

PRODUCT MONOGRAPH

PrBIAXIN BID[®]

clarithromycin tablets, film-coated
250 mg and 500 mg
USP

PrBIAXIN[®] XL

clarithromycin extended-release tablets
500 mg
Abbott Standard

PrBIAXIN[®]

clarithromycin for oral suspension
125 mg/5 mL and 250 mg/5 mL
USP

Antibiotic

NOTE: WHEN USED IN COMBINATION WITH ACID ANTISECRETORY DRUGS AND OTHER ANTIMICROBIALS FOR THE ERADICATION OF *HELICOBACTER PYLORI*, THE PRODUCT MONOGRAPH FOR THOSE AGENTS SHOULD BE CONSULTED.

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PrBIAXIN BID®

clarithromycin tablets, film-coated

PrBIAXIN® XL

clarithromycin extended-release tablets

PrBIAXIN®

clarithromycin for oral suspension

PART I: HEALTH PROFESSIONAL INFORMATION

SUMMARY PRODUCT INFORMATION

Route of Administration	Dosage Form / Strength	Clinically Relevant Non-medicinal Ingredients
oral	film-coated tablets / 250 mg & 500 mg	cellulosic polymers, croscarmellose sodium, D&C Yellow No. 10, magnesium stearate, povidone, pregelatinized starch (250 mg only), propylene glycol, silicon dioxide, sorbic acid, sorbitan monooleate, stearic acid, talc, titanium dioxide and vanillin.
	extended-release tablets / 500 mg	cellulosic polymers, lactose monohydrate, magnesium stearate, propylene glycol, Quinoline Yellow Lake E104, sorbitan monooleate, talc, titanium dioxide and vanillin.
	oral suspension / 125 mg / 5 mL and 250 mg / 5 mL	artificial and natural fruit flavour, citric acid, carbopol, castor oil, hydroxypropyl methylcellulose phthalate, maltodextrin, potassium sorbate, povidone, silicon dioxide, sucrose or sugar, titanium dioxide and xanthan gum.
		<i>For a complete listing see DOSAGE FORMS, COMPOSITION AND PACKAGING section.</i>

INDICATIONS AND CLINICAL USE

BIAXIN BID[®] (clarithromycin tablets, USP, film-coated)

BIAXIN BID[®] (clarithromycin tablets, USP, film-coated) may be indicated in the treatment of mild to moderate infections caused by susceptible strains of the designated microorganisms in the diseases listed below:

Upper Respiratory Tract

Pharyngitis/tonsillitis, caused by *Streptococcus pyogenes* (Group A beta-hemolytic streptococci).

Acute maxillary sinusitis caused by *Streptococcus pneumoniae* (*S. pneumoniae*), *Haemophilus influenzae* (*H. influenzae*), and *Moraxella (Branhamella) catarrhalis* [*M. (Branhamella) catarrhalis*]

Lower Respiratory Tract

Acute bacterial exacerbation of chronic bronchitis caused by *S. pneumoniae*, *H. influenzae* (including beta-lactamase producing strains), *M. (Branhamella) catarrhalis* (including beta-lactamase producing strains).

Pneumonia caused by *S. pneumoniae* and *Mycoplasma pneumoniae* (*M. pneumoniae*).

Uncomplicated Skin and Skin Structure Infections

Uncomplicated Skin and Skin Structure Infections caused by *Streptococcus pyogenes* (*S. pyogenes*), *Staphylococcus aureus* (*S. aureus*).

Mycobacterial Infections

BIAXIN BID[®] (clarithromycin tablets, USP, film-coated) is indicated for the prevention of disseminated *Mycobacterium avium* complex (MAC) disease in patients with advanced HIV infection (see **CLINICAL TRIALS, Mycobacterial Infections**), and for the treatment of disseminated mycobacterial infections due to *Mycobacterium avium* (*M. avium*) and *Mycobacterium intracellulare* (*M. intracellulare*).

Eradication of *Helicobacter pylori*

BIAXIN BID[®] (clarithromycin tablets, USP, film-coated) in the presence of acid suppression (with omeprazole) with another antibiotic (amoxicillin) is indicated for the eradication of *Helicobacter pylori* (*H. pylori*) that may result in decreased recurrence of duodenal ulcer in patients with active duodenal ulcers and who are *H. pylori* positive. See (**CLINICAL TRIALS, Eradication of *Helicobacter pylori*, Triple Therapy: BIAXIN BID[®]/omeprazole/amoxicillin**) and (**CLINICAL TRIALS, Eradication of *Helicobacter pylori*, Dual Therapy: BIAXIN BID[®]/omeprazole**).

(For additional information on the use of BIAXIN BID[®] in triple therapy for the treatment of *H. pylori* infection and active duodenal ulcer recurrence, refer to the Hp-PAC[®] Product Monograph.)

BIAXIN[®] XL (clarithromycin extended-release tablets)

BIAXIN[®] XL (clarithromycin extended-release tablets) may be indicated in the treatment of mild to moderate infections caused by susceptible strains of the designated microorganisms in the diseases listed below:

Upper Respiratory Tract

Acute maxillary sinusitis due to *H. influenzae*, *M. catarrhalis*, or *S. pneumoniae*.

Lower Respiratory Tract

Acute bacterial exacerbation of chronic bronchitis due to *Haemophilus parainfluenzae* (*H. parainfluenzae*), *H. influenzae*, *M. catarrhalis*, *S. aureus*, or *S. pneumoniae*.

Community-acquired pneumonia due to *H. influenzae*, *H. parainfluenzae*, *M. catarrhalis*, *S. pneumoniae*, *Chlamydia pneumoniae* (TWAR), or *M. pneumoniae*.

The efficacy and safety of BIAXIN[®] XL in treating other infections for which BIAXIN BID[®] and BIAXIN[®] are approved have not been established.

BIAXIN[®] (clarithromycin for oral suspension, USP)

BIAXIN[®] (clarithromycin for oral suspension, USP) is indicated for the treatment of infections due to susceptible organisms, in the following conditions:

Upper Respiratory Tract

Pharyngitis caused by *S. pyogenes* (Group A β -hemolytic streptococci).

Acute otitis media caused by *H. influenzae*, *M. catarrhalis*, or *S. pneumoniae*. See (CLINICAL TRIALS, **Otitis Media**).

Lower Respiratory Tract

Mild to moderate community-acquired pneumonia caused by *S. pneumoniae*, *C. pneumoniae*, or *M. pneumoniae*.

Uncomplicated skin and skin structure infections

Uncomplicated skin and skin structure infections (i.e., impetigo and cellulitis) caused by *S. aureus* or *S. pyogenes*.

Mycobacterial Infections

Disseminated mycobacterial infections due to *M. avium* and *M. intracellulare*.

Pediatrics (6 months - 12 years of age): Dosing recommendations for children are based on body weight. See **DOSAGE AND ADMINISTRATION, Table 17** for determining dosage. For a brief discussion see **WARNINGS AND PRECAUTIONS, Special Populations, Pediatrics**.

Geriatrics (> 65 years of age): Dosage adjustment should be considered in elderly patients with severe renal impairment. For a brief discussion see **WARNINGS AND PRECAUTIONS, Special Populations, Geriatrics**.

CONTRAINDICATIONS

BIAXIN BID[®] (clarithromycin tablets, USP, film-coated), BIAXIN[®] XL (clarithromycin extended-release tablets) and BIAXIN[®] (clarithromycin for oral suspension, USP) are contraindicated in patients with a known hypersensitivity to clarithromycin, erythromycin, other macrolide antibacterial agents or to any ingredient in the formulation or component of the container. See (**DOSAGE FORMS, COMPOSITION AND PACKAGING**).

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

Clarithromycin is contraindicated in patients with history of QT prolongation or ventricular cardiac arrhythmia, including torsades de pointes. See (**WARNINGS AND PRECAUTIONS**) and (**DRUG INTERACTIONS, Drug-Drug Interactions**).

Clarithromycin is contraindicated as concurrent therapy with astemizole, terfenadine, cisapride, pimozone. There have been post-marketing reports of drug interactions when clarithromycin and/or erythromycin are co-administered with astemizole, terfenadine, cisapride or pimozone resulting in cardiac arrhythmias (QT prolongation, ventricular tachycardia, ventricular fibrillation, and torsades de pointes) most likely due to inhibition of hepatic metabolism of these drugs by erythromycin and clarithromycin. Fatalities have been reported. See (**DRUG INTERACTIONS, Drug-Drug Interactions, Table 14**).

Clarithromycin is contraindicated as concurrent therapy with lovastatin or simvastatin as may result in rhabdomyolysis. See (**DRUG INTERACTIONS, Drug-Drug Interactions, Table 14**).

Clarithromycin is contraindicated as concurrent therapy with ergotamine or dihydroergotamine as may result in ergot toxicity. See (**DRUG INTERACTIONS, Drug-Drug Interactions, Table 14**).

Clarithromycin is contraindicated as concurrent therapy with colchicine in patients with renal or hepatic impairment due to the risk of life threatening and fatal colchicine toxicity. This risk may be further increased with concomitant medications metabolized by P-glycoprotein or strong CYP3A inhibitors. See (**WARNINGS AND PRECAUTIONS, Colchicine**) and (**DRUG INTERACTIONS, Drug-Drug Interactions, Table 14**).

WARNINGS AND PRECAUTIONS

Serious Warnings and Precautions

- Clarithromycin should not be used in **pregnancy** except where no alternative therapy is appropriate, particularly during the first 3 months of pregnancy. If pregnancy occurs while taking the drug, the patient should be apprised of the potential hazard to the fetus (see **WARNINGS AND PRECAUTIONS, Special Populations, Pregnant Women**).
- The concomitant administration of clarithromycin and drugs metabolized by CYP3A and/or transported by P-gp may result in significant safety concerns. See (**WARNINGS AND PRECAUTIONS**) and (**DRUG INTERACTIONS, Overview**).

General

Clarithromycin should be administered with caution to any patient who has demonstrated some form of drug allergy, particularly to structurally related-drugs. If an allergic reaction to clarithromycin occurs, administration of the drug should be discontinued. Serious hypersensitivity reactions may require epinephrine, antihistamines, or corticosteroids. See (**WARNINGS AND PRECAUTIONS, Immune, Hypersensitivity**).

Long-term use may, as with other antibiotics, result in colonization with increased numbers of non-susceptible bacteria and fungi. If superinfections occur, appropriate therapy should be instituted.

Patients Infected with Human Immunodeficiency Virus

Several studies of Human Immunodeficiency Virus (HIV)-positive patients receiving clarithromycin for treatment of MAC infection have shown poorer survival in those patients randomized to receive doses higher than 500 mg twice daily. The explanation for the poorer survival associated with doses higher than 500 mg twice daily has not been determined. Treatment or prophylaxis of MAC infection with clarithromycin should not exceed the approved dose of 500 mg twice daily.

Myasthenia Gravis

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

Use of Clarithromycin with Other Drugs

Use of clarithromycin with other drugs may lead to drug-drug interactions.

Colchicine

Life-threatening and fatal drug interactions have been reported in patients treated with clarithromycin and colchicine. Clarithromycin is a strong CYP3A4 inhibitor and this interaction may occur while using both drugs at their recommended doses. If co-administration of clarithromycin and colchicine is necessary in patients with normal renal and hepatic function, the dose of colchicine should be reduced. Patients should be monitored for clinical symptoms of colchicine toxicity. See **(CONTRAINDICATIONS)**.

There have been post-marketing reports of colchicine toxicity with concurrent use of clarithromycin and colchicine. In patients with impaired renal and/or hepatic function and/or who are elderly, colchicine and clarithromycin should not be used concurrently due to the risk of colchicine toxicity. Deaths have been reported in some patients. See **(DRUG INTERACTIONS, Drug-Drug Interactions, Table 14)** and **(ADVERSE REACTIONS, Post-Market Adverse Drug Reactions, Colchicine)**.

Oral Hypoglycemic Agents/Insulin

The concomitant use of clarithromycin and oral hypoglycaemic agents and/or insulin can result in significant hypoglycaemia. With certain hypoglycaemic drugs such as nateglinide, pioglitazone, repaglinide and rosiglitazone, inhibition of CYP3A enzyme by clarithromycin may be involved and could cause hypoglycaemia when used concomitantly. Careful monitoring of glucose is recommended. See **(DRUG INTERACTIONS, Drug-Drug Interactions, Table 14)**.

Oral Anticoagulants

There is a risk of serious hemorrhage and significant elevations in International Normalized Ratio (INR) and prothrombin time when clarithromycin is co-administered with warfarin. INR and prothrombin times should be frequently monitored while patients are receiving clarithromycin and oral anticoagulants concurrently. See **(DRUG INTERACTIONS, Drug-Drug Interactions, Table 14)**.

HMG-CoA Reductase Inhibitors

Concomitant use of clarithromycin with lovastatin or simvastatin is contraindicated. See **(CONTRAINDICATIONS)**. As with other macrolides, clarithromycin has been reported to increase concentrations of HMG-CoA reductase inhibitors. Rare reports of rhabdomyolysis have

been reported in patients taking these drugs concomitantly. Patients should be monitored for signs and symptoms of myopathy.

Rare reports of rhabdomyolysis have also been reported in patients taking atorvastatin or rosuvastatin concomitantly with clarithromycin. When used with clarithromycin, atorvastatin or rosuvastatin should be administered in the lowest possible doses. Adjustment of the statin dose or use of a statin that is not dependent on CYP3A metabolism (e.g., fluvastatin or pravastatin) should be considered. See (**DRUG INTERACTIONS, Drug-Drug Interactions, Table 14**).

Triazolobenzodiazepines and Related Benzodiazepines

Caution is advised regarding the concomitant administration of clarithromycin with triazolobenzodiazepines (such as triazolam and alprazolam), or with other benzodiazepines (such as midazolam) due to the serious risk of central nervous system (CNS) effects (e.g., somnolence and confusion). See (**DRUG INTERACTIONS, Drug-Drug Interactions, Table 14**).

Calcium Channel Blockers

Caution is advised regarding the concomitant administration of clarithromycin and calcium channel blockers metabolized by CYP3A4 (e.g., verapamil, amlodipine, diltiazem) due to the risk of hypotension. See (**DRUG INTERACTIONS, Drug-Drug Interactions, Table 14**).

Hypotension, bradyarrhythmias, and lactic acidosis have been observed in patients receiving concurrent verapamil, belonging to the calcium channel blockers drug class. See (**DRUG INTERACTIONS, Drug-Drug Interactions, Table 14**).

Other Drugs

For other established or potential drug-drug interactions and their mechanisms, see (**CONTRAINDICATIONS**) and (**DRUG INTERACTIONS, Drug-Drug Interactions**).

Carcinogenesis and Mutagenesis

Long-term studies in animals have not been performed to evaluate the carcinogenic potential of clarithromycin.

The following *in vitro* mutagenicity tests have been conducted with clarithromycin: Salmonella/mammalian microsome test, bacterial induced mutation frequency test, *in vitro* chromosome aberration test, rat hepatocyte DNA synthesis assay, mouse lymphoma assay, mouse dominant lethal study, mouse micronucleus test. All tests had negative results except the *in vitro* chromosome aberration test which was weakly positive in one test and negative in another. In addition, a Bacterial Reverse-Mutation Test (Ames Test) has been performed on clarithromycin metabolites with negative results.

Cardiovascular

Clarithromycin should be used with caution in patients with a medical condition associated with a potential risk of QT prolongation and torsades de pointes. See (**CONTRAINDICATIONS**) and (**DRUG INTERACTIONS, Drug-Drug Interactions**).

Gastrointestinal

***Clostridium difficile*-Associated Disease**

Clostridium difficile-associated disease (CDAD) has been reported with use of many antibacterial agents, including clarithromycin. CDAD may range in severity from mild diarrhea to fatal colitis. It is important to consider this diagnosis in patients who present with diarrhea, or symptoms of colitis, pseudomembranous colitis, toxic megacolon, or perforation of colon subsequent to the administration of any antibacterial agent. CDAD has been reported to occur over 2 months after the administration of antibacterial agents.

Treatment with antibacterial agents may alter the normal flora of the colon and may permit overgrowth of *Clostridium difficile*. *Clostridium difficile* produces toxins A and B, which contribute to the development of CDAD. CDAD may cause significant morbidity and mortality. CDAD can be refractory to antimicrobial therapy.

If the diagnosis of CDAD is suspected or confirmed, appropriate therapeutic measures should be initiated. Mild cases of CDAD usually respond to discontinuation of antibacterial agents not directed against *Clostridium difficile*. In moderate to severe cases, consideration should be given to management with fluids and electrolytes, protein supplementation, and treatment with an antibacterial drug clinically effective against *Clostridium difficile*. Surgical evaluation should be instituted as clinically indicated, as surgical intervention may be required in certain severe cases. See (**ADVERSE REACTIONS**).

Hepatic/Biliary/Pancreatic

Clarithromycin is principally excreted by the liver and kidney. In patients with both hepatic and renal impairments or in the presence of severe renal impairment, decreased dosage of clarithromycin or prolonged dosing intervals might be appropriate. See (**DOSAGE AND ADMINISTRATION, Recommended Dose and Dosage Adjustment**).

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

Immune

Hypersensitivity Reactions

Severe acute hypersensitivity reactions, such as anaphylaxis, Stevens - Johnson syndrome, toxic epidermal necrolysis, DRESS, and Henoch-Schonlein purpura have been reported. In the event of severe acute hypersensitivity reactions, clarithromycin therapy should be discontinued immediately and appropriate treatment should be urgently initiated.

Renal

Caution is advised in patients with severe renal insufficiency.

Clarithromycin is principally excreted by the liver and kidney. In patients with both hepatic and renal impairments or in the presence of severe renal impairment, decreased dosage of clarithromycin or prolonged dosing intervals might be appropriate. See **(DOSAGE AND ADMINISTRATION, Recommended Dose and Dosage Adjustment)**.

For the eradication of *H. pylori*, amoxicillin and clarithromycin should not be administered to patients with renal impairment since the appropriate dosage in this patient population has not yet been established.

Sensitivity/Resistance

The development of resistance (11 out of 19 breakthrough isolates in 1 study) has been seen in HIV positive patients receiving clarithromycin for prophylaxis and treatment of MAC infection.

In view of the emerging resistance of *Streptococcus pneumoniae*, *Staphylococcus aureus* and *Streptococcus pyogenes* to macrolides, it is important that sensitivity testing be performed when prescribing clarithromycin for community-acquired pneumonia and uncomplicated skin and skin structure infections.

To avoid failure of the eradication treatment with a potential for developing antimicrobial resistance and a risk of failure with subsequent therapy, patients should be instructed to follow closely the prescribed regimen.

Antibiotic Resistance in Relation to *Helicobacter pylori* Eradication

Use of any antimicrobial therapy, such as clarithromycin, to treat *H. pylori* infection may select for drug-resistant organisms.

Triple and Dual Therapy with Omeprazole

Among the 113 triple therapy recipients with pretreatment *H. pylori* isolates susceptible to clarithromycin, 2/102 patients (2%) developed resistance after treatment with omeprazole, clarithromycin, and amoxicillin. Among patients who received triple therapy, 6/108 (5.6%) patients had pretreatment *H. pylori* isolates resistant to clarithromycin. Of these 6 patients, 3 (50%) had *H. pylori* eradicated at follow-up, and 3 (50%) remained positive after treatment. In 5/113 (4.4%) patients, no susceptibility data for clarithromycin pretreatment were available. Twenty-six of 104 patients (25%) with pretreatment isolates susceptible to clarithromycin developed resistance after treatment with omeprazole and clarithromycin. Development of clarithromycin resistance should be considered as a possible risk especially when less efficient treatment regimens are used.

Special Populations

Pregnant Women

There are no adequate and well-controlled studies in pregnant women. The benefits against risk, particularly during the first 3 months of pregnancy should be carefully weighed by a physician. See (**WARNINGS AND PRECAUTIONS, Serious Warnings and Precautions**).

