Acute generalized exanthematous-pustulosis, drug eruption, increased sweating, exfoliative skin disorders including Stevens-Johnson syndrome and toxic epidermal necrolysis alopecia.

**Adverse Reactions in Children**

The pattern and incidence of adverse events and laboratory abnormalities recorded during pediatric clinical trials are comparable to those seen in adults.

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In Phase II/III clinical trials conducted in the United States and in Europe, 577 pediatric patients, ages 1 day to 17 years were treated with fluconazole at doses up to 15 mg/kg/day for up to 1,616 days. Thirteen percent of children experienced treatment-related adverse events. The most commonly reported events were vomiting (5%), abdominal pain (3%), nausea (2%), and diarrhea (2%). Treatment was discontinued in 2.3% of patients due to adverse clinical events and in 1.4% of patients due to laboratory test abnormalities. The majority of treatment-related laboratory abnormalities were elevations of transaminases or alkaline phosphatase.

**Percentage of Patients With Treatment-Related Side Effects**

	<b>Fluconazole (N=577)</b>	<b>Comparative Agents (N=451)</b>
With any side effect	13.0	9.3
Vomiting	5.4	5.1
Abdominal pain	2.8	1.6
Nausea	2.3	1.6
Diarrhea	2.1	2.2

**4.9 OVERDOSE**

There have been reports of overdose with fluconazole accompanied by hallucination and paranoid behavior.

In the event of overdose, symptomatic treatment (with supportive measures and gastric lavage if clinically indicated) should be instituted.

Fluconazole is largely excreted in urine. A three-hour hemodialysis session decreases plasma levels by approximately 50%.

In mice and rats receiving very high doses of fluconazole, clinical effects in both species included decreased motility and respiration, ptosis, lacrimation, salivation, urinary incontinence, loss of righting reflex, and cyanosis; death was sometimes preceded by clonic convulsions.

**5. PHARMACOLOGICAL PROPERTIES**

**5.1 PHARMACODYNAMICS**

*Pharmacotherapeutic group:* Antimycotics for systemic use, triazole derivatives, *ATC code:* J02AC01

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Highly selective inhibitor of fungal cytochrome P-450-dependent enzyme lanosterol 14-alpha-demethylase

Subsequent loss of normal sterols correlates with accumulation of 14 alpha-methyl sterols in fungi and may be responsible for the fungistatic activity of fluconazole

## **5.2 PHARMACOKINETIC PROPERTIES**

The pharmacokinetic properties of fluconazole are similar following administration by the intravenous or oral routes. In normal volunteers, the bioavailability of orally administered fluconazole is over 90% compared with intravenous administration. Bioequivalence was established between the 100 mg tablet and both suspension strengths when administered as a single 200 mg dose.

Peak plasma concentrations ( $C_{max}$ ) in fasted normal volunteers occur between 1 and 2 hours with a terminal plasma elimination half-life of approximately 30 hours (range: 20 to 50 hours) after oral administration.

In fasted normal volunteers, administration of a single oral 400 mg dose of fluconazole leads to a mean  $C_{max}$  of 6.72  $\mu\text{g/mL}$  (range: 4.12 to 8.08  $\mu\text{g/mL}$ ) and after single oral doses of 50 to 400 mg, fluconazole plasma concentrations and AUC (area under the plasma concentration-time curve) are dose proportional.

The  $C_{max}$  and AUC data from a food-effect study involving administration of fluconazole tablets, USP to healthy volunteers under fasting conditions and with a high-fat meal indicated that exposure to the drug is not affected by food. Therefore, fluconazole tablets, USP may be taken without regard to meals.

Administration of a single oral 150 mg tablet of fluconazole to ten lactating women resulted in a mean  $C_{max}$  of 2.61  $\mu\text{g/mL}$  (range: 1.57 to 3.65  $\mu\text{g/mL}$ ).

