

Rx Pipravid*

Piperacillin and Tazobactam Injection IP 4.5gm

COMPOSITION

Each Combipack Contains:

1. Piperacillin and Tazobactam For Injection IP 4.5 gm

Each vial contains:

Piperacillin Sodium USP

Equivalent to Piperacillin.....4.0 gm

Tazobactam Sodium

Equivalent to Tazobactam.....0.5 gm

Sodium Content 9.40 meq

(Approx. 216 mg)

2. Sterile Water For Injections IP.....20 ml

DOSAGE FORM AND STRENGTH

Powder for solution for infusion.

THERAPEUTIC INDICATIONS

Pipravid IV is indicated in the treatment of LRTI/UTI/Intra-abdominal infections, skin and skin structure infections, bacterial septicemic polymicrobial infections.

PSOLOGY AND METHOD OF ADMINISTRATION

The dose and frequency of piperacillin / tazobactam depends on the severity and localization of the infection and expected pathogens.

Adult and adolescent patients

Infections

The usual dose is 4 g piperacillin/0.5 g tazobactam given every 8 hours.

For nosocomial pneumonia and bacterial infections in neutropenic patients, the recommended dose is 4 g piperacillin / 0.5 g tazobactam administered every 6 hours. This regimen may also be applicable to treat patients with other indicated infections when particularly severe.

The following table summarizes the treatment frequency and the recommended dose for adult and adolescent patients by indication or condition:

Treatment frequency	Piperacillin / tazobactam 4 g/0.5 g
Every 6 hours	Pneumonia
Every 8 hours	Urinary tract infections
	Intra-abdominal infections
	Skin and soft tissue infections

Treatment duration

The usual duration of treatment for most indications is in the range of 5-14 days. However, the duration of treatment should be guided by the severity of the infection, the pathogen(s) and the patient's clinical and bacteriological progress.

Special Population

Renal impairment

The intravenous dose should be adjusted to the degree of actual renal impairment as follows (each patient must be monitored closely for signs of substance toxicity; medicinal product dose and interval should be adjusted accordingly):

Creatinine clearance (ml/min)	Piperacillin / tazobactam (recommended dose)
> 40	No dose adjustment necessary
20-40	Maximum dose suggested: 4 g / 0.5 g every 8 hours
< 20	Maximum dose suggested: 4 g / 0.5 g every 12 hours

For patients on haemodialysis, one additional dose of piperacillin / tazobactam 2 g/0.25 g should be administered following each dialysis period, because haemodialysis removes 30%-50% of piperacillin in 4 hours.

Hepatic impairment

No dose adjustment is necessary.

Elderly

No dose adjustment is required for the elderly with normal renal function or creatinine clearance values above 40 ml/min.

Paediatric population (2-12 years of age)

Infections

The following table summarises the treatment frequency and the dose per body weight for paediatric patients 2-12 years of age by indication or condition:

Dose per weight and treatment frequency	Indication / condition
80 mg Piperacillin / 10 mg Tazobactam per kg body weight / every 6 hours	Neutropenic children with fever suspected to be due to bacterial infections*
100 mg Piperacillin / 12.5 mg Tazobactam per kg body weight / every 8 hours	Complicated intra-abdominal infections*

* Not to exceed the maximum 4 g/0.5 g per dose over 30 minutes.

Renal impairment

The intravenous dose should be adjusted to the degree of actual renal impairment as follows (each patient must be monitored closely for signs of substance toxicity; medicinal product dose and interval should be adjusted accordingly):

Creatinine clearance (ml/min)	Piperacillin / tazobactam (recommended dose)
> 50	No dose adjustment needed.
≤ 50	70 mg Piperacillin / 8.75 mg Tazobactam / kg every 8 hours.

For children on haemodialysis, one additional dose of 40 mg Piperacillin / 5 mg Tazobactam / kg should be administered following each dialysis period.

Use in children aged below 2 years

The safety and efficacy of piperacillin / tazobactam in children 0-2 years of age has not been established.

No data from controlled clinical studies are available.

Method of administration

Piperacillin / tazobactam 4 g/0.5 g is administered by intravenous infusion (over 30 minutes).

The reconstitution and dilution are to be made under aseptic conditions. The solution is to be inspected visually for particulate matter and discolouration prior to administration and should only be used if it is clear and free from particles.