Four teratogenicity studies in rats (3 with oral doses and 1 with intravenous doses up to 160 mg/kg/day administered during the period of major organogenesis) and 2 in rabbits (at oral doses up to 125 mg/kg/day or intravenous doses of 30 mg/kg/day administered during gestation days 6 to 18) failed to demonstrate any teratogenicity from clarithromycin. Two additional oral studies in a different rat strain at similar doses and similar conditions demonstrated a low incidence of cardiovascular anomalies at doses of 150 mg/kg/day administered during gestation days 6 to 15. Plasma levels after 150 mg/kg/day were 2 times the human serum levels.

Four studies in mice revealed a variable incidence of cleft palate following oral doses of 1000 mg/kg/day during gestation days 6 to 15. Cleft palate was also seen at 500 mg/kg/day. The 1000 mg/kg/day exposure resulted in plasma levels 17 times the human serum levels. In monkeys, an oral dose of 70 mg/kg/day produced fetal growth retardation at plasma levels that were 2 times the human serum levels.

Embryonic loss has been seen in monkeys and rabbits. See (**TOXICOLOGY, Reproduction and Teratology**).

Nursing Women

The safety of clarithromycin for use during breast-feeding of infants has not been established. Clarithromycin is excreted in human milk.

Preweaned rats, exposed indirectly via consumption of milk from dams treated with 150 mg/kg/day for 3 weeks, were not adversely affected, despite data indicating higher drug levels in milk than in plasma.

Pediatrics (6 months to 12 years of age)

Use of BIAXIN BID[®] (clarithromycin tablets, USP, film-coated) and BIAXIN[®] XL (clarithromycin extended-release tablets) in children under 12 years of age has not been studied.

Use of BIAXIN[®] (clarithromycin for oral suspension, USP) in children under 6 months has not been studied. In pneumonia, clarithromycin granules were not studied in children younger than 3 years.

The safety of clarithromycin has not been studied in MAC patients under the age of 20 months.

Neonatal and juvenile animals tolerated clarithromycin in a manner similar to adult animals. Young animals were slightly more intolerant to acute overdosage and to subtle reductions in erythrocytes, platelets and leukocytes, but were less sensitive to toxicity in the liver, kidney, thymus and genitalia.

Increased valproate and phenobarbital concentrations and extreme sedation were noted in a 3-year old patient coincident with clarithromycin therapy. Cause and effect relationship cannot be established. However, monitoring of valproate and phenobarbital concentrations may be considered.

Geriatrics (> 65 years of age)

Dosage adjustment should be considered in elderly patients with severe renal impairment. In a steady-state study in which healthy elderly subjects (age 65 to 81 years old) were given 500 mg every 12 hours, the maximum concentrations of clarithromycin and 14-OH-clarithromycin were increased. The AUC was also increased. These changes in pharmacokinetics parallel known age-related decreases in renal function. In clinical trials, elderly patients did not have an increased incidence of adverse events when compared to younger patients.

ADVERSE REACTIONS

Adverse Drug Reaction Overview

The majority of side effects observed in clinical trials involving 3563 patients treated with BIAXIN BID[®] were of a mild and transient nature. Fewer than 3% of adult patients without mycobacterial infections discontinued therapy because of drug-related side-effects. The most common drug-related adverse reactions in adults taking BIAXIN BID[®] were nausea, diarrhea, abdominal pain, dyspepsia, headache, taste perversion and vomiting. The most frequently reported events in adults taking BIAXIN[®] XL were diarrhea, abnormal taste and nausea. In pediatric patients taking BIAXIN[®] (oral suspension), the most frequently reported events were diarrhea, vomiting, abdominal pain, dyspepsia, taste perversion and infection.

Clinical Trial Adverse Drug Reactions

Because clinical trials are conducted under very specific conditions, the adverse reaction rates observed in the clinical trials may not reflect the rates observed in practice and should not be compared to the rates in the clinical trials of another drug. Adverse drug reaction information from clinical trials is useful for identifying drug-related adverse events and for approximating rates.

BIAXIN BID[®] (clarithromycin tablets, USP, film-coated)

Patients with Respiratory Tract or Skin Infections

Table 1 provides a listing of adverse reactions from clinical trials or post-marketing surveillance as well as adverse events reported during post-marketing surveillance. Adverse events reported during post-marketing surveillance may include patients treated for various infections and are not limited to patients with respiratory tract or skin infections.

Table 1 Adverse Events/Adverse Drug Reactions in Patients with Respiratory Tract or Skin Infections or Other Infections Treated with BIAXIN BID[®]	
System Organ Class	Adverse Reaction/Adverse Event
General disorders and administration site conditions	Asthenia Pain Chest pain
Infections and infestations	Infection Colitis pseudomembranous Candidiasis Rhinitis Pharyngitis Vaginal candidiasis Vaginal infection
Musculoskeletal and connective tissue disorders	Back pain Myalgia
Investigations	Increased liver enzymes
Cardiac disorders*	Electrocardiogram QT prolonged Ventricular tachycardia Torsades de pointes
Gastrointestinal disorders	Constipation Flatulence Dry mouth Glossitis Stomatitis Gastrointestinal disorder Tongue discolouration Tooth discolouration Pancreatitis

Table 1 Adverse Events/Adverse Drug Reactions in Patients with Respiratory Tract or Skin Infections or Other Infections Treated with BIAXIN BID[®]	
System Organ Class	Adverse Reaction/Adverse Event
Metabolism and nutrition disorders	Anorexia Hypoglycemia**
Hepatobiliary disorders	Hepatomegaly Hepatic function abnormal Hepatitis Hepatitis cholestatic Jaundice (cholestatic and hepatocellular) Hepatic failure ***
Nervous system disorders	Dizziness Somnolence Convulsion Parosmia Dysgeusia Ageusia
Ear and labyrinth disorders	Vertigo Tinnitus Ear disorder Deafness****
Psychiatric disorders	Nervousness Anxiety Insomnia Nightmare Depression Confusional state Disorientation Depersonalisation Hallucination Psychotic disorder
Respiratory, thoracic and mediastinal disorders	Cough Dyspnea Asthma
Skin and subcutaneous tissue disorders	Pruritus Rash Hyperhidrosis Urticaria Stevens-Johnson syndrome Toxic epidermal necrosis
Immune system disorders	Anaphylactic reaction Myasthenia gravis
Eye disorders	Visual disturbance Conjunctivitis
Renal and urinary disorders	Hematuria Nephritis interstitial

Table 1 Adverse Events/Adverse Drug Reactions in Patients with Respiratory Tract or Skin Infections or Other Infections Treated with BIAXIN BID[®]	
System Organ Class	Adverse Reaction/Adverse Event
Reproductive system and breast disorders	Dysmenorrhea
Blood and lymphatic system disorders	Eosinophilia Anemia Leukopenia Thrombocythemia Thrombocytopenia
<p>* As with other macrolides, QT prolongation, ventricular tachycardia, and torsades de pointes have been reported with clarithromycin.</p> <p>** There have been reports of hypoglycemia, some of which have occurred in patients on concomitant oral hypoglycemic agents or insulin.</p> <p>*** Hepatic dysfunction may be severe and is usually reversible. Hepatic failure with fatal outcome has been reported and generally has been associated with serious underlying diseases and/or concomitant medications.</p> <p>**** There have been reports of hearing loss with clarithromycin which is usually reversible upon withdrawal of therapy.</p>	

In studies of adults with pneumonia comparing clarithromycin to erythromycin base or erythromycin stearate, there were significantly fewer adverse events involving the digestive system in patients treated with clarithromycin.

Abnormal Laboratory Values

Changes in laboratory values with possible clinical significance reported during clinical studies or during post-marketing surveillance are displayed in **Table 2**.

Table 2 Abnormal Hematologic and Clinical Chemistry Findings in Patients with Respiratory Tract or Skin Infections Treated with BIAXIN BID[®]		
System Organ Class	Laboratory Values	Frequency
Investigations	Alanine aminotransferase increased Aspartate aminotransferase increased Gamma-glutamyltransferase increased Blood alkaline phosphatase increased Blood lactate dehydrogenase increased Blood bilirubin increased Blood creatinine increased White blood cell count decreased	Uncommon (Less than 1%)
	Prothrombin time prolonged Blood urea increased	

Patients with Mycobacterial Infections

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

Prophylaxis

Discontinuation due to adverse events was required in 18% of AIDS patients receiving clarithromycin 500 mg twice daily, compared to 17% of patients receiving placebo in a randomized, double-blind study. Primary reasons for discontinuation in the clarithromycin-treated patients include headache, nausea, vomiting, depression and taste perversion. The most frequently reported adverse events with an incidence of 2% or greater, excluding those due to the patient's concurrent condition, are listed in **Table 3**. Among these events, taste perversion was the only event that had significantly higher incidence in the clarithromycin-treated compared to the placebo-treated group.

System Organ Class‡	Adverse Reaction	Clarithromycin (n=339) %	Placebo (n = 339) %
Gastrointestinal disorders	Abdominal pain	5.0%	3.5%
	Nausea	11.2%	7.1%
	Diarrhea	7.7%	4.1%
	Vomiting	5.9%	3.2%
	Dyspepsia	3.8%	2.7%
	Flatulence	2.4%	0.9%
Nervous system disorders	Dysgeusia	8.0%	0.3%
	Headache	2.7%	0.9%
Skin and subcutaneous tissue disorders	Rash	3.2%	3.5%
* Includes those events possibly or probably related to study drug and excludes concurrent conditions.			
‡ ≥ 2% Adverse Event Incidence Rates for either treatment group.			

Abnormal Laboratory Values

In immunocompromised patients receiving prophylaxis against *M. avium*, those laboratory values outside the extreme high or low limit for the specified test were analyzed (**Table 4**).

Table 4 Percentage of Patients* Exceeding Extreme Laboratory Value in Immunocompromised Patients Receiving Prophylaxis Against <i>M. avium</i> Complex					
System Organ Class	Laboratory Values	Clarithromycin 500 mg b.i.d.		Placebo	
Investigations	Hemoglobin decreased < 8 g/dL	4/118	3%	5/103	5%
	Platelet count decreased < 50 x 10 ⁹ /L	11/249	4%	12/250	5%
	White blood cell count decreased < 1 x 10 ⁹ /L	2/103	4%	0/95	0%
	Aspartate aminotransferase increased > 5 x ULN	7/196	4%	5/208	2%
	Alanine aminotransferase increased > 5 x ULN	6/217	3%	4/232	2%
	Blood alkaline phosphatase increased > 5 x ULN	5/220	2%	5/218	2%
* Includes only patients with baseline values within the normal range or borderline high (hematology variables) and within the normal range or borderline low (chemistry variables). Legend: b.i.d. = twice daily; ULN = Upper Limit of Normal					

Treatment of Patients with Mycobacterial Infections

Excluding those patients who discontinued therapy due to complications of their underlying non-mycobacterial diseases (including death), approximately 14% of the patients discontinued therapy due to drug-related adverse events.

In adult patients, the most frequently reported adverse events with an incidence of 3% or greater, excluding those due to the patient's concurrent condition, are listed in **Table 5** by the total daily dose the patient was receiving at the time of the event. A total of 867 patients were treated with clarithromycin for mycobacterial infections. Of these, 43% reported one or more adverse events. Most of these events were described as mild to moderate in severity, although 14% were described as severe.

Incidence of adverse events was higher in patients taking 4000 mg total daily doses compared to lower doses (**Table 5**).

Table 5 Percentage of Adverse Events* in Immunocompromised Adult Patients Treated with Clarithromycin for Mycobacterial Infections Presented by Total Daily Dose at Time of the Event				
System Organ Class	Adverse Reaction	1000 mg (n=463)	2000 mg (n=516)	4000 mg (n=87)
Gastrointestinal disorders	Nausea	11%	16%	40%
	Vomiting	7%	9%	24%

Table 5 Percentage of Adverse Events* in Immunocompromised Adult Patients Treated with Clarithromycin for Mycobacterial Infections Presented by Total Daily Dose at Time of the Event				
System Organ Class	Adverse Reaction	1000 mg (n=463)	2000 mg (n=516)	4000 mg (n=87)
	Abdominal Pain	5%	7%	20%
	Diarrhea	4%	6%	17%
	Flatulence	1%	2%	7%
	Constipation	1%	< 1%	5%
	Dry Mouth	< 1%	0%	5%
Nervous system disorders	Dysgeusia	6%	7%	29%
	Headache	2%	2%	7%
Skin and subcutaneous tissue disorders	Rash	4%	3%	2%
Investigations	Aspartate aminotransferase increased	2%	2%	11%
	Alanine aminotransferase increased	1%	1%	9%
Respiratory, thoracic and mediastinal disorders	Dyspnea	< 1%	< 1%	7%
Psychiatric disorders	Insomnia	< 1%	< 1%	6%
Ear and labyrinth disorders	Hearing impaired**	3%	2%	5%
* Related adverse events considered to be definitely, probably, possibly or remotely related to study events. ** Sum of patients with deafness, ear disorder, partial transitory deafness, and/or tinnitus. n = Number of adverse events.				

A limited number of pediatric AIDS patients have been treated with clarithromycin suspension for mycobacterial infections. The most frequently reported adverse events, excluding those due to the patient's concurrent condition, are listed in **Table 6** by the total daily dose of clarithromycin the patient received.

Table 6 Number of Pediatric AIDS Patients Treated with Clarithromycin for Mycobacterial Infections Who Experienced Adverse Events				
Presented by Total Daily Dose at Time of the Event				
System Organ Class	Adverse Event	< 15 mg/kg/day (n=19)	15 to < 25 mg/kg/day (n=13)	≥ 25 mg/kg/day (n=12)
Ear and labyrinth disorders	Tinnitus	2	0	0
	Deafness	1	1	0
Gastrointestinal disorders	Vomiting	1	0	0
	Nausea	1	0	0
	Abdominal Pain	1	0	0
	Pancreatitis	1	0	0
Skin and subcutaneous tissue disorders	Purpuric Rash	1	0	0
Investigations	Amylase Increased	0	0	1

Abnormal Laboratory Values

In immunocompromised patients treated with clarithromycin for mycobacterial infections, evaluations of laboratory values were made by analysing those values outside the seriously abnormal level (i.e., the extreme high or low limit) for the specified test (**Table 7** and **Table 8**).

Table 7 Percentage of Immunocompromised Adult Patients Treated with Clarithromycin for Mycobacterial Infections who had On-Treatment Laboratory Values that Were Outside the Seriously Abnormal Level					
Presented by Total Daily Dose					
System Organ Class	Laboratory Values	Seriously Abnormal Level	1000 mg	2000 mg	4000 mg
Investigations	Aspartate aminotransferase increased	> 5 x ULN	3%	2%	4%
	Alanine aminotransferase increased	> 5 x ULN	2%	2%	7%
	Platelet count decreased	< 50 x 10 ⁹ /L	2%	2%	4%
	White blood cell count decreased	< 1 x 10 ⁹ /L	0%	2%	0%
	Blood urea increased	> 50 mg/dL	<1%	<1%	4%
Legend: ULN = Upper Limit of Normal.					

Table 8 Number of Pediatric AIDS Patients Treated with Clarithromycin for Mycobacterial Infections who had On-Treatment Laboratory Values that Were Outside the Seriously Abnormal Level					
Presented by Total Daily Dose					
System Organ Class	Laboratory Values	Seriously Abnormal Level	< 15 mg/kg/day	15 to < 25 mg/kg/day	≥ 25 mg/kg/day
Investigations	Alanine aminotransferase increased	> 5 x ULN	0	1	0
	Blood bilirubin increased	> 12 mg/dL	1	0	0
	Platelet count decreased	< 50 x 10 ⁹ /L	0	1	0
	Blood urea increased	> 50 mg/dL	0	1	0

Legend: ULN = Upper Limit of Normal.

Patients with *Helicobacter pylori* Infection

Triple Therapy: clarithromycin/omeprazole/amoxicillin

A summary of drug-related adverse event incidence rates is presented in **Table 9**.

Table 9 Summary of Drug-Related Adverse Event Incidence Rates by System Organ Class		
System Organ Class	Patients With Drug-Related Adverse Events (% of Patients Treated)*	
	Omeprazole + Clarithromycin + Amoxicillin (n=137)	Omeprazole + Clarithromycin (n=130)
Gastrointestinal disorders	24 (18%)	21 (16%)
General disorders and administration site conditions	5 (4%)	0 (0%)
Nervous system disorders	15 (11%)	30 (23%)
Cardiac disorders	0 (0%)	1 (1%)
Investigations	9 (7%)	0 (0%)
Infections and infestations	1 (1%)	1 (1%)
Hepatobiliary disorders	2 (1%)	0 (0%)
Psychiatric disorders	1 (1%)	1 (1%)
Ear and labyrinth disorders	1 (1%)	2 (2%)
Respiratory, thoracic and mediastinal disorders	1 (1%)	0 (0%)
Skin and subcutaneous tissue disorders	3 (2%)	1 (1%)
Eye disorders	0 (0%)	1 (1%)
Reproductive system and breast disorders	1 (1%)	0 (0%)

Table 9		
Summary of Drug-Related Adverse Event Incidence Rates by System Organ Class		
	Patients With Drug-Related Adverse Events (% of Patients Treated)*	
System Organ Class	Omeprazole + Clarithromycin + Amoxicillin (n=137)	Omeprazole + Clarithromycin (n=130)
* Patients with more than 1 event within a system organ class are counted only once in the total for that system organ class		
Note: There is a statistical difference (Fisher's exact two-sided, p-value = 0.009) between omeprazole + clarithromycin + amoxicillin (11%) versus omeprazole + clarithromycin (23%) in regard to nervous system disorders.		

Dual Therapy: clarithromycin/omeprazole

Of 346 patients, 156 (45%) reported at least 1 adverse event. Adverse events associated with the Gastrointestinal disorders, Nervous system disorders, and Infections and infestations system organ class (SOC) were the most commonly reported adverse events among clarithromycin/omeprazole-treated patients. One hundred and two patients (29%) reported gastrointestinal disorder events. The most common adverse events reported in the Gastrointestinal disorder SOC were nausea (5%) diarrhea (4%), vomiting (3%), and abdominal pain (3%). Eighty-three patients (24%) reported adverse events in the Nervous system disorders SOC. Dysgeusia (15%), headache (5%), and dizziness (2%) were the most frequently reported events in the Nervous system disorders SOC. Twenty-nine patients (8%) reported adverse events in the Infections and infestations SOC. Infection (3%) was the most frequently reported adverse event in the Infections and infestations SOC.

Adverse events by system organ class for all patients treated with clarithromycin and omeprazole are presented in **Table 10**.

Table 10	
Summary of Adverse Event Incidence by System Organ Class all Patients Treated with Clarithromycin/Omeprazole	
<i>System Organ Class*</i>	<i>Number (%) of Patients (N=346)</i>
Infections and infestations	29 (8%)
Neoplasma benign, malignant and unspecified	2 (< 1%)
Metabolism and nutrition disorders	1 (< 1%)
Psychiatric disorders	12 (3%)
Nervous system disorders	83 (24%)
Eye disorders	2 (< 1%)
Ear and labyrinth disorders	1 (< 1%)
Cardiac disorders	6 (2%)
Vascular disorders	1 (< 1%)
Respiratory, thoracic and mediastinal disorders	5 (1%)
Gastrointestinal disorders	102 (29%)

Table 10 Summary of Adverse Event Incidence by System Organ Class all Patients Treated with Clarithromycin/Omeprazole	
<i>System Organ Class*</i>	<i>Number (%) of Patients</i> <i>(N=346)</i>
Hepatobiliary disorders	1 (< 1%)
Skin and subcutaneous tissue disorders	11 (3%)
Musculoskeletal and connective tissue disorders	12 (3%)
Renal and urinary disorders	2 (< 1%)
General disorders and administration site conditions	24 (7%)
Investigations	8 (2%)
Injury, poisoning and procedural complications	3 (1%)
TOTAL **	156 (45%)
* Patients with more than one event within a system organ class are counted only once in the total for that system organ class.	
** Patients with event in more than one system organ class are counted only once in the total.	

The most commonly reported adverse events for the 346 patients who received clarithromycin and omeprazole were: taste perversion (15%), nausea (5%), headache (5%), diarrhea (4%), vomiting (3%), abdominal pain (3%), and infection (3%).

Table 11 presents adverse events reported by 1% or more of clarithromycin/omeprazole-treated patients.