Steady-state concentrations are reached within 5 to 10 days following oral doses of 50 to 400 mg given once daily. Administration of a loading dose (on day 1) of twice the usual daily dose results in plasma concentrations close to steady-state by the second day. The apparent volume of distribution of fluconazole approximates that of total body water. Plasma protein binding is low (11 to 12%). Following either single- or multiple oral doses for up to 14 days, fluconazole penetrates into all body fluids studied (see table below). In normal volunteers, saliva concentrations of fluconazole were equal to or slightly greater than plasma concentrations regardless of dose, route, or duration of dosing. In patients with bronchiectasis, sputum concentrations of fluconazole following a single 150 mg oral dose were equal to plasma concentrations at both 4 and 24 hours post dose. In patients with fungal meningitis, fluconazole concentrations in the CSF are approximately 80% of the corresponding plasma concentrations.

A single oral 150 mg dose of fluconazole administered to 27 patients penetrated into vaginal tissue, resulting in tissue:plasma ratios ranging from 0.94 to 1.14 over the first 48 hours following dosing.

A single oral 150 mg dose of fluconazole administered to 14 patients penetrated into vaginal fluid, resulting in fluid:plasma ratios ranging from 0.36 to 0.71 over the first 72 hours following dosing.

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**Tissue or Fluid**                      **Ratio of Fluconazole Tissue (Fluid)/Plasma Concentration\***

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\* Relative to concurrent concentrations in plasma in subjects with normal renal function.

† Independent of degree of meningeal inflammation.

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Cerebrospinal fluid†	0.5-0.9
Saliva	1
Sputum	1
Blister fluid	1
Urine	10
Normal skin	10
Nails	1
Blister skin	2
Vaginal tissue	1
Vaginal fluid	0.4-0.7

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In normal volunteers, fluconazole is cleared primarily by renal excretion, with approximately 80% of the administered dose appearing in the urine as unchanged drug. About 11% of the dose is excreted in the urine as metabolites.

The pharmacokinetics of fluconazole are markedly affected by reduction in renal function. There is an inverse relationship between the elimination half-life and creatinine clearance. The dose of fluconazole may need to be reduced in patients with impaired renal function. A 3-hour hemodialysis session decreases plasma concentrations by approximately 50%.

In normal volunteers, fluconazole administration (doses ranging from 200 mg to 400 mg once daily for up to 14 days) was associated with small and inconsistent effects on testosterone concentrations, endogenous corticosteroid concentrations, and the ACTH-stimulated cortisol response.

**Pharmacokinetics in Children**

In children, the following pharmacokinetic data {Mean (%cv)} have been reported:

Age Studied	Dose (mg/kg)	Clearance (mL/min/kg)	Half-life (Hours)	C <sub>max</sub> (µg/mL)	V <sub>dss</sub> (L/kg)
9 Months-13 years	Single-Oral 2 mg/kg	0.40 (38%) N=14	25.0	2.9 (22%) N=16	-

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Age Studied	Dose (mg/kg)	Clearance (mL/min/kg)	Half-life (Hours)	C <sub>max</sub> (µg/mL)	V <sub>dss</sub> (L/kg)
9 Months-13 years	Single-Oral 8 mg/kg	0.51 (60%) N=15	19.5	9.8 (20%) N=15	-
5-15 years	Multiple IV 2 mg/kg	0.49 (40%) N=4	17.4	5.5 (25%) N=5	0.722 (36%) N=4
5-15 years	Multiple IV 4 mg/kg	0.59 (64%) N=5	15.2	11.4 (44%) N=6	0.729 (33%) N=5
5-15 years	Multiple IV 8 mg/kg	0.66 (31%) N=7	17.6	14.1 (22%) N=8	1.069 (37%) N=7

Clearance corrected for body weight was not affected by age in these studies. Mean body clearance in adults is reported to be 0.23 (17%) mL/min/kg.

In premature newborns (gestational age 26 to 29 weeks), the mean (%cv) clearance within 36 hours of birth was 0.180 (35%, N=7) mL/min/kg, which increased with time to a mean of 0.218 (31%, N=9) mL/min/kg six days later and 0.333 (56%, N=4) mL/min/kg 12 days later. Similarly, the half-life was 73.6 hours, which decreased with time to a mean of 53.2 hours six days later and 46.6 hours 12 days later.