Intravenous use

Reconstitution and dilution steps are described hereafter.

1) Reconstitution step

Each injection vial of Piperacillin/Tazobactam needs to be reconstituted by adding one of the following solutions:

- Sterile water for injection
- 0.9% (9 mg/ml) sodium chloride solution for injection
- Glucose 5%

2) Add the volume of solution indicated in the table below to each vial:

Content of the vial	Volume of solution to be added to the vial
2 g / 0.25 g (2 g piperacillin and 0.25 g tazobactam)	10 ml
4 g / 0.5 g (4 g piperacillin and 0.5 g tazobactam)	20 ml

3) Dilution step

The reconstituted solution should be withdrawn from the vial by syringe. When reconstituted as directed, the vial contents withdrawn by syringe will provide the labelled amount of piperacillin and tazobactam.

The reconstituted solutions may be further diluted to the desired volume (e.g. 50 ml to 150 ml) by adding the withdrawn volume to one of the following solutions:

- Sterile water for injection (maximum recommended volume per dose is 50 ml)
- 0.9% (9 mg/ml) sodium chloride solution for injection
- Glucose 5%

Shake strongly again until it is completely dissolved.

CONTRAINDICATIONS

Hypersensitivity to the active substances or any other penicillin-antibacterial agent.

History of acute severe allergic reaction to any other beta-lactam active substances (e.g. cephalosporin, monobactam or carbapenem).

SPECIAL WARNINGS AND PRECAUTIONS FOR USE

The selection of piperacillin / tazobactam to treat an individual patient should take into account the appropriateness of using a broad-spectrum semi-synthetic penicillin based on factors such as the severity of the infection and the prevalence of resistance to other suitable antibacterial agents.

Before initiating therapy with piperacillin / tazobactam, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, other beta-lactam agents (e.g. cephalosporin, monobactam or carbapenem) and other allergens. Serious and occasionally fatal hypersensitivity (anaphylactic/anaphylactoid (including shock)) reactions have been reported in patients receiving therapy with penicillins, including piperacillin / tazobactam. These reactions are more likely to occur in persons with a history of sensitivity to multiple allergens. Serious hypersensitivity reactions require the discontinuation of the antibiotic, and may require administration of epinephrine and other emergency measures.

Therapy with piperacillin / tazobactam may cause severe cutaneous adverse reactions, such as Stevens-Johnson syndrome, toxic epidermal necrolysis, drug reaction with eosinophilia and systemic symptoms, and acute generalised exanthematous pustulosis. If patients develop a skin rash they should be monitored closely and piperacillin/tazobactam discontinued if lesions progress.

Antibiotic-induced pseudomembranous colitis may be manifested by severe, persistent diarrhoea which may be life-threatening. The onset of pseudomembranous colitis symptoms may occur during or after antibacterial treatment. In these cases piperacillin / tazobactam, should be discontinued.

Therapy with piperacillin / tazobactam may result in the emergence of resistant organisms, which might cause super-infections.

Bleeding manifestations have occurred in some patients receiving beta-lactam antibiotics. These reactions sometimes have been associated with abnormalities of coagulation tests, such as clotting time, platelet aggregation and prothrombin time, and are more likely to occur in patients with renal failure. If bleeding manifestations occur, the antibiotic should be discontinued and appropriate therapy instituted.

Leukopenia and neutropenia may occur, especially during prolonged therapy; therefore, periodic assessment of haematopoietic function should be performed.

As with treatment with other penicillins, neurological complications in the form of convulsions may occur when high doses are administered, especially in patients with impaired renal function. Hypokalaemia may occur in patients with low potassium reserves or those receiving concomitant medicinal products that may lower potassium levels; periodic electrolyte determinations may be advisable in such patients.

Renal Impairment

Due to its potential nephrotoxicity, piperacillin/tazobactam should be used with care in patients with renal impairment or in hemodialysis patients. Intravenous dosages and administration intervals should be adjusted to the degree of renal function impairment.

In a secondary analysis using data from a large multicenter, randomized-controlled trial when glomerular filtration rate (GFR) was examined after administration of frequently used antibiotics in critically ill patients, the use of piperacillin/tazobactam was associated with a lower rate of reversible GFR improvement compared with the other antibiotics. This secondary analysis concluded that piperacillin/tazobactam was a cause of delayed renal recovery in these patients.