Table 11 Rank-Order of Adverse Events for Patients who Received Clarithromycin and Omeprazole		
System Organ Class	Adverse Event*	Number (%) of Patients
Nervous system disorders	Dysgeusia	53 (15%)
	Headache	16 (5%)
	Dizziness	7 (2%)
Gastrointestinal disorders	Nausea	18 (5%)
	Diarrhea	15 (4%)
	Vomiting	12 (3%)
	Abdominal Pain	11 (3%)
	Tongue Discoloration	8 (2%)
	Constipation	5 (1%)
	Dry Mouth	4 (1%)
Infections and infestations	Infection	9 (3%)
	Rhinitis	7 (2%)
	Pharyngitis	5 (1%)

Table 11
Rank-Order of Adverse Events for Patients
who Received Clarithromycin and Omeprazole

System Organ Class	Adverse Event*	Number (%) of Patients
General disorders and administration site conditions	Pain	6 (2%)
	Asthenia	4 (1%)
	Chills	4 (1%)
	Influenza	4 (1%)
Musculoskeletal and connective tissue disorders	Back Pain	5 (1%)
Skin and subcutaneous tissue disorders	Rash	4 (1%)

* Events reported in at least 1% of the clarithromycin/omeprazole population.

Twelve (4%) of the clarithromycin/omeprazole-treated patients prematurely discontinued from study drug therapy due to adverse events. The most frequently reported adverse events leading to withdrawal included taste perversion, nausea, and headache. Three patients treated with clarithromycin and omeprazole died during follow-up periods; none of the deaths were considered by the investigator to be related to study drug administration.

Few laboratory abnormalities were observed among clarithromycin/omeprazole-treated patients. The incidence of possibly clinically significant hematology and serum chemistry variables was < 1% for any variable evaluated.

Less Common Clinical Trial Adverse Drug Reactions (<1%) for BIAXIN BID[®]

The following adverse drug reactions are applicable to all indications approved for this formulation.

Blood and Lymphatic System Disorders:	eosinophilia and neutropenia
Gastrointestinal Disorders:	abdominal distension
General Disorders and Administration Site Conditions:	chest pain, chills, fatigue and malaise
Hepatobiliary Disorders:	cholestasis, gamma-glutamyltransferase increased and hepatitis
Investigations:	blood alkaline phosphatase increased and blood lactate dehydrogenase increased

BIAXIN[®] XL (clarithromycin extended-release tablets)

Fewer than 2% of adult patients taking BIAXIN[®] XL (clarithromycin extended-release tablets) discontinued therapy because of drug-related side effects. The most frequently reported adverse events in adults taking clarithromycin extended-release tablets were diarrhea (6%), abnormal taste (7%), and nausea (3%). Most of these events were described as mild or moderate in severity. Of the reported adverse events, less than 1% were described as severe.

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

Less Common Clinical Trial Adverse Drug Reactions (<1%) for BIAXIN[®] XL

The following adverse drug reactions are applicable to all indications approved for this formulation.

Gastrointestinal Disorders:	gastroesophageal reflux disease and proctalgia
Infections and Infestations:	gastroenteritis
Musculoskeletal and Connective Tissue Disorders:	myalgia
Respiratory, Thoracic and Mediastinal Disorders:	epistaxis

BIAXIN[®] (clarithromycin for oral suspension, USP)

The safety profile of BIAXIN[®] (clarithromycin for oral suspension, USP) is similar to that of the 250 mg tablet in adult patients.

As with other macrolides, hepatic dysfunction, including increased liver enzymes, and hepatocellular and/or cholestatic hepatitis, with or without jaundice, has been infrequently reported with BIAXIN[®]. This hepatic dysfunction may be severe and is usually reversible. In very rare instances, hepatic failure with fatal outcome has been reported and generally has been associated with serious underlying diseases and/or concomitant medications.

Allergic reactions ranging from urticaria and mild skin eruptions to anaphylaxis and Stevens-Johnson Syndrome/toxic epidermal necrolysis have occurred with orally administered clarithromycin.

There have been rare reports of pancreatitis and convulsions.

Of the 1829 patients who received clarithromycin for oral suspension, 571 (31%) reported at least one adverse event. The adverse events reported are summarized in **Table 12**.

Table 12	
Adverse Events Reported in Pediatric Clinical Trials	
System Organ Class	Number (%) of Patients N=1829
Infections and infestations	172 (9%)
Neoplasms benign, malignant and unspecified (including cysts and polyps)	1 (< 1%)
Blood and the lymphatic system disorders	14 (< 1%)
Metabolism and nutrition disorders	9 (< 1%)
Psychiatric disorders	12 (0.7%)
Nervous system disorders	41 (2%)
Eye disorders	22 (1%)
Ear and labyrinth disorders	25 (1%)
Vascular disorders	2 (< 1%)
Respiratory, thoracic and mediastinal disorders	61 (3%)
Gastrointestinal disorders	355 (19%)
Skin and subcutaneous disorders	66 (4%)
Musculoskeletal and connective tissue disorders	2 (< 1%)
Renal and urinary disorders	5 (< 1%)
Reproductive system and breast disorders	2 (< 1%)
General disorders and administration site conditions	56 (3%)
Investigations	29 (2%)
Injury, poisoning and procedural complications	19 (1%)
TOTAL*	571 (31%)
* Patients with more than one event within a system organ class are only counted once in the total for that system organ class. Patients with events in more than one system organ class are counted only once in the overall total.	

The majority of the patients reported adverse event in the Gastrointestinal disorders SOC (19%), and the Infections and infestations SOC (9%).

The events occurring most frequently in the Gastrointestinal disorder SOC were diarrhea (7%), vomiting (7%), abdominal pain (3%), dyspepsia (3%) and nausea (1%).

Other adverse events included infection (3%), rhinitis (2.2%), rash (2.2%), increased cough (2.1%), fever (2.2%), headache (1.6%), conjunctivitis (1.1%), dysgeusia (3%) and transient elevation of AST (0.9%).

The majority of adverse events were considered by the investigators to have either mild or moderate severity. Three hundred and seventy-five of 1829 patients (21%) had mild adverse events, 175/1829 patients (10%) had moderate adverse events and 20/1829 patients (1%) had severe adverse events.

In the 2 U.S. acute otitis media studies of clarithromycin *versus* antimicrobial/beta-lactamase inhibitor, the incidence of adverse events in all patients treated, primarily diarrhea (15% *vs.* 38%) and diaper rash (3% *vs.* 11%) in young children, was clinically or statistically lower in the clarithromycin arm *versus* the control arm.

In another U.S. otitis media study of clarithromycin *versus* cephalosporin, the incidence of adverse events in all patients treated, primarily diarrhea and vomiting, did not differ clinically or statistically for the 2 agents.

Less Common Clinical Trial Adverse Drug Reactions (<1%) for BIAXIN® pediatric

The following adverse drug reactions are applicable to all indications approved for this formulation.

- Blood and Lymphatic System Disorders: thrombocythemia
- General Disorders and Administration Site Conditions: pyrexia
- Infections and Infestations: infection
- Musculoskeletal and Connective Tissue Disorders: muscle spasms
- Psychiatric Disorders: nervousness and screaming
- Skin and Subcutaneous Tissue Disorders: rash maculo-papular

Other adverse reactions have been observed in different patient populations and during post-marketing surveillance. See ADVERSE REACTIONS, Clinical Trial Adverse Drug Reactions, Table 1.

Post-Market Adverse Drug Reactions

The following list of adverse events is a compilation of adverse reactions from Post-marketing Surveillance and Post-marketing Clinical Studies for all clarithromycin formulations.

Table 13 Post-Market Adverse Drug Reactions	
System Organ Class	Adverse Event
Blood and lymphatic system disorders	Leukopenia
	Thrombocytopenia
	Agranulocytosis

Table 13
Post-Market Adverse Drug Reactions

System Organ Class	Adverse Event
Cardiac disorders ¹	Atrial fibrillation
	Cardiac arrest
	Extrasystoles
	Electrocardiogram QT prolonged
	Ventricular tachycardia
	Torsades de pointes
	Palpitations
Gastrointestinal disorders	Abdominal pain
	Constipation
	Dyspepsia
	Dry mouth
	Eructation
	Esophagitis
	Flatulence
	Vomiting
	Glossitis
	Gastritis
	Stomatitis
	Tongue discolouration
	Tooth discolouration
Pancreatitis	
General disorders and administration site conditions	Asthenia
Infections and infestations	Candidiasis
	Cellulitis
	Pseudomembranous colitis
	Vaginal infection
Hepatobiliary disorders	Hepatitis
	Hepatitis cholestatic
	Hepatic failure ²
	Jaundice (cholestatic and hepatocellular)
Investigations	Albumin globulin ratio abnormal
	Alanine aminotransferase increased
	Aspartate aminotransferase increased
	Liver function test abnormal
	Increased liver enzymes
	Blood creatinine increased
	Blood urea increased
	International normalized ration (INR) increased ⁶
	Prothrombin time prolonged ⁶
Urine color abnormal ⁷	

Table 13
Post-Market Adverse Drug Reactions

System Organ Class	Adverse Event
Metabolism and nutrition disorders	Hypoglycemia ³
	Anorexia
	Decreased appetite
Musculoskeletal and connective tissue disorders	Myalgia
	Myopathy
	Rhabdomyolysis ⁴
	Musculoskeletal stiffness
Nervous system disorders	Dizziness
	Tremor
	Alteration of sense of smell
	Convulsions
	Ageusia
	Anosmia
	Loss of consciousness
	Parosmia
	Somnolence
	Dysgeusia
	Dyskinesia
	Headache
Psychiatric disorders	Anxiety
	Insomnia
	Bad dreams
	Confusion
	Disorientation
	Hallucination
	Psychosis
	Depersonalization
Depression	
Respiratory, thoracic and mediastinal disorders	Asthma
	Pulmonary embolism
Skin and subcutaneous tissue disorders	Acne
	Dermatitis bullous
	Pruritus
	Hyperhidrosis
	Urticaria
	Rash
	Stevens Johnson syndrome
	Toxic epidermal necrosis
	Drug rash with eosinophilia and systemic symptoms (DRESS)
Henoch-Schonlein purpura	

Table 13
Post-Market Adverse Drug Reactions

System Organ Class	Adverse Event
Immune system disorders	Anaphylaxis
	Anaphylactic reaction
	Anaphylactoid reaction
	Hypersensitivity
	Myasthenia gravis
Ear and labyrinth disorders	Tinnitus
	Hearing loss ⁵
	Deafness
	Hearing impaired
	Vertigo
Renal and urinary disorders	Interstitial nephritis
	Renal failure
Vascular disorders	Hemorrhage ⁶
	Vasodilation
¹	As with other macrolides, QT prolongation, ventricular tachycardia, and torsades de pointes have been reported with clarithromycin.
²	Hepatic dysfunction may be severe and is usually reversible. Hepatic failure with fatal outcome has been reported and generally has been associated with serious underlying diseases and/or concomitant medications.
³	There have been reports of hypoglycemia, some of which have occurred in patients on concomitant oral hypoglycemic agents or insulin.
⁴	In some of the reports of rhabdomyolysis, clarithromycin was administered concomitantly with statins, fibrates, colchicine or allopurinol.
⁵	There have been reports of hearing loss with clarithromycin which is usually reversible upon withdrawal of therapy
⁶	When clarithromycin is co-administered with warfarin.
⁷	Symptom of hepatic failure.

Colchicine

There have been post-marketing reports of colchicine toxicity with concomitant use of clarithromycin and colchicine, especially in the elderly, some of which occurred in patients with renal insufficiency. Deaths have been reported in some patients. See **(CONTRAINDICATIONS)**, **(WARNINGS AND PRECAUTIONS, General)** and **(DRUG INTERACTIONS, Drug-Drug Interactions)**.

DRUG INTERACTIONS

Serious Drug Interactions

- Concomitant administration of clarithromycin with astemizole, cisapride, pimozide, terfenadine, lovastatin, simvastatin, ergotamine, or dihydroergotamine is contraindicated. See **(CONTRAINDICATIONS)** and **(DRUG INTERACTIONS, Drug-Drug Interactions)**.
- Clarithromycin is an inhibitor of the cytochrome P450 3A isoform subfamily (CYP3A) and the P-glycoprotein transporter (P-gp). The concomitant administration of clarithromycin and drugs metabolized by CYP3A and/or transported by P-gp may lead to an increase in the plasma concentrations of the co-administered drug which could result in clinically significant safety concerns.

Overview

Many categories of drugs are metabolized by CYP3A and/or transported by P-gp located in the liver and in the intestine. Some drugs may inhibit or induce the activities of CYP3A and/or P-gp. Administration of such inhibitors or inducers may impact upon the metabolism. In some cases serum concentrations may be increased and in others decreased. Care must therefore be exercised when co-administering such drugs.

Effects of clarithromycin on Other Drugs

Clarithromycin is an inhibitor of CYP3A and P-gp. This inhibition may lead to increased or prolonged serum levels of those drugs also metabolized by CYP3A or transported by P-gp when co-administered with clarithromycin. For such drugs the monitoring of their serum concentrations may be necessary.

Clarithromycin should be used with caution in patients receiving treatment with other drugs known to be CYP3A and/or P-gp substrates, especially if the CYP3A/P-gp substrate has a narrow safety margin (e.g., carbamazepine) and/or the substrate is extensively metabolized by CYP3A or transported by P-gp. Dosage adjustments may be considered, and when possible,

serum concentrations of these drugs should be monitored closely in patients concurrently receiving clarithromycin.

With certain drugs, co-administration of clarithromycin is contraindicated or should be avoided (**Table 14**).

Effects of Other Drugs on Clarithromycin

Clarithromycin is a substrate of CYP3A. Co-administration of strong inducers of the cytochrome P450 metabolism system may accelerate the metabolism of clarithromycin and thus lower exposure to clarithromycin while increasing exposure to its metabolite 14-OH-clarithromycin which could impair the intended therapeutic effect. Furthermore, it might be necessary to monitor the plasma levels of the CYP3A inducer, which could be increased owing to the inhibition of CYP3A by clarithromycin (see also the relevant product information for the CYP3A4 inhibitor administered). Co-administration of potent CYP3A inhibitors may lead to increased exposure to clarithromycin and decreased exposure to its metabolite 14-OH-clarithromycin. Clarithromycin dosage adjustment or consideration of alternative treatments may be required.

Bi-Directional Drug Interactions

Bi-directional drug interactions are complex and may occur if both of the interacting drugs are substrates and inhibitors/inducers of CYP3A.

Additional Mechanisms

Interactions with clarithromycin have been reported with drugs metabolized by cytochrome P450 isoforms other than CYP3A system. Additional mechanisms, such as effects upon absorption, may also be responsible for interaction between drugs, including zidovudine and clarithromycin.

Drug-Drug Interactions

Some of the drug-drug interactions which have been reported between clarithromycin-macrolides and other drugs or drug categories are listed in **Table 14**. The drugs listed in this table are based on drug interactions case reports, clinical trials, or potential interactions due to the expected mechanism of the interaction.

Table 14
Established or Potential Drug-Drug Interactions with Clarithromycin

Concomitant Medication	Ref	Effect	Clinical Comments
Astemizole* / Terfenadine	CT	terfenadine-acid metabolite concentrations increase ↑ QT interval	Macrolides have been reported to alter the metabolism of terfenadine resulting in increased serum levels of terfenadine which has occasionally been associated with cardiac arrhythmias such as QT prolongation, ventricular tachycardia, ventricular fibrillation and torsade de pointes. See (CONTRAINDICATIONS). In a study involving 14 healthy volunteers, the concomitant administration of BIAXIN BID [®] tablets and terfenadine resulted in a 2- to 3-fold increase in the serum levels of the acid metabolite of terfenadine, MDL 16, 455, and in prolongation of the QT interval. Similar effects have been observed with concomitant administration of astemizole and other macrolides.
Atazanavir	CT	↑ clarithromycin levels ↑ atazanavir AUC	Both clarithromycin and atazanavir are substrates and inhibitors of CYP3A, and there is evidence of a bi-directional drug interaction. Co-administration of clarithromycin (500 mg twice daily) with atazanavir (400 mg once daily) resulted in a 2-fold increase in exposure to clarithromycin and a 70% decrease in exposure to 14-OH-clarithromycin, with a 28% increase in the AUC of atazanavir. Because of the large therapeutic window for clarithromycin, no dosage reduction should be necessary in patients with normal renal function. For patients with moderate renal function (creatinine clearance 30 to 60 mL/min), the dose of clarithromycin should be decreased by 50%. For patients with creatinine clearance < 30 mL/min, the dose of clarithromycin should be decreased by 75% using an appropriate clarithromycin formulation. Doses of clarithromycin greater than 1000 mg per day should not be co-administered with protease inhibitors.
Carbamazepine	C	↑ levels of carbamazepine	Clarithromycin administration in patients receiving carbamazepine has been reported to cause increased levels of carbamazepine. Blood level monitoring of carbamazepine should be considered.
Cisapride* / Pimozide	C	↑ levels of cisapride ↑ levels of pimozide	Elevated cisapride levels have been reported in patients receiving clarithromycin and cisapride concomitantly. This may result in QT prolongation and cardiac arrhythmias including ventricular tachycardia, ventricular fibrillation and torsade de pointes. Similar effects have been observed in patients taking clarithromycin and pimozide concomitantly. See (CONTRAINDICATIONS).

Table 14			
Established or Potential Drug-Drug Interactions with Clarithromycin			
Concomitant Medication	Ref	Effect	Clinical Comments
Colchicine	C	Potential colchicine toxicity	Colchicine is a substrate for both CYP3A and the efflux transporter, P-gp. Clarithromycin and other macrolides are known to inhibit CYP3A and P-gp. When clarithromycin and colchicine are administered together, inhibition of P-gp and/or CYP3A by clarithromycin may lead to increased exposure to colchicine. Patients should be monitored for clinical symptoms of colchicine toxicity. See (CONTRAINDICATIONS), (WARNINGS AND PRECAUTIONS, General) and (ADVERSE REACTIONS, <u>Post-Market Adverse Drug Reactions</u>) .
Cyclosporine	C	↑ levels of cyclosporine	There have been reports of elevated cyclosporine serum concentrations when clarithromycin and cyclosporine are used concurrently. Cyclosporine levels should be monitored and the dosage should be adjusted as necessary. Patients should also be monitored for increased cyclosporine toxicity.
Didanosine	CT	No change in didanosine pharmacokinetics in HIV-infected patients (n=12)	Simultaneous administration of BIAXIN BID [®] tablets and didanosine to 12 HIV-infected adult patients resulted in no statistically significant change in didanosine pharmacokinetics.
Digoxin	C	↑ levels of digoxin	Digoxin is thought to be a substrate for the efflux transporter, P-gp. Clarithromycin is known to inhibit P-gp. When clarithromycin and digoxin are administered together, inhibition of P-gp by clarithromycin may lead to increased exposure to digoxin. Elevated digoxin serum concentrations have been reported in patients receiving BIAXIN BID [®] tablets and digoxin concomitantly. In post-marketing surveillance some patients have shown clinical signs consistent with digoxin toxicity, including potentially fatal arrhythmias. Serum digoxin levels should be carefully monitored while patients are receiving digoxin and clarithromycin simultaneously.