### Pharmacokinetics in Elderly

A pharmacokinetic study was conducted in 22 subjects, 65 years of age or older receiving a single 50 mg oral dose of fluconazole. Ten of these patients were concomitantly receiving diuretics. The C<sub>max</sub> was 1.54 mcg/mL and occurred at 1.3 hours post dose. The mean AUC was 76.4 ± 20.3 mcg·h/mL, and the mean terminal half-life was 46.2 hours. These pharmacokinetic parameter values are higher than analogous values reported for normal young male volunteers. Coadministration of diuretics did not significantly alter AUC or C<sub>max</sub>. In addition, creatinine clearance (74 mL/min), the percent of drug recovered unchanged in urine (0 to 24 hr, 22%), and the fluconazole renal clearance estimates (0.124 mL/min/kg) for the elderly were generally lower than those of younger volunteers. Thus, the alteration of fluconazole disposition in the elderly appears to be related to reduced renal function

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characteristic of this group. A plot of each subject's terminal elimination half-life versus creatinine clearance compared with the predicted half-life – creatinine clearance curve derived from normal subjects and subjects with varying degrees of renal insufficiency indicated that 21 of 22 subjects fell within the 95% confidence limit of the predicted half-life – creatinine clearance curves. These results are consistent with the hypothesis that higher values for the pharmacokinetic parameters observed in the elderly subjects compared with normal young male volunteers are due to the decreased kidney function that is expected in the elderly.

### **5.3 PRECLINICAL SAFETY DATA**

Fluconazole showed no evidence of carcinogenic potential in mice and rats treated orally for 24 months at doses of 2.5, 5, or 10 mg/kg/day (approximately 2 to 7 times the recommended human dose). Male rats treated with 5 and 10 mg/kg/day had an increased incidence of hepatocellular adenomas.

Fluconazole, with or without metabolic activation, was negative in tests for mutagenicity in 4 strains of *S. typhimurium*, and in the mouse lymphoma L5178Y system. Cytogenetic studies *in vivo* (murine bone marrow cells, following oral administration of fluconazole) and *in vitro* (human lymphocytes exposed to fluconazole at 1000 µg/mL) showed no evidence of chromosomal mutations.

Fluconazole did not affect the fertility of male or female rats treated orally with daily doses of 5, 10, or 20 mg/kg or with parenteral doses of 5, 25, or 75 mg/kg, although the onset of parturition was slightly delayed at 20 mg/kg PO. In an intravenous perinatal study in rats at 5, 20, and 40 mg/kg, dystocia and prolongation of parturition were observed in a few dams at 20 mg/kg (approximately 5 to 15 times the recommended human dose) and 40 mg/kg, but not at 5 mg/kg. The disturbances in parturition were reflected by a slight increase in the number of still-born pups and decrease of neonatal survival at these dose levels. The effects on parturition in rats are consistent with the species specific estrogen-lowering property produced by high doses of fluconazole. Such a hormone change has not been observed in women treated with fluconazole.

## **6. PHARMACEUTICAL PARTICULARS**

### **6.1 LIST OF EXCIPIENTS**

Maize Starch BP  
Lactose BP  
Microcrystalline Cellulose BP  
Sodium Starch Glycollate BP  
Maize Starch (For Paste) BP  
Methyl Paraben BP  
Propyl Paraben BP  
Colour Erythrosine Supra IHS  
Purified Talc BP  
Magnesium Stearate BP  
Cros Carmellose Sodium BP

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**6.2 INCOMPATIBILITIES**

Not applicable.

**6.3 SHELF LIFE**

3 Years

**6.4 SPECIAL PRECAUTIONS FOR STORAGE**

Store below 30°C.

**6.5 NATURE AND CONTENTS OF CONTAINER**

ALU - ALU Blister Pack

**6.6 SPECIAL PRECAUTIONS FOR DISPOSAL**

**Not Applicable**

**7. APPLICANT/MANUFACTURER**

MEDICO REMEDIES LTD.

Address: 8 & 9, Dewan & Sons Udyog Nagar,  
Palghar, Dist. Thane, Maharashtra.

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