Combined use of piperacillin/tazobactam and vancomycin may be associated with an increased incidence of acute kidney injury.

Excipients

This medicinal product contains 206.6 mg sodium per vial, equivalent to 10.3% of the WHO recommended maximum daily intake of 2 g sodium for an adult.

DRUG INTERACTIONS

Non-depolarising muscle relaxants

Piperacillin when used concomitantly with vecuronium has been implicated in the prolongation of the neuromuscular blockade of vecuronium. Due to their similar mechanisms of action, it is expected that the neuromuscular blockade produced by any of the non-depolarising muscle relaxants could be prolonged in the presence of piperacillin.

Oral anticoagulants

During simultaneous administration of heparin, oral anticoagulants and other substances that may affect the blood coagulation system including thrombocyte function, appropriate coagulation tests should be performed more frequently and monitored regularly.

Methotrexate

Piperacillin may reduce the excretion of methotrexate; therefore, serum levels of methotrexate should be monitored in patients to avoid substance toxicity.

Probenecid

As with other penicillins, concurrent administration of probenecid and piperacillin / tazobactam produces a longer half-life and lower renal clearance for both piperacillin and tazobactam; however, peak plasma concentrations of either substances are unaffected.

Aminoglycosides

Piperacillin, either alone or with tazobactam, did not significantly alter the pharmacokinetics of tobramycin in subjects with normal renal function and with mild or moderate renal impairment. The pharmacokinetics of piperacillin, tazobactam, and the M1 metabolite were also not significantly altered by tobramycin administration.

The inactivation of tobramycin and gentamicin by piperacillin has been demonstrated in patients with severe renal impairment.

Whenever piperacillin/tazobactam is used concurrently with another antibiotic (e.g. aminoglycosides), the substances must be administered separately. The mixing of beta-lactam antibiotics with an aminoglycoside in vitro can result in substantial inactivation of the aminoglycoside.

Vancomycin

Studies have detected an increased incidence of acute kidney injury in patients concomitantly administered piperacillin/tazobactam and vancomycin as compared to vancomycin alone. Some of these studies have reported that the interaction is vancomycin dose-dependent.

No pharmacokinetic interactions have been noted between piperacillin / tazobactam and vancomycin.

Effects on laboratory tests

Non-enzymatic methods of measuring urinary glucose may lead to false-positive results, as with other penicillins. Therefore, enzymatic urinary glucose measurement is required under piperacillin / tazobactam therapy.

A number of chemical urine protein measurement methods may lead to false-positive results. Protein measurement with dip sticks is not affected.

The direct Coombs test may be positive.

Bio-Rad Laboratories Platelia Aspergillus EIA tests may lead to false-positive results for patients receiving piperacillin / tazobactam. Cross-reactions with non-Aspergillus polysaccharides and polyfuranoses with Bio-Rad Laboratories Platelia Aspergillus EIA test have been reported.

Positive test results for the assays listed above in patients receiving piperacillin / tazobactam should be confirmed by other diagnostic methods.

USE IN SPECIFIC POPULATIONS

Pregnancy

There are no or a limited amount of data from the use of piperacillin / tazobactam in pregnant women. Studies in animals have shown developmental toxicity, but no evidence of teratogenicity, at doses that are maternally toxic. Piperacillin and tazobactam cross the placenta. Piperacillin / tazobactam should only be used during pregnancy if clearly indicated, i.e. only if the expected benefit outweighs the possible risks to the pregnant woman and foetus.

Lactation

Piperacillin is excreted in low concentrations in human milk; tazobactam concentrations in human milk have not been studied. Women who are breast-feeding should be treated only if the expected benefit outweighs the possible risks to the woman and child.

EFFECTS ON ABILITY TO DRIVE AND USE MACHINES

No studies on the effect on the ability to drive and use machines have been performed.

UNDESIRABLE EFFECTS

The most commonly reported adverse reaction is diarrhoea (occurring in 1 patient out of 10).

Among the most serious adverse reactions pseudo-membranous colitis and toxic epidermal necrolysis occur in 1 to 10 patients in 10,000. The frequencies for pancytopenia, anaphylactic shock and Stevens-Johnson syndrome cannot be estimated from the currently available data.