Table 14			
Established or Potential Drug-Drug Interactions with Clarithromycin			
Concomitant Medication	Ref	Effect	Clinical Comments
Disopyramide / Quinidine	C	<p>↑ levels of disopyramide, resulting in ventricular fibrillation & QT prolongation (rarely reported)</p> <p>Torsades de pointes</p>	<p>Increased disopyramide plasma levels, resulting in ventricular fibrillation and QT prolongation, coincident with the co-administration of disopyramide and clarithromycin have rarely been reported.</p> <p>There have been post-marketed reports of torsades de pointes occurring with concurrent use of clarithromycin and quinidine or disopyramide. Electrocardiograms should be monitored for QTc prolongation during co-administration of clarithromycin with these drugs. Serum levels of these medications should be monitored during clarithromycin therapy.</p>
Ergotamine / Dihydroergotamine	C	<p>Potential ischemic reactions</p> <p>Potential ergot toxicity</p>	<p>Post-marketing reports indicate that co-administration of clarithromycin with ergotamine or dihydroergotamine has been associated with acute ergot toxicity characterized by severe peripheral vasospasm, dysesthesia, and ischemia of the extremities and other tissues including the central nervous system. Concomitant administration of clarithromycin and these medicinal products is contraindicated. See (CONTRAINDICATIONS)</p>
Etravirine	CT	<p>↓ clarithromycin</p> <p>↑ 14-OH-clarithromycin</p>	<p>Clarithromycin exposure was decreased by etravirine; however, concentrations of the active metabolite, 14-OH-clarithromycin, were increased. Because 14-OH-clarithromycin has reduced activity against Mycobacterium avium complex (MAC), overall activity against this pathogen may be altered; therefore alternatives to clarithromycin should be considered for the treatment of MAC.</p>
Fluconazole	CT	<p>↑ clarithromycin C_{min} & AUC</p>	<p>Concomitant administration of fluconazole 200 mg daily and clarithromycin 500 mg twice daily to 21 healthy volunteers led to increases in the mean steady-state clarithromycin C_{min} and AUC of 33% and 18%, respectively.</p> <p>Steady-state concentrations of 14-OH-clarithromycin were not significantly affected by concomitant administration of fluconazole. No clarithromycin dose adjustment is necessary.</p>
Itraconazole	CT, P	<p>↑ levels of clarithromycin</p> <p>↑ levels of itraconazole</p>	<p>Both clarithromycin and itraconazole are substrates and inhibitors of CYP3A, leading to a bi-directional drug interaction. Clarithromycin may increase the plasma levels of itraconazole, while itraconazole may increase the plasma levels of clarithromycin. Patients taking itraconazole and clarithromycin concomitantly should be monitored closely for signs or symptoms of</p>

Table 14			
Established or Potential Drug-Drug Interactions with Clarithromycin			
Concomitant Medication	Ref	Effect	Clinical Comments
			increased or prolonged pharmacologic effect.
Lansoprazole / Omeprazole	CT	Mild change of lansoprazole and 14-OH-clarithromycin concentrations ↑ omeprazole C _{max} & AUC ₀₋₂₄ ↑ levels of clarithromycin	One study demonstrated that concomitant administration of clarithromycin and lansoprazole resulted in mild changes of serum concentrations of lansoprazole and 14-OH-clarithromycin. However, no dosage adjustment is considered necessary based on these data. Clarithromycin 500 mg three times daily was given in combination with omeprazole 40 mg once daily to healthy subjects. The steady-state plasma concentrations of omeprazole were increased (i.e., C _{max} , AUC ₀₋₂₄ , and t _{1/2} increased by 30%, 89%, and 34%, respectively), by concomitant administration of clarithromycin. The mean 24-hour gastric pH value was 5.2 when omeprazole was administered alone and 5.7 when co-administered with clarithromycin. To a lesser extent, omeprazole administration increases the serum concentrations of clarithromycin. Omeprazole administration also increases tissue and mucus concentrations of clarithromycin.
HMG-CoA Reductase Inhibitors Lovastatin / Simvastatin Atorvastatin Rosuvastatin	C C	Rhabdomyolysis (rarely reported)	Concomitant use of clarithromycin with lovastatin or simvastatin is contraindicated. See (CONTRAINDICATIONS) and (WARNINGS AND PRECAUTIONS, HMG-CoA Reductase Inhibitors) . Rhabdomyolysis coincident with the co-administration of clarithromycin and the HMG-CoA reductase inhibitors, lovastatin and simvastatin, has rarely been reported. Rare reports of rhabdomyolysis have also been reported in patients taking atorvastatin or rosuvastatin concomitantly with clarithromycin. Concurrent use of atorvastatin and clarithromycin may result in increased atorvastatin exposure.
Oral Hypoglycemic Agents Insulin	C P	Hypoglycemia	The concomitant use of clarithromycin and oral hypoglycaemic agents and/or insulin can result in significant hypoglycaemia. With certain hypoglycaemic drugs such as nateglinide, pioglitazone, repaglinide and rosiglitazone, inhibition of CYP3A enzyme by clarithromycin may be involved and could cause hypoglycaemia when used concomitantly. Careful monitoring of glucose is recommended.

Table 14
Established or Potential Drug-Drug Interactions with Clarithromycin

Concomitant Medication	Ref	Effect	Clinical Comments
Rifabutin	C	↓ clarithromycin ↑ rifabutin	<p>Clarithromycin has been reported to increase serum and tissue concentration of rifabutin and thus may increase the risk of toxicity. Clarithromycin levels decrease when co-administered with rifabutin.</p> <p>Concomitant administration of clarithromycin and rifabutin in the treatment of <i>Mycobacterial Avium</i> complex infections resulted in rifabutin-associated uveitis.</p> <p>A case control study in AIDS patients showed that concomitant administration of rifabutin and clarithromycin resulted in an approximately 50% reduction in serum clarithromycin concentration, approximately 77% increase in the area under the plasma concentration-time curve of rifabutin, and a 236% increase in the area under the plasma concentration-time curve of rifabutin's active metabolite. The increase in rifabutin and/or its metabolite contributed to the development of uveitis (the incidence of uveitis was 14% in patients weighing >65 kg, 45% in patients between 55 and 65 kg, and 64% in patients <55 kg).</p>
Ritonavir / Indinavir	CT	↑ clarithromycin C_{max} , C_{min} , & AUC	<p>A pharmacokinetic study demonstrated that the concomitant administration of ritonavir 200 mg every 8 hours and clarithromycin 500 mg every 12 hours resulted in a marked inhibition of the metabolism of clarithromycin. The clarithromycin C_{max} increased by 31%, C_{min} increased 182% and AUC increased by 77% with concomitant administration of ritonavir. An essentially complete inhibition of the formation of 14-[R]-hydroxy-clarithromycin was noted. Because of the large therapeutic window for clarithromycin, no dosage reduction should be necessary in patients with normal renal function. However, for patients with renal impairment, the following dosage adjustments should be considered: For patients with creatinine clearance 30 to 60 mL/min the dose of clarithromycin should be reduced by 50%. For patients with creatinine clearance < 30 mL/min the dose of clarithromycin should be decreased by 75%. Doses of clarithromycin greater than 1g/day should not be co-administered with ritonavir.</p> <p>Similar dose adjustments should be considered in patients with reduced renal function when ritonavir is used as a pharmacokinetic enhancer with other HIV protease inhibitors including atazanavir and saquinavir.</p>

Table 14			
Established or Potential Drug-Drug Interactions with Clarithromycin			
Concomitant Medication	Ref	Effect	Clinical Comments
		<p>↑ indinavir AUC ↑ clarithromycin AUC</p>	<p>One study demonstrated that the concomitant administration of clarithromycin and indinavir resulted in a metabolic interaction; the clarithromycin AUC increased by 53% and the indinavir AUC was increased by 20%, but the individual variation was large. No dose adjustment is necessary with normal renal function.</p>
Saquinavir	CT	<p>↑ saquinavir AUC and C_{max}</p> <p>↑ clarithromycin AUC</p>	<p>Both clarithromycin and saquinavir are substrates and inhibitors of CYP3A, and there is evidence of a bi-directional drug interaction.</p> <p>Concomitant administration of clarithromycin (500 mg twice daily) and saquinavir (soft gelatin capsules, 1200 mg three times daily) to 12 healthy volunteers resulted in steady-state AUC and C_{max} values of saquinavir which were 177% and 187% higher than those seen with saquinavir alone. Clarithromycin AUC and C_{max} values were approximately 40% higher than those seen with clarithromycin alone.</p> <p>No dose adjustment is required when the 2 drugs are co-administered for a limited time at the doses/formulations studied.</p> <p>Observations from drug interaction studies using the soft gelatin capsule formulation may not be representative of the effects seen using the saquinavir hard gelatin capsule. Observations from drug interaction studies performed with saquinavir alone may not be representative of the effects seen with saquinavir/ritonavir therapy. When saquinavir is co-administered with ritonavir, consideration should be given to the potential effects of ritonavir on clarithromycin.</p>
Tacrolimus	P	Potential ↑ in tacrolimus concentrations	Concomitant administration of tacrolimus and clarithromycin may result in increased plasma levels of tacrolimus and increased risk of toxicity.
Theophylline	P	Potential ↑ in theophylline concentrations	<p>Clarithromycin use in patients who are receiving theophylline may be associated with an increase of serum theophylline concentrations.</p> <p>Monitoring of serum theophylline concentrations should be considered for patients receiving high doses of theophylline or with baseline concentrations in the upper therapeutic range.</p>

Table 14
Established or Potential Drug-Drug Interactions with Clarithromycin

Concomitant Medication	Ref	Effect	Clinical Comments
Tolterodine	P	↑ serum tolterodine concentrations	The primary route of metabolism for tolterodine is via the 2D6 isoform of cytochrome P450 (CYP2D6). However, in a subset of the population devoid of CYP2D6, the identified pathway of metabolism is via CYP3A. In this population subset, inhibition of CYP3A results in significantly higher serum concentrations of tolterodine. A reduction of tolterodine dosage may be necessary in the presence of CYP3A inhibitors, such as clarithromycin in the CYP2D6 poor metabolizer population.
Calcium Channel Blockers Verapamil Amlodipine Diltiazem	C	Potential ↑ in verapamil concentrations	Hypotension, bradyarrhythmias, and lactic acidosis have been observed in patients receiving concurrent verapamil, belonging to the calcium channel blockers drug class.
Oral Anticoagulants Warfarin / Acenocoumarol	C	↑ anticoagulant effect	There have been reports of increased anticoagulant effect when clarithromycin and oral anticoagulants are used concurrently. Anticoagulant parameters should be closely monitored. Adjustment of the anticoagulant dose may be necessary. Clarithromycin has also been reported to increase the anticoagulant effect of acenocoumarol. There is a risk of serious hemorrhage and significant elevations in International Normalized Ratio (INR) and prothrombin time when clarithromycin is co-administered with warfarin. INR and prothrombin times should be frequently monitored while patients are receiving clarithromycin and oral anticoagulants concurrently. See (WARNINGS AND PRECAUTIONS, Use with Other Drugs, Oral Anticoagulants).
Zidovudine	C	Potential ↓ in zidovudine concentrations	Simultaneous oral administration of BIAXIN BID [®] tablets and zidovudine to HIV-infected adult patients may result in decreased steady-state zidovudine concentrations. Clarithromycin appears to interfere with the absorption of simultaneously administered oral zidovudine, and therefore, this interaction can be largely avoided by staggering the doses of clarithromycin and zidovudine. This interaction does not appear to occur in pediatric HIV-infected patients taking clarithromycin suspension with zidovudine or dideoxyinosine. Similar interaction studies have not been conducted with clarithromycin extended-release (ER) and zidovudine.

Table 14
Established or Potential Drug-Drug Interactions with Clarithromycin

Concomitant Medication	Ref	Effect	Clinical Comments
Phosphodiesterase inhibitors	P	↑ phosphodiesterase inhibitor exposure	Sildenafil, tadalafil, and vardenafil are metabolized, at least in part, by CYP3A, and CYP3A may be inhibited by concomitantly administered clarithromycin. Co-administration of clarithromycin with sildenafil, tadalafil or vardenafil would likely result in increased phosphodiesterase inhibitor exposure. Reduction of sildenafil, tadalafil and vardenafil dosages should be considered when these drugs are co-administered with clarithromycin.
Triazolobenzodiazepines (e.g., triazolam, alzaprazol) Other related benzodiazepines (e.g., midazolam)	CT, C, P	↑ midazolam AUC	When midazolam was co-administered with clarithromycin tablets (500 mg twice daily), midazolam AUC was increased 2.7-fold after intravenous administration of midazolam and 7-fold after oral administration. Concomitant administration of oral midazolam and clarithromycin should be avoided. If intravenous midazolam is co-administered with clarithromycin, the patient must be closely monitored to allow dose adjustment of midazolam. The same precautions should also apply to other benzodiazepines that are metabolized by CYP3A, including triazolam and alprazolam. For benzodiazepines which are not dependent on CYP3A for their elimination (temazepam, nitrazepam, lorazepam), a clinically important interaction with clarithromycin is unlikely. There have been post-marketing reports of drug interactions and central nervous system (CNS) effects (e.g., somnolence and confusion) with the concomitant use of clarithromycin and triazolam. Monitoring the patient for increased CNS pharmacological effects is suggested.
Other drugs metabolized by CYP3A (e.g., alfentanil, bromocriptine, cilostazol, methylprednisolone, vinblastine)	C, P	Potential increase in serum concentration	Interactions with erythromycin and/or clarithromycin have been reported with a number of other drugs metabolized by CYP3A, such as alfentanil, bromocriptine, cilostazol, methylprednisolone, or vinblastine. Serum concentrations of drugs metabolized by CYP3A should be monitored closely in patients concurrently receiving erythromycin or clarithromycin.

Table 14			
Established or Potential Drug-Drug Interactions with Clarithromycin			
Concomitant Medication	Ref	Effect	Clinical Comments
Other drugs metabolized by cytochrome P450 isoforms other than CYP3A (e.g., hexobarbital, phenytoin, and valproate)	C, P	Potential change in serum concentration	Interactions with erythromycin and/or clarithromycin have been reported with drugs metabolized by other cytochrome P450 isoforms (i.e., not CYP3A), such as hexobarbital, phenytoin, and valproate. Serum concentrations of these drugs should be monitored closely in patients concurrently receiving erythromycin or clarithromycin.
Other drug inducers of the cytochrome P450 system (e.g., efavirenz, nevirapine, rifampin, rifabutin, rifampicin, phenobarbital, rifapentine)	CT, P	↓ levels of clarithromycin	Strong inducers of the cytochrome P450 metabolism system such as efavirenz, nevirapine, rifampin, rifabutin, rifampicin, phenobarbital and rifapentine* may accelerate the metabolism of clarithromycin and thus lower the plasma levels of clarithromycin, while increasing those of 14-OH-clarithromycin, a metabolite that is also microbiologically active. Since the microbiological activities of clarithromycin and 14-OH-clarithromycin are different for different bacteria, the intended therapeutic effect could be impaired during concomitant administration of clarithromycin and enzyme inducers.
Legend: C = Case Study; CT = Clinical Trial; P = Potential Interactions with other drugs have not been established.			
* not marketed in Canada.			

Combination Therapy with Omeprazole and/or Amoxicillin

For more information on drug interactions for omeprazole and amoxicillin, refer to their respective Product Monographs, under **DRUG INTERACTIONS**.

Drug-Food Interactions

BIAXIN BID[®] (clarithromycin tablets, USP, film-coated) and BIAXIN[®] (clarithromycin for oral suspension, USP) may be given with or without meals. BIAXIN[®] XL (clarithromycin extended-release tablets) must be taken with food.

Drug-Herb Interactions

St. John's Wort (*Hypericum perforatum*) is an inducer of CYP3A and may induce the metabolism of clarithromycin. This may result in sub-therapeutic levels of clarithromycin leading to reduced efficacy.

Drug-Laboratory Interactions

Interactions with laboratory tests have not been established.

Drug-Lifestyle Interactions

Effects on Ability to Drive and Use Machines

There are no data on the effect of clarithromycin on the ability to drive or use machines. The potential for dizziness, vertigo, confusion and disorientation, which may occur with the medication, should be taken into account before patients drive or use machines.

DOSAGE AND ADMINISTRATION

Dosing Considerations

BIAXIN BID[®] (clarithromycin tablets, USP, film-coated) and BIAXIN[®] (clarithromycin for oral suspension, USP) may be given with or without meals. BIAXIN[®] XL (clarithromycin extended-release tablets) must be taken with food.

In patients with both hepatic and renal impairments or in the presence of severe renal impairment, decreased dosage of clarithromycin or prolonged dosing intervals might be appropriate. See **(DOSAGE AND ADMINISTRATION, Recommended Dose and Dosage Adjustment)**.

In children with renal impairment and a creatinine clearance < 30 mL/min, the dosage of BIAXIN[®] should be reduced by one-half, i.e., up to 250 mg once daily, or 250 mg twice daily in more severe infections. Dosage should not be continued beyond 14 days in these patients.

Recommended Dose and Dosage Adjustment

BIAXIN BID[®] (clarithromycin tablets, USP, film-coated)

Adults with Respiratory Tract or Skin Infections

The adult dosage of BIAXIN BID[®] is 250 mg to 500 mg every 12 hours (**Table 15**) for 7 to 14 days. For infections caused by less susceptible organisms, the upper dosage should be used.

Infection	Dosage (b.i.d.)	Duration
Upper Respiratory Tract Pharyngitis/tonsillitis Acute maxillary sinusitis	250-500 mg 250 mg 500 mg	10 days 7 to 14 days
Lower Respiratory Tract Acute exacerbation of chronic bronchitis and pneumonia	250-500 mg 250-500 mg	7 to 14 days
Uncomplicated Skin and Skin Structure Infections	250 mg	7 to 14 days
Legend: b.i.d. = twice daily		

In the treatment of Group A streptococcus infections, therapy should be continued for 10 days. The usual drug of choice in the treatment of streptococcal infections and the prophylaxis of rheumatic fever is penicillin administered by either the intramuscular or the oral route.

Clarithromycin is generally effective in the eradication of *S. pyogenes* from the nasopharynx; however, data establishing the efficacy of clarithromycin in the subsequent prevention of rheumatic fever are not presently available.

Renal Impairment

In patients with renal impairment and a creatinine clearance < 30 mL/min., the dosage of BIAXIN BID[®] should be reduced by one-half, i.e., 250 mg once daily, or 250 mg twice daily in more severe infections. Dosage should not be continued beyond 14 days in these patients. The safety and efficacy of 500 mg clarithromycin in patients with severe renal impairment has not been established.

Hepatic Impairment

In patients with both hepatic and renal impairments or in the presence of severe renal impairment, decreased dosage of clarithromycin or prolonged dosing intervals may be appropriate. Clarithromycin may be administered without dosage adjustment in the presence of hepatic impairment if there is normal renal function.

Eradication of *Helicobacter Pylori*

Triple Therapy: BIAXIN BID[®]/omeprazole/amoxicillin

The recommended dose is clarithromycin 500 mg twice daily in conjunction with omeprazole 20 mg daily and amoxicillin 1 g twice daily for 10 days. See (**CLINICAL TRIALS, Eradication of *Helicobacter pylori*, Triple Therapy: BIAXIN BID[®]/omeprazole/amoxicillin**).

For more information on omeprazole or amoxicillin, refer to their respective Product Monographs, under **DOSAGE AND ADMINISTRATION**.

(For additional information on the use of BIAXIN BID[®] in triple therapy for the treatment of *H. pylori* infection and active duodenal ulcer recurrence, refer to the Hp-PAC[®] Product Monograph.)

Dual Therapy: BIAXIN BID[®]/omeprazole

In patients who are sensitive to penicillin-based therapy (e.g. amoxicillin), dual therapy with clarithromycin and omeprazole may provide a feasible alternative.

The recommended dose is clarithromycin 500 mg three times daily plus omeprazole 40 mg once daily for 14 days, followed by 20 mg omeprazole once daily for 14 days. See (**CLINICAL TRIALS, Eradication of *Helicobacter pylori*, Dual Therapy: BIAXIN BID[®]/omeprazole**).

Optimal therapeutic regimens consisting of a shorter treatment duration for the eradication of *H. pylori* are yet to be determined.

Adults with Mycobacterial Infections

Prophylaxis

The recommended dose of BIAXIN BID[®] for the prevention of disseminated *M. avium* disease is 500 mg twice daily.

Treatment

Clarithromycin is recommended as the primary agent for the treatment of disseminated infection due to MAC. Clarithromycin should be used in combination with other antimycobacterial drugs which have shown *in vitro* activity against MAC, including ethambutol and rifampin. Although no controlled clinical trial information is available for combination therapy with clarithromycin, the U.S. Public Health Service Task Force has provided recommendations for the treatment of MAC.

The recommended dose for mycobacterial infections in adults is 500 mg twice daily.

Treatment of disseminated MAC infections in AIDS patients should continue for life if clinical and mycobacterial improvement are observed.