In the following table, adverse reactions are listed by system organ class and MedDRA-preferred term. Within each frequency grouping, undesirable effects are presented in order of decreasing seriousness.

System Organ Class	Very common ≥ 1/10	Common ≥ 1/100 to < 1/10	Uncommon ≥ 1/1,000 to < 1/100	Rare ≥ 1/10,000 to < 1/1,000	Frequency not known (cannot be estimated from available data)
Infections and infestations		candida infection*		pseudo-membranous colitis	
Blood and lymphatic system disorders		thrombocytopenia, anaemia*	leukopenia	agranulocytosis	pancytopenia*, neutropenia, haemolytic anaemia*, thrombocytosis*, eosinophilia*,
Immune system disorders					anaphylactoid shock*, anaphylactic shock*, anaphylactoid reaction*, anaphylactic reaction*, hypersensitivity*
Metabolism and nutrition disorders			hypokalaemia		
Psychiatric disorders		insomnia			
Nervous system disorders		headache			
Vascular disorders			hypotension, phlebitis, thrombophlebitis, flushing		
Respiratory, thoracic and mediastinal disorders				epistaxis	eosinophilic pneumonia
Gastrointestinal disorders	diarrhoea	abdominal pain, vomiting, constipation, nausea, dyspepsia		stomatitis	
Hepatobiliary disorders					hepatitis*, jaundice
Skin and subcutaneous tissue disorders		rash, pruritus	erythema multiforme*, urticaria, rash maculopapular*	toxic epidermal necrolysis*	Stevens-Johnson syndrome*, dermatitis exfoliative, drug reaction with eosinophilia and systemic symptoms (DRESS)*, acute generalised exanthematous pustulosis (AGEP)*, dermatitis bullous, purpura
Musculoskeletal and connective tissue disorders			arthralgia, myalgia		
Renal and urinary disorders					renal failure, tubulointerstitial nephritis*
General disorders and administration site conditions		pyrexia, injection-site reaction	chills		
Investigations		alanine aminotransferase increased, aspartate aminotransferase increased, protein total decreased, blood albumin decreased, Coombs direct test positive, blood creatinine increased, blood alkaline phosphatase increased, blood urea increased, activated partial thromboplastin time prolonged	blood glucose decreased, blood bilirubin increased, prothrombin time prolonged		bleeding time prolonged, gamma-glutamyltransferase increased

* ADR identified post marketing

Piperacillin therapy has been associated with an increased incidence of fever and rash in cystic fibrosis patients.

Reporting of suspected adverse reactions

Reporting suspected adverse reactions after authorisation of the medicine is important. It allows continued monitoring of the benefit/risk balance of the medicine. Kindly report any suspected adverse reactions to pharmavigil@jbcpl.com.

OVERDOSE

Symptoms

There have been post-marketing reports of overdose with piperacillin / tazobactam. The majority of those events experienced, including nausea, vomiting, and diarrhoea, have also been reported with the usual recommended dose. Patients may experience neuromuscular excitability or convulsions if higher than recommended doses are given intravenously (particularly in the presence of renal failure).

Treatment of overdose

In the event of an overdose, piperacillin / tazobactam treatment should be discontinued. No specific antidote is known. Treatment should be supportive and symptomatic according to the patient's clinical presentation. Excessive serum concentrations of either piperacillin or tazobactam may be reduced by haemodialysis.

PHARMACOLOGICAL PROPERTIES

Pharmacodynamic properties

Pharmacotherapeutic group: Antibacterials for systemic use, Combinations of penicillins incl. beta-lactamase inhibitors.

Mechanism of action

Piperacillin, a broad-spectrum, semisynthetic penicillin exerts bactericidal activity by inhibition of both septum and cell-wall synthesis.

Tazobactam, a beta-lactam structurally related to penicillins, is an inhibitor of many beta-lactamases, which commonly cause resistance to penicillins and cephalosporins but it does not inhibit AmpC enzymes or metallo beta-lactamases. Tazobactam extends the antibiotic spectrum of piperacillin to include many beta-lactamase-producing bacteria that have acquired resistance to piperacillin alone.

Pharmacokinetic / Pharmacodynamic relationship

The time above the minimum inhibitory concentration (T>MIC) is considered to be the major pharmacodynamic determinant of efficacy for piperacillin.