BIAXIN[®] XL (clarithromycin extended-release tablets)

Adults with Respiratory Tract Infection

The adult dosage is 1000 mg every 24 hours for 5, 7 or 14 days. Clarithromycin extended-release tablets must be taken with food. Clarithromycin extended-release tablets should be swallowed whole and not chewed, broken or crushed. **Table 16** provides dosage guidelines.

Infection	Dosage (Once daily)	Duration (days)
Acute maxillary sinusitis	1000 mg	14
Acute bacterial exacerbation of chronic bronchitis	1000 mg	5 or 7
Community-acquired pneumonia	1000 mg	7

Renal Impairment

Based on a study done with BIAXIN BID[®], patients with severe renal impairment (creatinine clearance < 30 mL/min) have greater clarithromycin exposure than patients with normal renal function (creatinine clearance \geq 80 mL/min). Clarithromycin C_{max} was about 3.3 times higher and AUC was about 4.2 times higher in the patients with severe renal impairment. The maximum daily clarithromycin dose for patients with severe renal impairment is 500 mg. The safety and efficacy of 500 mg clarithromycin in patients with severe renal impairment has not been established.

In the same study, patients with moderate renal impairment (creatinine clearance 30 to 79 mL/min) had greater clarithromycin exposure than patients with normal renal function, but the elevations were much less than those observed in severe renal impairment. Compared to the subjects with normal renal function, the clarithromycin C_{max} was about 52% higher and the AUC was about 74% higher in the patients with moderate renal impairment. No clarithromycin dose adjustment is required for patients with moderate renal impairment.

Hepatic Impairment

Based on studies done with BIAXIN BID[®], no adjustment of dosage is necessary for subjects with moderate or severe hepatic impairment but with normal renal function.

BIAXIN[®] (clarithromycin for oral suspension, USP)

The recommended daily dosage of BIAXIN[®] (clarithromycin for oral suspension, USP) is 15 mg/kg/day, in divided doses every 12 hours, not to exceed 1000 mg/day. The usual duration of treatment is for 5 to 10 days depending on the pathogen involved and the severity of the condition. Treatment for pharyngitis caused by *Streptococcal* species should be 10 days.

In children with renal impairment and a creatinine clearance < 30 mL/min, the dosage of BIAXIN[®] should be reduced by one-half, i.e., up to 250 mg once daily, or 250 mg twice daily in more severe infections. Dosage should not be continued beyond 14 days in these patients.

Table 17 is a suggested guide for determining dosage.

Table 17 BIAXIN[®] Oral Suspension Pediatric Dosage Guidelines Based on Body Weight in kg		
	125 mg/5 mL	250 mg/5 mL
Weight*	Dosage (mL) given twice daily	Dosage (mL) given twice daily
8 to 11 kg (1 to 2 years)**	2.5	1.25
12 to 19 kg (2 to 4 years)	5	2.5
20 to 29 kg (4 to 8 years)	7.5	3.75
30 to 40 kg (8 to 12 years)	10	5
* Children < 8 kg should be dosed on a per kg basis (approximately 7.5 mg/kg twice daily). ** Approximate ages.		

Children with Mycobacterial Infections

Clarithromycin is recommended as the primary agent for the treatment of disseminated infection due to MAC. Clarithromycin should be used in combination with other antimycobacterial drugs which have shown *in vitro* activity against MAC, including ethambutol and rifampin. Although no controlled clinical trial information is available for combination therapy with clarithromycin, the U.S. Public Health Service Task Force has provided recommendations for the treatment of MAC.

In children, the recommended dose is 7.5 mg/kg twice daily up to 500 mg twice daily clarithromycin per day in 2 divided doses. Dosing recommendations for children are shown in **Table 17** above.

Treatment of disseminated MAC infections in AIDS patients should continue for life if clinical and mycobacterial improvement are observed.

Missed Dose

If a dose of clarithromycin is missed, the patient should take the dose as soon as possible and then return to their normal scheduled dose. However, if a dose is skipped, the patient should not double the next dose.

Administration

BIAXIN BID[®] may be taken with or without food.

BIAXIN[®] XL (clarithromycin extended-release tablets) must be taken with food. The tablets should be swallowed whole and not chewed, broken or crushed.

BIAXIN[®] (clarithromycin for oral suspension, USP) may be taken with or without food.

Directions for Reconstitution: 125 mg/5 mL

150 mL size: 79 mL of water should be added to the granules in the bottle and shaken to yield 150 mL of reconstituted suspension.

105 mL size: 55 mL of water should be added to the granules in the bottle and shaken to yield 105 mL of reconstituted suspension.

55 mL size: 29 mL of water should be added to the granules in the bottle and shaken to yield 55 mL of reconstituted suspension.

Directions for Reconstitution: 250 mg/5 mL

150 mL size: 77 mL of water should be added to the granules in the bottle and shaken to yield 150 mL of reconstituted suspension.

105 mL size: 54 mL of water should be added to the granules in the bottle and shaken to yield 105 mL of reconstituted suspension.

55 mL size: 28 mL of water should be added to the granules in the bottle and shaken to yield 55 mL of reconstituted suspension.

Shake well before use. The reconstituted suspension must not be refrigerated. Any reconstituted unused medication should be discarded after 14 days. The graduated syringe included in the package should be rinsed between uses. Do not leave syringe in bottle. Do not store reconstituted suspension in syringe.

OVERDOSAGE

For management of a suspected drug overdose, contact your regional Poison Control Center.

Reports indicate that the ingestion of large amounts of clarithromycin can be expected to produce gastrointestinal symptoms. Adverse reactions accompanying overdose should be treated by the prompt elimination of unabsorbed drug and supportive measures.

Clarithromycin is protein bound (70%). No data are available on the elimination of clarithromycin by hemodialysis or peritoneal dialysis.

ACTION AND CLINICAL PHARMACOLOGY

Mechanism of Action

General

Clarithromycin exerts its antibacterial action by binding to the 50S ribosomal subunit of susceptible bacteria and suppressing protein synthesis.

Pharmacodynamics

Eradication of *Helicobacter pylori*

H. pylori is now established as a major etiological factor in duodenal ulcer disease. The presence of *H. pylori* may damage the mucosal integrity due to the production of enzymes (catalase, lipases, phospholipases, proteases, and urease), adhesins and toxins; the generated inflammatory response contributes to mucosal damage.

The concomitant administration of an antimicrobial(s) such as clarithromycin and an antisecretory agent, improves the eradication of *H. pylori* as compared to individual drug administration. The higher pH resulting from antisecretory treatment optimizes the environment for the pharmacologic action of the antimicrobial agent(s) against *H. pylori*.

Pharmacokinetics

Clarithromycin Tablets, USP, film-coated

A summary of clarithromycin pharmacokinetic parameters following the administration of clarithromycin film-coated tablets is provided in **Table 18**. For details see **DETAILED PHARMACOLOGY, Pharmacokinetics** in PART II of the Product Monograph.

Table 18				
Clarithromycin Pharmacokinetic Parameters				
following the Administration of Clarithromycin Film-coated Tablets				
Single dose*	C_{max} (mg/L)	t_{max} (hr)	t_{1/2} (hr)	AUC_{0-t} (mg·hr/L)
250 mg				
Mean	1	1.5	2.7	5.47
500 mg				
Mean	1.77	2.2	---	11.66
Multiple Doses**				
250 mg b.i.d.				
Mean	1	---	3 to 4	6.34
500 mg b.i.d.				
Mean	3.38	2.1	5 to 7	44.19
* Single doses (from Table 60 and Table 61)				
** Multiple doses (from Table 54 and Table 61)				
Legend: b.i.d. = twice daily				

Clarithromycin Extended-Release Tablets

A summary of clarithromycin pharmacokinetic parameters following the administration of clarithromycin extended-release tablets is provided in **Table 19**. For details see **DETAILED PHARMACOLOGY, Pharmacokinetics** in PART II of the Product Monograph.

Table 19 Clarithromycin Pharmacokinetic Parameters following the Administration of Clarithromycin Extended-Release Tablets			
	C_{\max} (mg/L)	t_{\max} (hr)	AUC_{0-t} (mg·hr/L)
2 x 500 mg once daily Mean* (fasting conditions)	2.21	5.5	33.72
2 x 500 mg once daily Mean* (fed conditions)	3.77	5.6	48.09
* from Table 56			

Clarithromycin for Oral Suspension, USP

A summary of clarithromycin pharmacokinetic parameters in adult volunteers following the administration of clarithromycin for oral suspension is provided in **Table 20**. For details see **DETAILED PHARMACOLOGY, Pharmacokinetics** in PART II of the Product Monograph.

Table 20 Clarithromycin Pharmacokinetic Parameters in Adult Subjects following the Administration of Clarithromycin for Oral Suspension				
250 mg/10 mL	C_{\max} (mg/L)	T_{\max} (hr)	$t_{1/2}$ (hr)	$AUC_{0-\infty}$ (mg·hr/L)
Mean* (fasting conditions)	1.24	3.3	3.7	7.2
Mean* (fed conditions)	0.95	5.3	3.7	6.5
* from Table 57				

A summary of clarithromycin pharmacokinetic parameters in pediatric patients following the administration of clarithromycin for oral suspension is provided in **Table 21**. For details see **DETAILED PHARMACOLOGY, Pharmacokinetics** in PART II of the Product Monograph.

Table 21			
Clarithromycin Pharmacokinetic Parameters in Pediatric Patients following the Administration of Clarithromycin for Oral Suspension			
	C_{max} (mg/L)	t_{max} (hr)	AUC_{0-t} (mg· hr/L)
Single Dose (125 mg/5 mL)			
Mean* (fasting conditions)	3.59	3.1	10
Mean* (fed conditions)	4.58	2.8	14.2
Multiple Doses (7.5 mg/kg b.i.d.)			
Mean* (fasting conditions)	4.6	2.8	15.7
* from Table 64			
Legend: b.i.d. = twice daily			

Absorption

Clarithromycin Tablets, USP Film-Coated

The absolute bioavailability of 250 mg and 500 mg clarithromycin tablets is approximately 50%. Food slightly delays the onset of clarithromycin absorption but does not affect the extent of bioavailability. Therefore, BIAXIN BID[®] tablets may be given without regard to meals.

In fasting healthy human subjects, peak serum concentrations are attained within 2 hours after oral dosing. Steady-state peak serum clarithromycin concentrations, which are attained within 2 to 3 days, are approximately 1 mg/L with a 250 mg dose twice daily and 2 to 3 mg/L with a 500 mg dose twice daily. The elimination half-life of clarithromycin is about 3 to 4 hours with 250 mg twice daily dosing but increases to about 5 to 7 hours with 500 mg administered twice daily.

Clarithromycin displays non-linear pharmacokinetics at clinically relevant doses, producing greater than proportional increases in AUC with increasing dose. The degree of non-linearity is reduced on chronic clarithromycin administration (i.e., at steady-state). The non-linearity of the pharmacokinetics of the principle metabolite, 14-OH-clarithromycin, is slight at the recommended doses of 250 mg and 500 mg administered twice daily. With 250 mg twice daily, 14-OH-clarithromycin attains a peak steady-state concentration of about 0.6 mg/L and has an elimination half-life of 5 to 6 hours. With a 500 mg twice daily dose, the peak steady-state of 14 OH-concentrations of clarithromycin are slightly higher (up to 1 mg/L) and its elimination half-life is about 7 hours. With either dose, the steady-state concentration of this metabolite is generally attained within 2 to 3 days.

Adult Patients with HIV

Steady-state concentrations of clarithromycin and 14-OH-clarithromycin observed following administration of 500 mg doses of clarithromycin twice a day to adult patients with HIV infection were similar to those observed in healthy volunteers. However, at the higher clarithromycin doses

which may be required to treat mycobacterial infections, clarithromycin concentrations can be much higher than those observed at 500 mg clarithromycin doses. In adult HIV-infected patients taking 2000 mg/day in two divided doses, steady-state clarithromycin C_{\max} values ranged from 5 to 10 mg/L. C_{\max} values as high as 27 mg/L have been observed in HIV-infected adult patients taking 4000 mg/day in two divided doses of clarithromycin tablets.

Elimination half-lives appeared to be lengthened at these higher doses as well. The higher clarithromycin concentrations and longer elimination half-lives observed at these doses are consistent with the known non-linearity in clarithromycin pharmacokinetics.

Clarithromycin and omeprazole

Clarithromycin 500 mg three times daily and omeprazole 40 mg once daily were studied in fasting healthy adult subjects. When clarithromycin was given alone as 500 mg every 8 hours, the mean steady-state C_{\max} value was approximately 3.8 mcg/mL and the mean C_{\min} value was approximately 1.8 mcg/mL. The mean AUC_{0-8} for clarithromycin was 22.9 mcg-hr/mL. The T_{\max} and half-life were 2.1 hours and 5.3 hours, respectively, when clarithromycin was dosed at 500 mg three times daily. When clarithromycin was administered with omeprazole, increases in omeprazole half-life and AUC_{0-24} were observed. For all subjects combined, the mean omeprazole AUC_{0-24} was 89% greater and the harmonic mean for omeprazole $t_{1/2}$ was 34% greater when omeprazole was administered with clarithromycin than when omeprazole was administered alone. When clarithromycin was administered with omeprazole, the steady-state C_{\max} , C_{\min} , and AUC_{0-8} of clarithromycin were increased by 10%, 27%, and 15%, respectively over values achieved when clarithromycin was administered with placebo.

A re-formulated 500 mg BIAXIN BID[®] has been developed, an ovaloid smooth film-sealed tablet, which is slightly smaller than the original formulation. Overall bioavailability of both formulations is comparable.

Clarithromycin Extended-Release Tablets

Clarithromycin extended-release tablets provided extended absorption of clarithromycin from the gastrointestinal tract after oral administration. Relative to an equal dose of immediate-release clarithromycin film-coated tablets, clarithromycin extended-release tablets provide lower and later steady-state peak plasma concentrations, but equivalent 24-hour AUCs for both clarithromycin and its microbiologically-active metabolite, 14-OH-clarithromycin.

While the extent of formation of 14-OH-clarithromycin following administration of clarithromycin extended-release tablets (2 x 500 mg once daily) under steady-state conditions is not affected by food, administration under fasting conditions is associated with approximately 30% lower clarithromycin AUC relative to administration with food. Similarly, single-dose administration of clarithromycin extended-release (500 mg once daily) is associated with a 25% lower clarithromycin AUC relative to administration of clarithromycin immediate-release film-coated tablets (250 mg twice daily). Therefore, it is recommended that BIAXIN[®] XL (clarithromycin extended-release tablets) be given with food.

Figure 1 illustrates the steady-state clarithromycin plasma concentration-time profile for BIAXIN[®] XL (2 x 500 mg once daily) relative to BIAXIN[®] (500 mg twice daily).

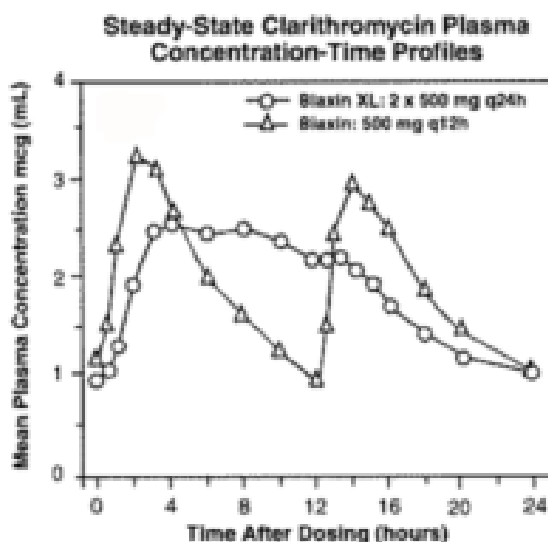


Figure 1: Steady-State Clarithromycin Plasma Concentration-Time Profiles for BIAXIN[®] XL (2 x 500 mg once daily) Relative to BIAXIN[®] (500 mg twice daily)

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

Clarithromycin for Oral Suspension, USP

Adult Volunteers

Single and multiple dose adult volunteer studies showed that the suspension formulation was not significantly different from the tablet formulation in terms of C_{max} of clarithromycin and AUC, although the onset and/or rate of absorption of the suspension formulation was slower than that of the tablet. As with the tablet formulation, steady-state is achieved by the fifth dose of a 12 hour multiple-dose suspension regimen.

Children

In children taking 15 to 30 mg/kg/day in two divided doses, steady-state clarithromycin C_{max} values generally ranged from 8 to 20 mcg/mL. C_{max} values as high as 23 mcg/mL have been observed in HIV-infected pediatric patients taking 30 mg/kg/day in two divided doses. In children requiring antibiotic therapy, administration of 7.5 mg/kg q12h doses every 12 hours of clarithromycin as the suspension generally resulted in steady-state peak plasma concentrations of 3 to 7 mcg/mL for clarithromycin, and 1 to 2 mcg/mL for 14-OH-clarithromycin. In HIV-infected children taking 15 mg/kg every 12 hours, steady-state clarithromycin peak concentrations generally ranged from 6 to 15 mcg/mL. A single and multiple dose study conducted in pediatric patients showed that food leads to a slight delay in the onset of absorption, but does not affect the overall bioavailability of clarithromycin.

Clarithromycin and its 14-OH metabolite penetrate into middle ear effusion (MEE) of patients with secretory otitis media.

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

Single dose adult volunteer studies show that the reformulated (125 mg/5 mL and 250 mg/5 mL) and the current (125 mg/5 mL) clarithromycin for oral suspension have comparable bioavailability under fasting and non-fasting conditions.

Distribution

Clarithromycin distributes readily into body tissues and fluids, and provides tissue concentrations that are higher than serum concentrations. Examples from tissue and serum concentrations are presented in **Table 22**.

Tissue Type	Concentrations	
	Tissue (mcg/g)	Serum (mg/L)
Tonsil	1.6	0.8
Lung	8.8	1.7
Leukocytes*	9.2	1.0

* *in vitro* data.
Legend: b.i.d. = twice daily

Metabolism

Clarithromycin is principally excreted by the liver and kidney. The major metabolite found in urine is 14-OH-clarithromycin.

Excretion

At 250 mg twice daily, approximately 20% of an orally administered dose of clarithromycin film-coated tablet is excreted in the urine as the unchanged parent drug. The urinary excretion of unchanged clarithromycin is somewhat greater (approximately 30%) with 500 mg twice daily dosing. The renal clearance of clarithromycin is, however, relatively independent of the dose size and approximates the normal glomerular filtration rate. The major metabolite found in urine is 14-OH-clarithromycin which accounts for an additional 10 to 15% of the dose with twice daily dosing at either 250 mg or 500 mg. Most of the remainder of the dose is eliminated in the feces, primarily via the bile. About 5 to 10% of the parent drug is recovered from the feces. Fecal metabolites are largely products of N-demethylation, 14-hydroxylation or both.

Special Populations and Conditions

Pediatrics

Refer to the **Absorption** section above.

Geriatrics

Dosage adjustment should be considered in elderly with severe renal impairment. In a steady-state study in which healthy elderly subjects (age 65 to 81 years old) were given 500 mg of clarithromycin every 12 hours, the maximum concentrations of clarithromycin and 14-OH-clarithromycin were increased. The AUC was also increased. These changes in pharmacokinetics parallel known age-related decreases in renal function. In clinical trials, elderly patients did not have an increased incidence of adverse events when compared to younger patients.

Hepatic Insufficiency

The steady-state concentrations of clarithromycin in subjects with impaired hepatic function did not differ from those in normal subjects; however, the 14-OH-clarithromycin concentrations were lower in the hepatically impaired subjects. The decreased formation of 14-OH-clarithromycin was at least partially offset by an increase in renal clearance of clarithromycin in subjects with impaired hepatic function when compared to healthy subjects. See (**WARNINGS AND PRECAUTIONS, Hepatic/Biliary/Pancreatic**) and (**DOSAGE AND ADMINISTRATION, Recommended Dose and Dosage Adjustment**).

Renal Insufficiency

The elimination of clarithromycin was impaired in patients with impaired renal function. The daily dose of clarithromycin should be limited to 500 mg in patients with severe renal impairment (creatinine clearance < 30 mL/min). See (**WARNINGS AND PRECAUTIONS, Renal**) and (**DOSAGE AND ADMINISTRATION, Recommended Dose and Dosage Adjustment**).

STORAGE AND STABILITY

BIAXIN BID[®] (clarithromycin tablets, USP, film-coated)

Store film-coated tablets between 15 and 25°C (59 and 77°F) in a tightly closed container. Protect from light.

BIAXIN[®] XL (clarithromycin extended-release tablets)

Store extended-release tablets between 15 and 25°C (59 and 77°F) in a tightly closed container. Protect from light.

BIAXIN[®] (clarithromycin for oral suspension, USP)

Store granules for suspension between 15 and 25°C (59 and 77°F) in a tightly closed bottle. Protect from light. The reconstituted suspension must not be refrigerated. Any reconstituted unused medication should be discarded after 14 days. The graduated syringe included in the package should be rinsed between uses. Do not leave syringe in bottle. Do not store reconstituted suspension in syringe.

DOSAGE FORMS, COMPOSITION AND PACKAGING

BIAXIN BID[®] (clarithromycin tablets, USP, film-coated)

BIAXIN BID[®] tablets are available in two strengths: 250 mg and 500 mg clarithromycin for oral administration.

BIAXIN BID[®] 250 mg tablets are supplied as yellow, film-coated, oval tablets printed with Abbott logo on one side and are available in HDPE bottles of 100 tablets.

BIAXIN BID[®] 500 mg tablets are supplied as pale yellow, film-coated, oval tablets printed with Abbott logo on one side and are available in HDPE bottles of 100 tablets.

Listing of Non-Medicinal Ingredients

Each BIAXIN BID[®] 250 mg tablet contains 250 mg of clarithromycin with the following non-medicinal ingredients: cellulosic polymers, croscarmellose sodium, D&C Yellow No. 10, magnesium stearate, povidone, pregelatinized starch, propylene glycol, silicon dioxide, sorbic acid, sorbitan monooleate, stearic acid, talc, titanium dioxide and vanillin. BIAXIN BID[®] does not contain tartrazine.

Each BIAXIN BID[®] 500 mg tablet contains 500 mg of clarithromycin with the following non-medicinal ingredients: cellulosic polymers, croscarmellose sodium, D&C Yellow No. 10, magnesium stearate, povidone, propylene glycol, silicon dioxide, sorbic acid, sorbitan monooleate, stearic acid, talc, titanium dioxide and vanillin. BIAXIN BID[®] does not contain tartrazine.

BIAXIN BID[®] (clarithromycin tablets, USP, film-coated: new formulation)

BIAXIN BID[®] 500 mg tablets (new formulation) are supplied as yellow, film-coated, oval, debossed tablets.

Listing of Non-Medicinal Ingredients

Each BIAXIN BID[®] 500 mg tablet (new formulation) contains 500 mg of clarithromycin with the following non-medicinal ingredients: cellulosic polymers, colloidal silicon dioxide, croscarmellose sodium, D&C Yellow No. 10, magnesium stearate, povidone, propylene glycol, sorbic acid, sorbitan monooleate, titanium dioxide and vanillin. BIAXIN BID[®] (new formulation) does not contain tartrazine.

BIAXIN[®] XL (clarithromycin extended-release tablets)

BIAXIN[®] XL 500 mg tablets are supplied as yellow, film-coated, oval, debossed tablets and are available in HDPE bottles of 60 tablets and in blisterpacks of 70 and 100 tablets.

Listing of Non-Medicinal Ingredients

Each BIAXIN[®] XL 500mg tablet contains 500 mg clarithromycin with the following non-medicinal ingredients: cellulosic polymers, lactose monohydrate, magnesium stearate, propylene glycol, Quinoline Yellow Lake E104, sorbitan monooleate, talc, titanium dioxide and vanillin.

BIAXIN[®] (clarithromycin for oral suspension, USP)

BIAXIN[®] 125 mg/5 mL oral suspension is supplied as a granular preparation of 55 mL, 105 mL and 150 mL in HDPE bottles. BIAXIN[®] 250 mg/5 mL oral suspension is supplied as a granular preparation of 105 mL in HDPE bottles. The bottles allow capacity for shaking and packaged with a graduated syringe.

Listing of Non-Medicinal Ingredients

BIAXIN[®] 125 mg/5 mL and 250 mg/5 mL oral suspensions contain a granular preparation of clarithromycin with carbopol and povidone (K90), coated with HP-55 polymer (hydroxypropyl methylcellulose phthalate). The coated granules are mixed with the following inactive ingredients: artificial and natural fruit flavour, castor oil, citric acid, maltodextrin, potassium sorbate, silicon dioxide, sucrose or sugar, titanium dioxide and xanthan gum. Water is added to reconstitute the suspension prior to use.

PART II: SCIENTIFIC INFORMATION

PHARMACEUTICAL INFORMATION

Drug Substance

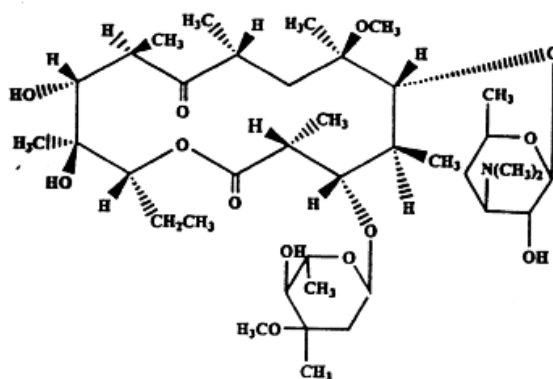
Proper name: Clarithromycin

Chemical name: (3R*, 4S*, 5S*, 6R*, 7R*, 9R*, 11R*, 12R*, 13S*, 14R*)-4-[(2,6-dideoxy-3-C-methyl-3-O-methyl- α -L-ribo-hexopyranosyl)oxy]-14-ethyl-12,13-dihydroxy-7-methoxy-3,5,7,9,11,13-hexamethyl-6-[[3,4,6-trideoxy-3-(dimethylamino)- β -D-xylo-hexopyranosyl]oxy]oxacyclotetradecane-2,10-dione.

Molecular formula: $C_{38}H_{69}NO_{13}$,

Molecular mass: 747.96

Structural formula:



Physicochemical properties: Clarithromycin is a white to off-white crystalline powder. It is slightly soluble in methanol, ethanol and acetonitrile, and practically insoluble in water. The pKa of clarithromycin is 8.48; the pH of a 0.2% (Methanol: Water, 5:95) slurry is 8.8.

The partition coefficient of clarithromycin is influenced by the pH of the water phase and polarity of the organic phase. For octanol (dipole moment = 0.25): water, the partition co-efficient varies from 5.63 to 46.0 for pH water increases from 2 to 8. The melting point of clarithromycin is approximately 225°C.

CLINICAL TRIALS

Mycobacterial Infections

Prophylaxis

Study #	Trial design	Dosage, route of administration and duration	Study subjects Immunocompromised patients with CD4 counts <100 cells/ μ L	Mean age (Range)
561	Double-blind	clarithromycin 500 mg b.i.d (\approx 10.6 months) Placebo b.i.d (8.2 months)	341 341	Adult
Legend: b.i.d. = twice daily				

More patients in the placebo arm than the clarithromycin arm discontinued prematurely from the study (75.6% and 67.4%, respectively). However, if premature discontinuations due to *Mycobacterium avium* complex (MAC) or death are excluded, approximately equal percentages of patients on each arm (54.8% on clarithromycin and 52.5% on placebo) discontinued study drug early for other reasons.

	Clarithromycin	Placebo	Hazard Ratio (95% CI)	p-value	Risk reduction
MAC bacteremia					
# patients developed MAC	19/333 (5.7%)	53/334 (15.9%)	0.307 (0.177, 0.533)	< 0.001*	- 69.3%
Survival					
# patients died	106/341 (31.1%)	136/341 (39.9%)	0.710 (0.533, 0.934)	0.014*	28.2%
Emergence of MAC Signs/Symptoms					

Table 24
Summary of Efficacy Results in Immunocompromised Adult Patients Receiving
Prophylaxis Against *M. avium* Complex

	# meeting criterion/total	# meeting criterion/total			
Wt. loss >10%	5/333 (2%)	23/322 (7%)	0.179 (0.067, 0.481)	0.001*	82.1%
Moderate/severe pyrexia	2/332 (< 1%)	10/329 (3%)	0.191 (0.041, 0.883)	0.034*	80.9%
Moderate/severe night sweats	1/325 (< 1%)	7/327 (2%)	0.130 (0.016, 1.081)	0.059	87.0%
Mod./severe night sweats or pyrexia	2/325 (< 1%)	13/326 (4%)	0.140 (0.031, 0.632)	0.011*	86.0%
Moderate/severe anemia	0/319 (0%)		0		
Grade 3 or 4 LFT	3/325 (< 1%)		0.739 (0.118, 4.649)	0.747	
Quality of Life Subscores (time to first decrease of ≥ 10 points)					
	# meeting criterion/total	# meeting criterion/total			
Overall health	180/317 (57%)	184/318 (58%)	0.809 (0.645, 1.015)	0.068	
Physical function	210/299 (70%)	236/306 (77%)	0.781 (0.637, 0.956)	0.017*	- 21.9%
Role function	111/189 (59%)	131/211 (62%)	0.922 (0.690, 1.233)	0.585	
Social function	187/327 (57%)	197/331 (60%)	0.823 (0.662, 1.024)	0.08	
Cognitive function	174/336 (52%)	170/339 (50%)	0.990 (0.790, 1.240)	0.929	
Pain	201/331 (61%)	217/336 (65%)	0.902 (0.731, 1.113)	0.355	
Mental Health	179/336 (53%)	184/338 (54%)	0.842 (0.672, 1.055)	0.134	
Energy/fatigue	208/328 (63%)	217/335 (65%)	0.784 (0.636, 0.966)	0.022*	- 21.6%
Health distress	170/335 (51%)	191/335 (57%)	0.807 (0.647, 1.007)	0.057	
Quality of life	199/330 (60%)	199/333 (60%)	0.902 (0.727, 1.120)	0.352	
Hospitalization					
# patients hospitalized	166/339 (49%)	189/330 (57%)	0.764 (0.610, 0.955)	0.018*	- 23.6%

On an intent-to-treat basis, the 1-year cumulative incidence of MAC bacteremia was 5.0% for patients randomized to clarithromycin and 19.4% for patients randomized to placebo (**Table 25**). While only 19 of the 341 patients randomized to clarithromycin developed MAC, 11 of these cases were resistant to clarithromycin. The patients with resistant MAC bacteremia had a median baseline CD₄ count of 10 cells/mm³ (range 2 to 25 cells/mm³). Information regarding the clinical course and response to treatment of the patients with resistant MAC bacteremia is limited. The 8 patients who received clarithromycin and developed susceptible MAC bacteremia had a median baseline CD₄ count of 25 cells/mm³ (range 10 to 80 cells/mm³). Comparatively, 53 of the 341 placebo patients developed MAC; none of these isolates were resistant to clarithromycin. The median baseline CD₄ count was 15 cells/mm³ for placebo patients that developed MAC.

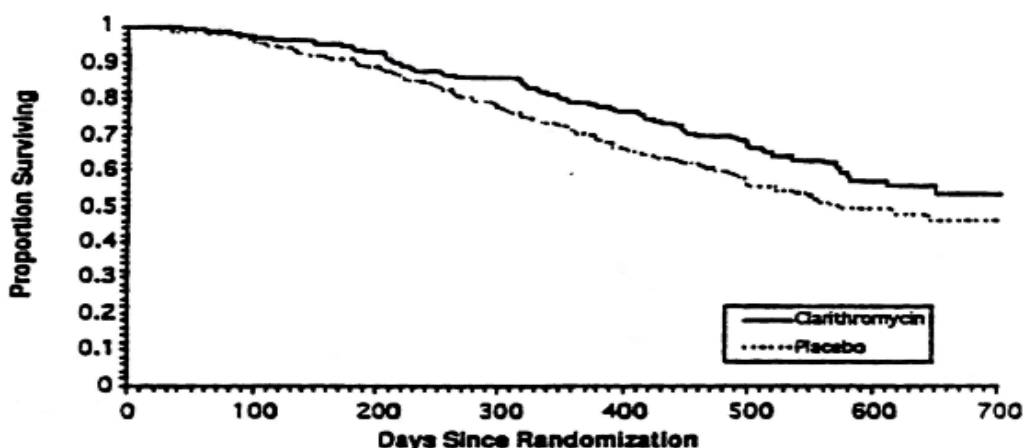


Figure 2: Survival of All Randomized Immunocompromised Adult Patients Receiving Clarithromycin in Prophylaxis Against *M. avium* Complex or Placebo

	Cumulative Incidence of MAC Bacteremia*		Cumulative Mortality	
	Clarithromycin	Placebo	Clarithromycin	Placebo
6 month	1.0 %	9.5 %	6.4 %	9.3 %
12 month	5.0 %	19.4 %	20.8 %	29.7 %
18 month	10.1 %	26.8 %	36.8 %	46.8 %

* from Kaplan-Meier estimates.

Since the analysis at 18 months includes patients no longer receiving prophylaxis the survival benefit of clarithromycin may be underestimated.

Treatment of Mycobacterial Infections

Three studies summarized in **Table 26** were designed to evaluate the following end points:

- Change in MAC bacteremia or blood cultures negative for *M. avium*.
- Change in clinical signs and symptoms of MAC infection including one or more of the following: fever, night sweats, weight loss, diarrhea, splenomegaly, and hepatomegaly.

Study #	Trial design	Dosage, route of administration and duration	Study subjects (n=number)	Mean age (Range)
500	Randomized, double-blind	500 mg b.i.d 1000 mg b.i.d 2000 mg b.i.d.	CDC-defined AIDS and CD ₄ counts < 100 cells/μL (n=154)	Adult

Study #	Trial design	Dosage, route of administration and duration	Study subjects (n=number)	Mean age (Range)
577	Open -label*	500 mg b.i.d 1000 mg b.i.d	CDC-defined AIDS and CD ₄ counts < 100 cells/μL (n=469)	Adult
521	Pediatric Study	3.75 mg/kg b.i.d. 7.5 mg/kg b.i.d. 15 mg/kg b.i.d.	CDC-defined AIDS and CD ₄ counts < 100 cells/μL (n=25)	1-20 mo

* compassionate use.
Legend: b.i.d. = twice daily

The results of the Study 500 are described below. The Study 577 results were similar to the results of the Study 500. Results with the 7.5 mg/kg twice daily dose in the pediatric study were comparable to those for the 500 mg twice daily regimen in the adult studies.

MAC Bacteremia

Decreases in MAC bacteremia or negative blood cultures were seen in the majority of patients in all dose groups. Mean reductions in colony forming units (CFU) are shown below. Included in the table are results from a separate study with a 4-drug regimen (ciprofloxacin, ethambutol, rifampicin, and clofazimine). Since patient populations and study procedures may vary between these 2 studies, comparisons between the clarithromycin results and the combination therapy results should be interpreted cautiously (**Table 27**).

500 mg b.i.d.	1000 mg b.i.d.	2000 mg b.i.d.	Four Drug Regimen
(N=35)	(N=32)	(N=26)	(N=24)
1.5	2.3	2.3	1.4

Legend: b.i.d. = twice daily

Although the 1000 mg and 2000 mg twice daily doses showed significantly better control of bacteremia during the first 4 weeks during therapy, no significant differences were seen beyond that point. The percent of patients whose blood was sterilized as shown by 1 or more negative cultures at any time during acute therapy was 61% (30/49) for the 500 mg twice daily group and 59% (29/49) and 52% (25/28) for the 1000 and 2000 mg twice daily groups, respectively. The percent of patients who had 2 or more negative cultures during acute therapy that were sustained through study Day 84 was 25% (12/49) in both the 500 and 1000 mg twice daily groups and 8% (4/48) for the 2000 mg twice daily group. By Day 84, 23% (11/49), 37% (18/49), and 56% (27/48) of patients had died or discontinued from the study, and 14% (7/49), 12% (6/49), and 13% (6/48) of patients had relapsed in the 500, 1000, and 2000 mg twice daily dose groups, respectively. All of the isolates had a minimum inhibitory concentration (MIC)

< 8 mcg/mL at pretreatment. Relapse was almost always accompanied by an increase in MIC. The median time to first negative culture was 54, 41, and 29 days for the 500, 1000, and 2000 mg twice daily groups, respectively.

Clinically Significant Disseminated MAC Disease

Among patients experiencing night sweats prior to therapy, 84% showed resolution or improvement at some point during the 12 weeks of clarithromycin at 500 to 2000 mg twice daily doses. Similarly, 77% of patients reported resolution or improvement in fevers at some point. Response rates for clinical signs of MAC are given in **Table 28**.

Table 28					
Response Rates for Clinical Signs of MAC					
Resolution of Fever			Resolution of Night Sweats		
b.i.d. dose (mg)	% ever afebrile	% afebrile ≥ 6 weeks	b.i.d. dose (mg)	% ever resolving	% resolving ≥ 6 weeks
500	67	23	500	85	42
1000	67	12	1000	70	33
2000	62	22	2000	72	36
Weight Gain > 3%			Hemoglobin Increase > 1 g		
b.i.d. dose (mg)	% ever gaining	% gaining ≥ 6 weeks	b.i.d. dose (mg)	% ever increasing	% increasing ≥ 6 weeks
500	33	14	500	58	26
1000	26	17	1000	37	6
2000	26	12	2000	62	18

Legend: b.i.d. = twice daily

The median duration of response, defined as improvement of resolution of clinical signs and symptoms, was 2 to 6 weeks.

Since the study was not designed to determine the benefit of monotherapy beyond 12 weeks, the duration of response may be underestimated for the 25 to 33% of patients who continued to show clinical response after 12 weeks.

Survival

Median survival time from study entry (Study 500) was 249 days at the 500 mg twice daily dose compared to 215 days with the 1000 mg twice daily dose. However, during the first 12 weeks of therapy, there were 2 deaths in 53 patients in the 500 mg twice daily group *versus* 13 deaths in 51 patients in the 1000 mg twice daily group. The reason for this apparent mortality difference is not known. Survival in the 2 groups was similar beyond 12 weeks. The median survival times for these dosages were similar to recent historical controls with MAC when treated with combination therapies.

Median survival time from study entry in Study 577 was 199 days for the 500 mg twice daily dose and 179 days for the 1000 mg twice daily dose. During the first 4 weeks of therapy, while patients were maintained on their originally assigned dose, there were 11 deaths in 255 patients taking 500 mg twice daily and 18 deaths in 214 patients taking 1000 mg twice daily.

Otitis Media

In a controlled clinical study (317) of acute otitis media performed in the United States, where significant rates of beta-lactamase producing organisms were found, clarithromycin was compared to an oral cephalosporin. In a small number of patients, microbiologic determinations were made at the pre-treatment visit. **Table 30** summarizes the presumptive bacterial eradications/clinical cure outcomes (i.e., clinical success). A summary of the study demographics and trial design is presented below.

Table 29 Summary of Demographics and Trial Design U.S. Acute Otitis Media Study Clarithromycin versus Oral Cephalosporin				
Study #	Trial design	Dosage, route of administration and duration	Study subjects (n=number)	Mean age (Range)
317	Phase III, single-blind (investigator-blind), randomized, multicenter	clarithromycin suspension 7.5 mg/ kg/ dose (max 500 mg) b.i.d. cefaclor suspension 20 mg/kg (max 100 mg q.d.) b.i.d.	379 patients	clarithromycin: 3.8 (0 to 13 years) cefaclor: 4.0 (0 to 12 years)
		oral 10 days		
497	Phase III, single-blind (investigator-blind), randomized, multicenter	clarithromycin suspension 7.5 mg/ kg/ dose (max 500 mg) b.i.d. Augmentin suspension 13.3 mg/ kg/ dose of the amoxicillin component (max 500 mg) q8h	433	clarithromycin: 3.5 (0 to 12 years) Augmentin: 3.3 (0 to 12 years)
		oral 10 days		
649	Phase III, single-blind (investigator-blind), randomized, multicenter	clarithromycin suspension 7.5 mg/ kg/ dose (max 500 mg) b.i.d. Augmentin suspension 13.3 mg/ kg/ dose of the amoxicillin component (max 500 mg)	312	Clarithromycin: 3.1 (6 months to 12 years) Augmentin: 3.5 (6 months to 12 years)
		oral 10 days		
Legend: b.i.d. = twice daily; q8h = every 8 hours; q.d. = once daily				

Table 30 U.S. Acute Otitis Media Study Clarithromycin versus Oral Cephalosporin	
Pathogen	Efficacy Results Outcome
<i>S. pneumoniae</i>	clarithromycin success rate, 13/15 (87%), control 4/5
<i>H. influenzae</i> *	clarithromycin success rate, 10/14 (71%), control 3/4
<i>M. catarrhalis</i>	clarithromycin success rate, 4/5, control 1/1
<i>S. pyogenes</i>	clarithromycin success rate, 3/3, control 0/1
Overall	clarithromycin success rate, 30/37 (81%), control 8/11 (73%)
* None of the <i>H. influenzae</i> isolated pre-treatment were resistant to clarithromycin; 6% were resistant to the control agent.	