Mechanism of resistance

The two main mechanisms of resistance to piperacillin / tazobactam are:

- Inactivation of the piperacillin component by those beta-lactamases that are not inhibited by tazobactam: beta-lactamases in the Molecular class B, C and D. In addition, tazobactam does not provide protection against extended-spectrum beta-lactamases (ESBLs) in the Molecular class A and D enzyme groups.
- Alteration of penicillin-binding proteins (PBPs), which results in the reduction of the affinity of piperacillin for the molecular target in bacteria.

Additionally, alterations in bacterial membrane permeability, as well as expression of multi-drug efflux pumps, may cause or contribute to bacterial resistance to piperacillin / tazobactam, especially in Gram-negative bacteria.

Susceptibility

The prevalence of acquired resistance may vary geographically and with time for selected species, and local information on resistance is desirable, particularly when treating severe infections. As necessary, expert advice should be sought when the local prevalence of resistance is such that the utility of the agent in at least some types of infections is questionable.

Groupings of relevant species according to piperacillin / tazobactam susceptibility
COMMONLY SUSCEPTIBLE SPECIES
Aerobic Gram-positive micro-organisms <i>Enterococcus faecalis</i> <i>Listeria monocytogenes</i> <i>Staphylococcus aureus</i> , methicillin-susceptible [‡] <i>Staphylococcus species</i> , coagulase negative, methicillin-susceptible <i>Streptococcus pyogenes</i> <i>Group B streptococci</i>
Aerobic Gram-negative micro-organisms <i>Citrobacter koseri</i> <i>Haemophilus influenza</i> <i>Moraxella catarrhalis</i> <i>Proteus mirabilis</i>
Anaerobic Gram-positive micro-organisms <i>Clostridium species</i> <i>Eubacterium species</i> <i>Peptostreptococcus species</i>
Anaerobic Gram-negative micro-organisms <i>Bacteroides fragilis group</i> <i>Fusobacterium species</i> <i>Porphyromonas species</i> <i>Prevotella species</i>
SPECIES FOR WHICH ACQUIRED RESISTANCE MAY BE A PROBLEM
Aerobic Gram-positive micro-organisms <i>Enterococcus faecium</i> ^{§,*} <i>Streptococcus pneumonia</i> <i>Streptococcus viridans group</i>
Aerobic Gram-negative micro-organisms <i>Acinetobacter baumannii</i> [‡] <i>Burkholderia cepacia</i> <i>Citrobacter freundii</i> <i>Enterobacter species</i> <i>Escherichia coli</i> <i>Klebsiella pneumonia</i> <i>Morganella morganii</i> <i>Proteus vulgaris</i> <i>Providencia ssp.</i> <i>Pseudomonas aeruginosa</i> <i>Serratia species</i>
INHERENTLY RESISTANT ORGANISMS
Aerobic Gram-positive micro-organisms <i>Corynebacterium jeikeium</i>
Aerobic Gram-negative micro-organisms <i>Legionella species</i> <i>Stenotrophomonas maltophilia</i> ^{‡,§}

Other microorganisms

Chlamydomyces pneumonia
Mycoplasma pneumonia

[‡] Species showing natural intermediate susceptibility.

* Species for which high-resistance rates (more than 50%) have been observed in one or more areas/countries/regions within the EU.

[‡] All methicillin-resistant staphylococci are resistant to piperacillin / tazobactam.

Pharmacokinetic properties

Absorption

The peak piperacillin and tazobactam concentrations after 4 g/0.5 g administered over 30 minutes by intravenous infusion are 298 µg/ml and 34 µg/ml respectively.

Distribution

Both piperacillin and tazobactam are approximately 30% bound to plasma proteins. The protein binding of either piperacillin or tazobactam is unaffected by the presence of the other compound. Protein binding of the tazobactam metabolite is negligible.

Piperacillin / tazobactam is widely distributed in tissues and body fluids including intestinal mucosa, gallbladder, lung, bile, and bone. Mean tissue concentrations are generally 50 to 100% of those in plasma. Distribution into cerebrospinal fluid is low in subjects with non-inflamed meninges, as with other penicillins.

Biotransformation

Piperacillin is metabolised to a minor microbiologically active desethyl metabolite. Tazobactam is metabolised to a single metabolite that has been found to be microbiologically inactive.

Elimination

Piperacillin and tazobactam are eliminated via the kidney by glomerular filtration and tubular secretion.

Piperacillin is excreted rapidly as unchanged substance, with 68% of the administered dose appearing in the urine. Tazobactam and its metabolite are eliminated primarily by renal excretion, with 80% of the administered dose appearing as unchanged substance and the remainder as the single metabolite.

Piperacillin, tazobactam, and desethyl piperacillin are also secreted into the bile.

Following single or multiple doses of piperacillin / tazobactam to healthy subjects, the plasma half-life of piperacillin and tazobactam ranged from 0.7 to 1.2 hours and was unaffected by dose or duration of infusion.

The elimination half-lives of both piperacillin and tazobactam are increased with decreasing renal clearance.

There are no significant changes in piperacillin pharmacokinetics due to tazobactam. Piperacillin appears to slightly reduce the clearance of tazobactam.

Special populations

The half-life of piperacillin and of tazobactam increases by approximately 25% and 18%, respectively, in patients with hepatic cirrhosis compared to healthy subjects.

The half-life of piperacillin and tazobactam increases with decreasing creatinine clearance. The increase in half-life is two-fold and four-fold for piperacillin and tazobactam, respectively, at creatinine clearance below 20 ml/min compared to patients with normal renal function.

Haemodialysis removes 30% to 50% of piperacillin / tazobactam, with an additional 5% of the tazobactam dose removed as the tazobactam metabolite. Peritoneal dialysis removes approximately 6% and 21% of the piperacillin and tazobactam doses, respectively, with up to 18% of the tazobactam dose removed as the tazobactam metabolite.

Paediatric population

In a population PK analysis, estimated clearance for 9 month-old to 12 year-old patients was comparable to adults, with a population mean (SE) value of 5.64 (0.34) ml/min/kg. The piperacillin clearance estimate is 80% of this value for paediatric patients 2-9 months of age. The population mean (SE) for piperacillin volume of distribution is 0.243 (0.011) l/kg and is independent of age.

Elderly

The mean half-life for piperacillin and tazobactam were 32% and 55% longer, respectively, in the elderly compared with younger subjects. This difference may be due to age-related changes in creatinine clearance.

DESCRIPTION

Piprabid IV is an antibacterial combination products consisting of the semisynthetic antibacterial piperacillin sodium and the β-lactamase inhibitor tazobactam sodium for intravenous administration. Piperacillin sodium is derived from D(-)-α-aminobenzyl-penicillin. The chemical name of piperacillin sodium is sodium (2*S*,5*R*,6*R*)-6-[(*R*)-2-(4-ethyl-2,3-dioxo-1-piperazinecarboxamido)-2-phenylacetamido]-3,3-dimethyl-7-oxo-4-thia-1-azabicyclo[3.2.0]heptane-2-carboxylate. The chemical formula is C₂₅H₃₆N₄NaO₅S and the molecular weight is 539.5.

Tazobactam sodium, a derivative of the penicillin nucleus, is a penicillanic acid sulfone. Its chemical name is sodium (2*S*,3*S*,5*R*)-3-methyl-7-oxo-3-(1*H*-1,2,3-triazol-1-ylmethyl)-4-thia-1-azabicyclo[3.2.0]heptane-2-carboxylate-4,4-dioxide. The chemical formula is C₁₀H₁₁N₄NaO₅S and the molecular weight is 322.3.

INCOMPATIBILITIES:

Whenever Piperacillin/Tazobactam is used concurrently with another antibiotic (e.g. aminoglycosides), the substances must be administered separately. The mixing of Piperacillin/Tazobactam with an aminoglycoside in vitro can result in substantial inactivation of the aminoglycoside.

Piperacillin/Tazobactam should not be mixed with other substances in a syringe or infusion bottle since compatibility has not been established.

Because of chemical instability, Piperacillin/Tazobactam should not be used with solutions containing only sodium bicarbonate.

Lactated Ringer's solution is not compatible with Piperacillin/Tazobactam.

Piperacillin/Tazobactam should not be added to blood products or albumin hydrolysates

Storage and handling instructions: Store below 25°C. Protect from light and moisture.

Packaging information: 1 Vial + 20 ml SWFI + Insert Packed in a Carton



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