The incidence of adverse events in all patients treated, primarily diarrhea (15% vs. 38%) and diaper rash (3% vs. 11%) in young children, was clinically or statistically lower in the clarithromycin arm *versus* the control arm.

In 2 other controlled clinical trials of acute otitis media performed in the United States, where significant rates of beta-lactamase producing organisms were found, clarithromycin was compared to an oral antimicrobial agent that contained a specific beta-lactamase inhibitor.

For the patients who had microbiologic determinations at the pre-treatment visit, **Table 31** summarizes the presumptive bacterial eradication/clinical cure outcomes (i.e., clinical success).

Table 31 Two U.S. Acute Otitis Media Studies Clarithromycin versus Antimicrobial/Beta-Lactamase Inhibitor	
Pathogen	Efficacy Results Outcome
<i>S. pneumoniae</i>	clarithromycin success rate, 43/51 (84%), control 55/56 (98%)
<i>H. influenzae</i> *	clarithromycin success rate, 36/45 (80%), control 31/33 (94%)
<i>M. catarrhalis</i>	clarithromycin success rate, 9/10 (90%), control 6/6
<i>S. pyogenes</i>	clarithromycin success rate, 3/3, control 5/5
Overall	clarithromycin success rate, 91/109 (83%), control 97/100 (97%)
* Of the <i>H. influenzae</i> isolated pre-treatment, 3% were resistant to clarithromycin and 10% were resistant to the control agent.	

The incidence of adverse events in all patients treated, primarily diarrhea and vomiting, did not differ clinically or statistically for the 2 agents.

Appropriate culture and susceptibility tests should be performed prior to initiating treatment in order to isolate and identify organisms causing the infection and to determine their susceptibilities to clarithromycin. Therapy with clarithromycin may be initiated before results of these tests are known. However, modification of this treatment may be required once results become available or if there is no clinical improvement.

Eradication of *Helicobacter pylori*

Triple Therapy: BIAXIN BID[®]/omeprazole/amoxicillin

In a well controlled double-blind study, *Helicobacter pylori* (*H. pylori*) infected duodenal ulcer patients received triple therapy with clarithromycin 500 mg twice daily, omeprazole 20 mg daily and amoxicillin 1000 mg twice daily for 10 days or dual therapy with clarithromycin 500 mg three times daily and omeprazole 40 mg daily for 14 days. *H. pylori* was eradicated in 90% of the patients receiving clarithromycin triple therapy and in 60% of the patients receiving dual therapy.

A summary of the Trial Design is presented in **Table 32**.

Table 32 Summary of the Trial Design Efficacy of Clarithromycin in the Eradication of <i>Helicobacter pylori</i>—Triple Therapy				
Study #	Trial design	Dosage, route of administration and duration	Study subjects (n=number)	Mean age (Range)
183	Phase III, randomized, double-blind, multicenter	<u>Treatment 1</u> Clarithromycin 500 mg b.i.d. with Omeprazole 20 mg q.d. and Amoxicillin 1000 mg b.i.d.	267 patients	18 to 75 years
		<u>Treatment 2</u> Clarithromycin 500 mg b.i.d. with Omeprazole 40 mg q.d.		
		oral <u>Treatment 1:</u> 10 days <u>Treatment 2:</u> 14 days		
Legend: b.i.d. = twice daily; q.d. = once daily				

The ulcer healing rates and corresponding 95% confidence intervals are presented in **Table 33**.

Table 33			
Ulcer Healing [95% C.I.] at 4- to 6-Week Follow-up			
Patient Subset	Clarithromycin + Omeprazole + Amoxicillin	Clarithromycin + Omeprazole	p-value
Clinically Evaluable	93% (118/127) [87.0, 96.7]	91% (104/114) [84.5, 95.7]	0.641
Intent-to-Treat #1	93% (122/131) [87.4, 96.8]	92% (111/121) [85.3, 96.0]	0.812
Intent-to-Treat #2	90% (122/136) [83.3, 94.3]	85% (111/130) [78.1, 91.0]	0.353
<ul style="list-style-type: none"> An ulcer was defined as a circumscribed break in the duodenal mucosa that measured 5 to 25 mm in the longest diameter with apparent depth and was covered with an exudate. Duodenal ulcer was identified by endoscopy and <i>H. pylori</i> infection at baseline was defined as at least two of three positive tests from ¹³C UBT, CLOtest[®], histology and culture. <i>H. pylori</i> eradication at 4 to 6 weeks posttreatment was defined as at least two of three negative tests from ¹³C UBT gastric biopsy for culture, histology and CLOtest[®]. <p>Intent-to-Treat #1: excluded patients with no confirmed evidence of <i>H. pylori</i> pretreatment, patients who had no duodenal ulcer pretreatment, and patients who did not return for a particular visit or did not have a particular procedure performed (e.g., endoscopy).</p> <p>Intent-to-Treat #2: excluded patients with no confirmed evidence of <i>H. pylori</i> pretreatment and patients with no duodenal ulcer pretreatment, but included as failures patients who did not return for a particular visit or did not have a particular procedure performed (e.g., endoscopy).</p>			

The *H. pylori* eradication rates and corresponding 95% confidence intervals are summarized in **Table 34**.

For all patient subsets, triple therapy with clarithromycin, omeprazole, and amoxicillin achieved a statistically higher eradication rate than dual therapy ($p < 0.001$). These differences were also observed when the eradication rates were adjusted for potentially influential factors such as ulcer characteristics, age, and smoking. In addition, the eradication rates within each treatment group were similar for smokers and non-smokers.

Table 34			
Global Eradication [95% C.I.] at 4- to 6-Week Follow-up			
	Clarithromycin + Omeprazole + Amoxicillin	Clarithromycin + Omeprazole	p-value
Bacteriologically Evaluable	91% (115/127) [84.1, 95.0]	59% (68/115) [49.6, 68.2]	< 0.001
Intent-to-Treat #1	90% (120/133) [83.9, 94.7]	60% (72/120) [50.7, 68.8]	< 0.001
Intent-to-Treat #2	88% (120/136) [81.6, 93.1]	55% (72/130) [46.4, 64.1]	< 0.001
<ul style="list-style-type: none"> An ulcer was defined as a circumscribed break in the duodenal mucosa that measured 5 to 25 mm in the longest diameter with apparent depth and was covered with an exudate. Duodenal ulcer was identified by endoscopy and <i>H. pylori</i> infection at baseline was defined as at least two of three positive tests from ¹³C UBT, CLOtest[®], histology and culture. 			

Table 34			
Global Eradication [95% C.I.] at 4- to 6-Week Follow-up			
	Clarithromycin + Omeprazole + Amoxicillin	Clarithromycin + Omeprazole	p-value
<ul style="list-style-type: none"> <i>H. pylori</i> eradication at 4 to 6 weeks posttreatment was defined as at least two of three negative tests from ¹³C UBT gastric biopsy for culture, histology and CLOtest[®]. 			
Intent-to-Treat #1: excluded patients with no confirmed evidence of <i>H. pylori</i> pretreatment, patients who had no duodenal ulcer pretreatment, and patients who did not return for a particular visit or did not have a particular procedure performed (e.g., endoscopy).			
Intent-to-Treat #2: excluded patients with no confirmed evidence of <i>H. pylori</i> pretreatment and patients with no duodenal ulcer pretreatment, but included as failures patients who did not return for a particular visit or did not have a particular procedure performed (e.g., endoscopy).			

International, Randomized, Double-Blind, Placebo-Controlled Study

In an international, randomized, double-blind, placebo-controlled study involving more than 100 patients in each of 6 treatment groups, patients with proven duodenal ulcer disease were randomized to treatment twice daily for 1 week with omeprazole, 20 mg (O), plus either placebo (P) or combinations of 2 of the following antimicrobials: amoxicillin, 1g (A), clarithromycin, 250 mg or 500 mg (C250, C500), or metronidazole, 400 mg (M). *H. pylori* eradication rates for the “all-patients-treated” analysis were 96% (OAC500), 95% (OMC250), 90% (OMC500), 84% (OAC250), 79% (OAM), and 1% (OP).

Independent, Open and Non-Randomized Study

In an independent, open, and non-randomized study, *H. pylori* infected patients received eradication therapy with clarithromycin 500 mg twice daily in conjunction with amoxicillin 1000 mg twice daily and omeprazole 20 mg once daily (Group A) or omeprazole 20 mg twice daily (Group B) for 7 days. In those patients not previously treated with anti-*H. pylori* therapy, *H. pylori* was eradicated in 88% of patients in Group A and 86% of patients in Group B.

(For additional information on the use of BIAXIN BID[®] in triple therapy for the treatment of *H. pylori* infection and active duodenal ulcer recurrence, refer to the Hp-PAC[®] Product Monograph).

Dual Therapy: BIAXIN BID[®]/omeprazole

H. pylori is strongly associated with peptic ulcer disease. Ninety to 100% of patients with duodenal ulcers are infected with this pathogen. Eradication of *H. pylori* has been shown to reduce the rate of duodenal ulcer recurrence, thereby reducing the need for maintenance anti-secretory therapy.

In 4 well controlled, double-blind studies, *H. pylori* infected duodenal ulcer patients received eradication therapy with clarithromycin 500 mg three times daily and omeprazole 40 mg daily for 14 days followed by omeprazole 40 mg (study A) or omeprazole 20 mg (studies B, C and D) daily for an additional 14 days; patients in each control group received omeprazole alone for 28 days.

European Studies

A summary of the Trial Design is presented in **Table 35**.

Table 35 Summary of the Trial Design Efficacy of Clarithromycin in the Eradication of <i>Helicobacter pylori</i>—Dual Therapy			
Study #	Trial design	Dosage, route of administration and duration	Study subjects (n=number)
A	Phase III, randomized, controlled, double-blind, multicenter study	<i>Treatment (1):</i> Clarithromycin 500 mg t.i.d + omeprazole 40 mg q.d. for 14 days, followed by omeprazole 40 mg q.d. for 14 days.	<i>H. pylori</i> infected duodenal ulcer patients (n=69)*
		<i>Treatment (2):</i> Placebo (no clarithromycin) + omeprazole 40 mg q.d. for 14 days, followed by omeprazole 40 mg q.d. for 14 days.	<i>H. pylori</i> infected duodenal ulcer patients (n=75)*
* Number of evaluable patients as per Table 36 . Legend: t.i.d. = three times daily; q.d. = once daily			

Results of Study A are displayed in **Table 36**.

Table 36 Study A: Efficacy of Clarithromycin in the Eradication of <i>Helicobacter pylori</i>—Dual			
Results	Treatment (1) Clarithromycin + Omeprazole*	Treatment (2) Omeprazole*	Statistical Significance
Ulcer Healing Rates at Post-Treatment	100% (65/65)	99% (72/73)	> 0.999
Ulcer Prevalence Rate			
6-Month Follow-up Visit	4% (2/53)	54% (37/69)	< 0.001
12-Month Follow-Up Visit	4% (2/48)	78% (49/63)	< 0.001
<i>H. pylori</i> Global Eradication Rate			
4- to 6-Week Follow-up Visit	83% (57/69)	1% (1/75)	< 0.001
* For details of treatment see Table 35			

A summary of the Trial Design is presented in **Table 37**.

Table 37 Summary of the Trial Design Efficacy of Clarithromycin in the Eradication of <i>Helicobacter pylori</i> - Dual Therapy			
Study #	Trial design	Dosage, route of administration and duration	Study subjects (n=number)
B	Phase III, randomized, controlled, double-blind, multicenter study	<i>Treatment (1):</i> Clarithromycin 500 mg t.i.d + omeprazole 40 mg q.d. for 14 days, followed by omeprazole 20 mg q.d. for 14 days.	<i>H. pylori</i> infected duodenal ulcer patients (n=93)*
		<i>Treatment (2):</i> Placebo (no clarithromycin) + omeprazole 40 mg q.d. for 14 days, followed by omeprazole 20 mg q.d. for 14 days.	<i>H. pylori</i> infected duodenal ulcer patients (n=96)*
* Number of evaluable patients as per Table 38 Legend: t.i.d. = three times daily; q.d. = once daily			

Results of Study B are displayed in **Table 38**.

Results	Treatment (1) Clarithromycin + Omeprazole*	Treatment (2) Omeprazole*	Statistical Significance
Ulcer Healing Rates at Post-Treatment	99% (86/87)	95% (84/88)	0.368
Ulcer Prevalence Rate 6-Month Follow-up Visit 12-Month Follow-Up Visit	11% (9/79) N/A	52% (45/86) N/A	< 0.001 N/A
<i>H. pylori</i> Global Eradication Rate 4- to 6-Week Follow-up Visit	74% (69/93)	4% (4/96)	< 0.001

N/A No information available.
* For details of treatment see **Table 37**

North American Studies

A summary of the Trial Design is presented in **Table 39**.

Study #	Trial design	Dosage, route of administration and duration	Study subjects (n=number)
C	Controlled, double-blind study	<i>Treatment (1)</i> : Clarithromycin 500 mg t.i.d. + omeprazole 40 mg q.d. for 14 days, followed by 20 mg omeprazole q.d. for 14 days.	<i>H. pylori</i> infected duodenal ulcer patients (n=69)*
		<i>Treatment (2)</i> : Clarithromycin 500 mg t.i.d. for 14 days + placebo q.d. (no omeprazole) for 28 days.	<i>H. pylori</i> infected duodenal ulcer patients (n=70)*
		<i>Treatment (3)</i> : Placebo t.i.d. (no clarithromycin) + omeprazole 40 mg q.d. (14 days), followed by omeprazole 20 mg q.d. (14 days).	<i>H. pylori</i> infected duodenal ulcer patients (n=65)*

* Number of evaluable patients as per **Table 40**
Legend: t.i.d. = three times daily; q.d. = once daily

Results of the Study C are displayed in **Table 40**.

Results	Treatment (1) Clarithromycin + Omeprazole	Treatment (2) Clarithromycin	Treatment (3) Omeprazole	Treatment (1) vs Treatment (2) p-value	Treatment (1) vs Treatment (3) p-value
Ulcer Healing Rates at Post-Treatment	87% (60/69)	63% (44/70)	85% (55/65)	0.002	0.806
Ulcer Prevalence Rate 6-Month Follow-up Visit	53% (30/57)	65% (44/68)	72% (41/57)	0.203	0.053
<i>H. pylori</i> Global Eradication Rate 4- to 6-Wk Follow-up Visit 3-Month Follow-up Visit	74% (43/58) 77% (37/48)	34% (15/44) 37% (13/35)	0% (0/55) 3% (1/38)	< 0.001 < 0.001	< 0.001 < 0.001

A summary of the Trial Design is presented in **Table 41**.

Table 41 Summary of Demographics and Trial Design Efficacy of Clarithromycin in the Eradication of <i>Helicobacter pylori</i>—Dual Therapy			
Study #	Trial design	Dosage, route of administration and duration	Study subjects (n=number)
D	Controlled, double-blind study	<i>Treatment (1)</i> : Clarithromycin 500 mg t.i.d + omeprazole 40 mg q.d. for 14 days, followed by 20 mg omeprazole q.d. for 14 days.	<i>H. pylori</i> infected duodenal ulcer patients (n=82)*
		<i>Treatment (2)</i> : Clarithromycin 500 mg t.i.d. for 14 days + placebo q.d. (no omeprazole) for 28 days.	<i>H. pylori</i> infected duodenal ulcer patients (n=86)*
		<i>Treatment (3)</i> : Placebo t.i.d. (no clarithromycin) + omeprazole 40 mg q.d. (14 days), followed by omeprazole 20 mg q.d. (14 days).	<i>H. pylori</i> infected duodenal ulcer patients (n=88)*
* Number of enrolled patients			
Legend s: t.i.d. = three times daily; q.d. = once daily			

Results of the Study D are displayed in **Table 42**.

Table 42 Study D: Efficacy of Clarithromycin in the Eradication of <i>Helicobacter pylori</i>—Dual Therapy					
Results	Treatment (1) Clarithromycin + Omeprazole	Treatment (2) Clarithromycin	Treatment (3) Omeprazole	Treatment (1) vs Treatment (2) p-value	Treatment (1) vs Treatment (3) p-value
Ulcer Healing Rates at Post-Treatment	94% (60/64)	71% (50/70)	89% (62/70)	< 0.001	0.371
Ulcer Prevalence Rate 6-Month Follow-up Visit	30% (18/60)	49% (32/65)	76% (50/66)	0.031	< 0.001
<i>H. pylori</i> Global Eradication Rate					
4- to 6-Wk Follow-up Visit	64% (41/64)	38% (18/48)	0% (0/62)	0.007	< 0.001
3-Month Follow-up Visit	72% (41/57)	40% (19/48)	0% (0/44)	0.001	< 0.001

Overall summary

In study A, *H. pylori* was eradicated in over 80% of patients who received clarithromycin and omeprazole and in only 1% of patients receiving omeprazole alone. In studies B, C, and D, the combined eradication rate was over 70% in patients receiving clarithromycin and omeprazole and less than 1% in patients receiving omeprazole alone. In each study, the rate of ulcer recurrence at 6 months was statistically lower in the clarithromycin and omeprazole treated patients when compared to patients receiving omeprazole alone.

Pneumonia

BIAXIN[®] XL (clarithromycin extended-release tablets)

The clinical and the bacteriological cure rates for all Clinically and Bacteriologically Evaluable Subjects treated with clarithromycin extended-release (ER) in the Community-Acquired Pneumonia (CAP) pivotal study were 87% and 86%, respectively.

Clinical and bacteriological cure rates with the corresponding confidence intervals for Clinically and Bacteriologically Evaluable Subjects in 2 Studies are presented in **Table 44**.

A summary of the study demographics and trial design is presented below.

Table 43				
Summary of Demographics and Trial Design				
Study #	Trial design	Dosage, route of administration and duration	Study subjects (n=number)	Mean age (Range)
Pivotal Study: M99-077	Phase III, double-blind, randomized, parallel-group, multicenter	clarithromycin ER tablets 2 x 500 mg q.d.	299	clarithromycin: 49 (19 to 89 years)
		levofloxacin tablets 2 x 250 mg q.d.		levofloxacin: 51.2 (18 to 91 years)
		oral 7 days		
Non-Pivotal Study: M98-927	Phase III, double-blind, randomized, parallel-group, multicenter	clarithromycin IR tablets 1 x 250 mg b.i.d. / clarithromycin ER tablets 2 x 500 mg q.d.	176	clarithromycin ER: 47.6 (19 to 81 years)
		trovafloxacin mesylate tablets (placed in capsules) 1 x 200 mg q.d.		clarithromycin IR: 49.1 (18 to 76 years)
		oral 7 days		trovafloxacin : 47.3 (19 to 80 years)
Legend: ER = extended-release; q.d. = once daily				

Table 44		
Clinical Cure Rates and Bacteriological Cure Rate at the Test-of-Cure Visit*		
	Pivotal Study	Non Pivotal Study
	Clarithromycin ER n/N (%) [95% CI] ^a	Clarithromycin ER n/N (%) [95% CI] ^a
Clinical Cure Rate ^b	81/93 (87%) [78.5, 93.2]	52/58 (90%) [78.8, 96.1]
P-value ^c ; [95% CI] ^d	> 0.999, [-10.0, 8.9]	0.292, [-15.8, 3.6]
Bacteriological Cure Rate ^b	80/93 (86%) [77.3, 92.3]	52/58 (90%) [78.8, 96.1]
P-value ^c ; [95% CI] ^d	0.831, [-11.2, 8.0] ^e	0.728, [-14.5, 6.5] ^f
a Exact binomial confidence interval. b Assessment was made after 7 days posttreatment in pivotal study and between 7-28 days posttreatment in non-pivotal study unless the subject was a prior clinical failure. c P-value is from Fisher's exact test comparing treatment groups. d Binomial confidence interval based on normal approximation. e comparator is levofloxacin f comparator is trovafloxacin mesylate * Clinically and Bacteriologically Evaluable Subjects in the CAP Studies Legend: ER = extended-release		

Acute Bacterial Exacerbation of Chronic Bronchitis

BIAXIN[®] XL (clarithromycin extended-release tablets)

5-Day Treatment Regimen

One double-blind, controlled study was conducted to evaluate efficacy and safety of clarithromycin extended-release 1000 mg once daily for 5 days treatment of ABECB, as presented in **Table 45**.

Table 45				
Summary of Demographics and Trial Design				
Efficacy of Clarithromycin ER in Acute Bacterial Exacerbation of Chronic Bronchitis – 5-day treatment				
Study #	Trial design	Dosage, route of administration and duration	Study subjects (n=number)	Mean age (Range)
472	Phase III, Double-blind, randomized, parallel-group, multicenter	Clarithromycin ER 2 x 500 mg q.d for 5 days Clarithromycin IR 500 mg b.i.d for 7 days Oral	Patients with ABECB (n = 485)	Clarithromycin ER 62.1 (18-93) Clarithromycin IR 61.6 (34-88)
Legend: b.i.d. = twice daily; q.d. = once daily; ER = extended-release; IR = immediate-release				

The bacteriological cure rate for all Clinically and Bacteriologically Evaluable Subjects treated with clarithromycin extended-release in the Acute Bacterial Exacerbation of Chronic Bronchitis (ABECB) pivotal study was 87%.

Bacteriological cure rates with the corresponding confidence intervals for Clinically and Bacteriologically Evaluable Subjects are presented in **Table 46**.

Table 46		
Bacteriological Cure Rates at the Test-of-Cure Visit*		
	Clarithromycin ER n/N (%)	Clarithromycin IR n/N (%)
Bacteriological Cure Rate ^b	82/94 (87%)	91/102 (89%)
95% CI ^a	[78.8, 93.2]	[81.5, 94.5]
Comparison of Cure Rates		
P-value ^c :	p = 0.825	
95% CI for Difference in Cure Rate ^d	[-11.6, 7.6]	
a Exact binomial confidence interval. b Bacteriological assessment was made at Evaluation 4 (between Study Days 14 and 40), unless the subject was a bacteriological failure. c P-value is from Fisher's exact test comparing treatment groups. d Binomial confidence interval based on normal distribution approximation with a continuity correction * Clinically and Bacteriologically Evaluable Subjects in the ABECB Study Legend: ER = extended-release; IR = immediate-release		

The clinical cure rates for all Clinically and Bacteriologically Evaluable Subjects treated with clarithromycin extended-release in the Acute Bacterial Exacerbation of Chronic Bronchitis (ABECB) pivotal study are presented in **Table 47**.

Table 47			
Clinical Cure Rates for Target Pathogens			
Pretreatment Target Pathogen	Clarithromycin ER	Clarithromycin IR	p-value^a
<i>H. influenzae</i>	34/40 (85%)	34/38 (89%)	0.738
<i>H. parainfluenzae</i>	23/28 (82%)	39/43 (91%)	0.304
<i>M. catarrhalis</i>	24/26 (92%)	14/18 (78%)	0.208
<i>S. pneumoniae</i>	14/19 (74%)	15/20 (75%)	> 0.999
<i>S. aureus</i>	7/9 (78%)	10/12 (83%)	> 0.999
a p-value from Fisher's exact test comparing treatment groups Legend: ER = extended-release; IR = immediate-release			

Long-term (3 months) recurrence rates of ABECB after 5-day treatment with clarithromycin extended-release has not been investigated in the pivotal trial.

7-Day Treatment Regimen

One double-blind controlled clinical trial was conducted to evaluate the efficacy and safety of clarithromycin 500 mg two tablets once daily for 7 days treatment of ABECB, as presented in **Table 48**.

Table 48 Summary of Demographics and Trial Design Efficacy of Clarithromycin ER in Acute Bacterial Exacerbation of Chronic Bronchitis - 7days treatment				
Study #	Trial design	Dosage, route of administration and duration	Study subjects (n=number)	Mean age (Range)
756	Phase III, Double-blind, randomized, parallel-group, multicenter	Clarithromycin ER 2 x 500 mg q.d for 7 days Clarithromycin IR 500 mg b.i.d for 7 days	Patients with ABECB (n = 627)	54.4 years (14 to 89)
Legend: b.i.d. = twice daily; q.d. = once daily; ER = extended-release; IR = immediate-release				

The primary efficacy parameters evaluated in Study 756 were the bacteriological cure rates, target pathogen eradication and clinical cure rates. Bacteriological and clinical cure rates with the corresponding confidence intervals for Clinically and Bacteriologically Evaluable Subjects are presented in **Table 49**.

Table 49 Bacteriological and Clinical Cure Rates at Test-of-Cure Visit - Study 756			
	Clarithromycin ER n/N (%) [95% CI] ^b	Clarithromycin IR n/N (%) [95% CI] ^b	P-value ^a [95% CI] ^c
Bacteriological Cure Rate ^d	85/99*(86%) [77.4, 92.0]	70/82 (85%) [75.8, 92.2]	> 0.999 [-9.8, 10.8]
Clinical Cure Rate	83/100 (83 %) [74.2, 89.8]	67/82 (82%) [71.6, 89.4]	0.847 [-9.9, 12.4]
* One subject with indeterminate bacteriological response was not included in calculating the rate. ^a P-value is from Fisher's exact test comparing treatment groups. ^b Exact binomial confidence interval. ^c Binomial confidence interval based on normal approximation. ^d Assessment was made at Evaluation 3 (7 to 23 days post-treatment) unless the subject was a bacteriological failure before Evaluation 3. Legend: ER = extended-release; IR = immediate-release			

Overall eradication rates and corresponding confidence intervals, as well as target pathogen eradication rates, for clinically and bacteriologically evaluable subjects are presented in **Table 50**.

Table 50			
Target Pathogen Eradication Rates at Test-of-Cure Visit - Study 756			
	Clarithromycin ER n/N (%) [95% CI] ^b	Clarithromycin IR n/N (%) [95% CI] ^b	P-value ^a [95% CI] ^c
Overall Pathogen Eradication Rate ^d	100/116 (86 %) [78.6, 91.9]	86/98 (88%) [79.6, 93.5]	0.840 [-10.6, 7.5]
Eradication Rate ^d			
<i>H. influenzae</i>	22/28 (79%)	17/22 (77%)	0.840 [-10.6, 7.5]
<i>M. catarrhalis</i>	22/25* (88%)	25/26* (96%)	
<i>S. pneumoniae</i>	22/25 (88%)	9/11 (82%)	
<i>H. parainfluenzae</i>	24/26 (92%)	25/28 (89%)	
<i>S. aureus</i>	10/12 (83%)	10/11 (91%)	
* One subject with indeterminate bacteriological response was not included in calculating the rate.			
a P-value is from Fisher's exact test comparing treatment groups.			
b Exact binomial confidence interval.			
c Binomial confidence interval based on normal approximation.			
d Assessment was made at Evaluation 3 (7 to 23 days post-treatment) unless the subject was a bacteriological failure before Evaluation 3.			

Comparative Bioavailability Studies

Relative Bioavailability of Clarithromycin Film-Coated Tablet (Reformulated) and Clarithromycin Film-Coated Tablet Formulations

A re-formulated 500 mg BIAXIN BID[®] has been developed. The new ovaloid, smooth, film-sealed tablet is slightly smaller than the original formulation. The results of the bioequivalence study comparing the two BIAXIN BID[®] formulations may be found in **Table 52**, and the effect of food on the new tablet may be found in **Table 53**. A summary of the study demographics and trial design is presented in **Table 51**.

Table 51				
Summary of Demographics and Trial Design				
Study #	Trial design	Dosage, route of administration and duration	Study subjects (n=number) enrolled	Mean age (Range)
747	Phase I, Single-dose, open-label, randomized, four-period complete crossover in fasting and non-fasting healthy subjects	500 mg clarithromycin tablets (test formulation) single dose 500 mg clarithromycin tablets (reference formulation) single dose	56*	34.6 (19 to 49)
		oral		
		single dose in each of the 4 periods.		
* 54 subjects completed the study				

Table 52 Comparative Single-Dose Bioavailability Data for Clarithromycin – BIAVIN BID [®] 500 mg (New Formulation) versus BIAVIN BID [®] 500 mg (Original Formulation) under Fasting Conditions				
Parameter	Arithmetic Mean (CV%)		Relative Bioavailability	
	BIAVIN BID [®] Test 500 mg film-coated tablet (New Formulation)	BIAVIN BID [®] Reference 500 mg film-coated tablet (Original Formulation)	Point Estimate (%)+	90% Confidence Interval
AUC _T (mcg·h/mL)	16.3 (30)	16.9 (36)	99.5	92.5 – 107.1
AUC _∞ (mcg·h/mL)	17.8 (38)	17.6 (34)	101.7	94.2 – 109.8
C _{max} (mcg/mL)	2.38 (36)	2.39 (41)	103.2	93.0 – 114.5
T _{max} (hr)	1.9 (41)	2.4 (90)	--	--
t _{1/2} (hr)	5.9 (150)	5.0 (33)	--	--

+ Antilogarithm of the difference (test minus reference) of the least squares means for logarithms.

Table 53 Effect of Food Data for Clarithromycin – BIAVIN BID [®] 500 mg (New Formulation) Non-Fasting (High-Fat Meal) versus Fasting Conditions				
Parameter	Arithmetic Mean (CV%)		Relative Bioavailability	
	BIAVIN BID [®] 500 mg film-coated tablet (New Formulation) High- Fat Meal	BIAVIN BID [®] 500 mg film-coated tablet (New Formulation) Fasting	Point Estimate (%)+	90% Confidence Interval
AUC _T (mcg·h/mL)	16.8 (36)	16.3 (30)	100.1	91.7 – 109.2
AUC _∞ (mcg·h/mL)	17.3 (36)	17.8 (38)	95.8	87.4 – 104.9
C _{max} (mcg/mL)	2.98 (38)	2.38 (36)	123.6	109.3 – 139.9
T _{max} (hr)	2.5 (40)	1.9 (41)	--	--
t _{1/2} (hr)	4.4 (18)	5.9 (150)	--	--

+ Antilogarithm of the difference (test minus reference) of the least squares means for logarithms.

Because the 90% confidence intervals (90% CIs) for C_{max} and AUC in **Table 52** are within the range of 80 to 125%, the new and original tablet formulations are bioequivalent under fasting conditions.

When administered under non-fasting (high-fat meal) conditions, the C_{max} for the new tablet is slightly higher than when it is administered under fasting conditions and the upper limit of the 90% CI (139.9%) is greater than 125%. However, the AUC values under fasting and non-fasting conditions are bioequivalent (90% CIs for AUC in **Table 53** are within the range 80 to 125%). As with the original tablet formulation, the new BIAVIN BID[®] tablet may be taken without regard to meals.

BIAXIN[®] XL (clarithromycin extended-release tablets)

Relative Bioavailability of Clarithromycin Extended-Release Tablet and Clarithromycin Film-Coated Tablet Formulations

Steady-state pharmacokinetic studies compared the new clarithromycin extended-release 500 mg tablet dosage form to the standard 250 mg and 500 mg clarithromycin immediate-release film-coated tablets.

In the first study, the steady-state pharmacokinetics of clarithromycin and 14-OH-clarithromycin were studied in 30 healthy subjects under non-fasting (moderate-fat meal) conditions. The subjects received clarithromycin extended-release tablets (2 x 500 mg once daily) or clarithromycin immediate-release film-coated tablets (500 mg twice daily). The pharmacokinetic and bioavailability parameters for clarithromycin are summarized in **Table 54**.

Table 54 Comparative Steady-State Bioavailability Data for Clarithromycin – Three Lots of BIAXIN [®] XL 500 mg (ER Tablets) versus BIAXIN BID [®] 500 mg (IR Tablets) under Non-Fasting (Moderate-Fat Meal) Conditions						
Parameter	Arithmetic Mean (CV%)				Relative Bioavailability	
	ER Tablet Regimen A	ER Tablet Regimen B	ER Tablet Regimen C	IR Tablet Regimen D	Point Estimate (%) ⁺	Confidence Interval [*]
AUC _τ (mcg·h/mL)	42.2 (30)	44.9 (34)	42.1 (31)	46.1 (30)	A vs. D: 92.1 B vs. D: 96.2 C vs. D: 90.3	85.4 – 99.4 89.1 – 103.8 83.7 – 97.5
C _{max} (mcg/mL)	2.81 (37)	2.78 (34)	2.59 (27)	3.51 (28)	A vs. D: 79.2 B vs. D: 77.2 C vs. D: 72.9	71.8 – 87.3 70.0 – 85.1 66.1 – 80.4
C _{min} (mcg/mL)	0.83 (41)	0.83 (53)	0.76 (49)	0.91 (43)	A vs. D: 94.3 B vs. D: 86.0 C vs. D: 79.0	75.9 – 117.3 69.1 – 106.9 63.5 – 98.2
T _{max} (hr)	6.5 (61)	5.5 (63)	7.8 (51)	2.1 (28)	--	--
FI (%)	113 (26)	107 (27)	108 (26)	138 (18)	--	--
Regimen A = 2 x 500 mg clarithromycin ER tablet lot 1, every morning for 5 days. Regimen B = 2 x 500 mg clarithromycin ER tablet lot 2, every morning for 5 days. Regimen C = 2 x 500 mg clarithromycin ER tablet lot 3, every morning for 5 days. Regimen D = 1 x 500 mg clarithromycin immediate-release film-coated (IR) tablet, every 12 hours for 5 days. ⁺ Antilogarithm of the difference (test minus reference) of the least squares means for logarithms. [*] 90% confidence intervals for AUC _τ ; 95% confidence intervals for C _{max} and C _{min} . Legend: ER = extended-release; FI = Fluctuation Index; IR = immediate release						

The results from this multiple-dose study showed that at steady-state under non-fasting conditions, all 3 lots of the test extended-release formulation met the requirements for demonstrating bioavailability with respect to AUC_τ. The significantly lower clarithromycin C_{max} values and the longer T_{max} values suggested that the test formulation provided extended release of

clarithromycin *in vivo*. The significantly lower fluctuation index (FI) values indicated that clarithromycin plasma concentrations fluctuated less for the extended-release tablet regimens than for the immediate-release tablet regimen.

In the second study, the steady-state pharmacokinetics of clarithromycin and 14-OH-clarithromycin were studied in 32 healthy subjects under non-fasting (moderate-fat meal) conditions. The subjects received a clarithromycin extended-release 500 mg tablet once daily or clarithromycin 250 mg immediate-release film-coated tablet twice daily.

The pharmacokinetic and bioavailability parameters for clarithromycin are summarized in **Table 55**.

Table 55				
Comparative Steady-State Bioavailability Data for Clarithromycin – BIAXIN[®] XL 500 mg (ER Tablets) versus BIAXIN BID[®] 250 mg (IR Tablets) under Non-Fasting (Moderate-Fat Meal) Conditions				
Parameter	Arithmetic Mean (CV%)		Relative Bioavailability	
	ER Tablet Regimen A	IR Tablet Regimen B	Point Estimate (%) +	Confidence Interval*
AUC _τ (mcg·h/mL)	20.4 (43)	21.0 (33)	94.6	84.8 – 105.5
C _{max} (mcg/mL)	1.45 (30)	1.94 (35)	75.8	67.7 – 84.9
C _{min} (mcg/mL)	0.31 (73)	0.34 (45)	75.1	59.2 – 102.8
T _{max} (hr)	5.6 (38)	2.4 (59)	--	--
FI (%)	148 (36)	184 (22)	--	--

Regimen A = 1 x 500 mg clarithromycin ER tablet, every morning for five days.
 Regimen B = 1 x 250 mg clarithromycin immediate-release film-coated (IR) tablet, every 12 hours for five days.
 + Antilogarithm of the difference (test minus reference) of the least squares means for logarithms.
 * 90% confidence intervals for AUC_τ; 95% confidence intervals for C_{max} and C_{min}.
 Legend: ER = extended-release; FI = Fluctuation Index; IR = immediate release

The results from this multiple-dose study showed that the extended-release tablet was not significantly different from the 250 mg film-coated tablet in terms of AUC_τ. The significantly lower clarithromycin C_{max} values and longer T_{max} values suggested that the test formulation provided extended release of clarithromycin *in vivo*. The significantly lower FI values indicated that clarithromycin plasma concentrations fluctuated less for the extended-release tablet regimen than for the immediate-release regimen.

In the third study, the steady-state pharmacokinetics of clarithromycin and 14-OH-clarithromycin were studied in 32 healthy subjects. The subjects received clarithromycin extended-release tablets (2 x 500 mg) once daily under fasting or non-fasting (high-fat meal) conditions. The pharmacokinetic and bioavailability parameters for clarithromycin are summarized in **Table 56**.

Table 56				
Effect of Food on the Steady-State Bioavailability of Clarithromycin – BIAXIN[®] XL 500 mg (ER Tablets) – Fasting <i>versus</i> Non-Fasting (High-Fat Meal) Conditions				
Parameter	Arithmetic Mean (CV%)		Relative Bioavailability	
	ER Tablet Fasting Regimen A	ER Tablet Non-Fasting Regimen B	Point Estimate (%)⁺	Confidence Interval[*]
AUC _τ (mcg·h/mL)	35.9 (35)	49.2 (21)	70.1	62.4 – 78.7
C _{max} (mcg/mL)	2.33 (30)	3.91 (27)	58.7	51.4 – 67.0
C _{min} (mcg/mL)	0.76 (58)	0.80 (48)	95.9	72.0 – 125.8
T _{max} (hr)	5.5 (57)	5.6 (35)	--	--
FI (%)	113 (40)	153 (29)	--	--

Regimen A = 2 x 500 mg clarithromycin ER tablets under fasting conditions, every morning for 5 days.
 Regimen B = 2 x 500 mg clarithromycin ER tablets under non-fasting conditions, every morning for 5 days.
⁺ Antilogarithm of the difference (test minus reference) of the least squares means for logarithms.
^{*} 90% confidence intervals for AUC_τ; 95% confidence intervals for C_{max} and C_{min}.
 Legend: ER = extended-release; FI = Fluctuation Index

The results from this multiple-dose study showed that the clarithromycin C_{max} and AUC_τ central values for the extended-release clarithromycin tablet formulation administered under fasting conditions were approximately 41% and 30% lower, respectively than the central values for the same formulation administered with high-fat meal. The clarithromycin C_{min} values were similar when the extended-release formulation was given under fasting *versus* non-fasting conditions.

BIAXIN[®] (clarithromycin for oral suspension, USP)

Relative Bioavailability of Clarithromycin for Oral Suspension and Clarithromycin Tablet Formulations

Plasma concentrations of clarithromycin and 14-OH-clarithromycin were studied in 22 healthy male adult volunteers following administration of single 250 mg oral doses of clarithromycin as granules for suspension or as a 250 mg immediate-release tablet. Each participant received 3 clarithromycin regimens:

- Regimen A: 250 mg (10 mL) clarithromycin oral suspension under non-fasting conditions (30 min after the start of breakfast);
- Regimen B: 250 mg (10 mL) clarithromycin oral suspension under fasting conditions (2 hours before breakfast after a minimum 12 hour overnight fast);
- Regimen C: one 250 mg immediate-release tablet under fasting conditions (2 hours before breakfast after a minimum 12-hour overnight fast).

Mean plasma concentrations of clarithromycin and 14-OH-clarithromycin are illustrated in **Figure 3**.

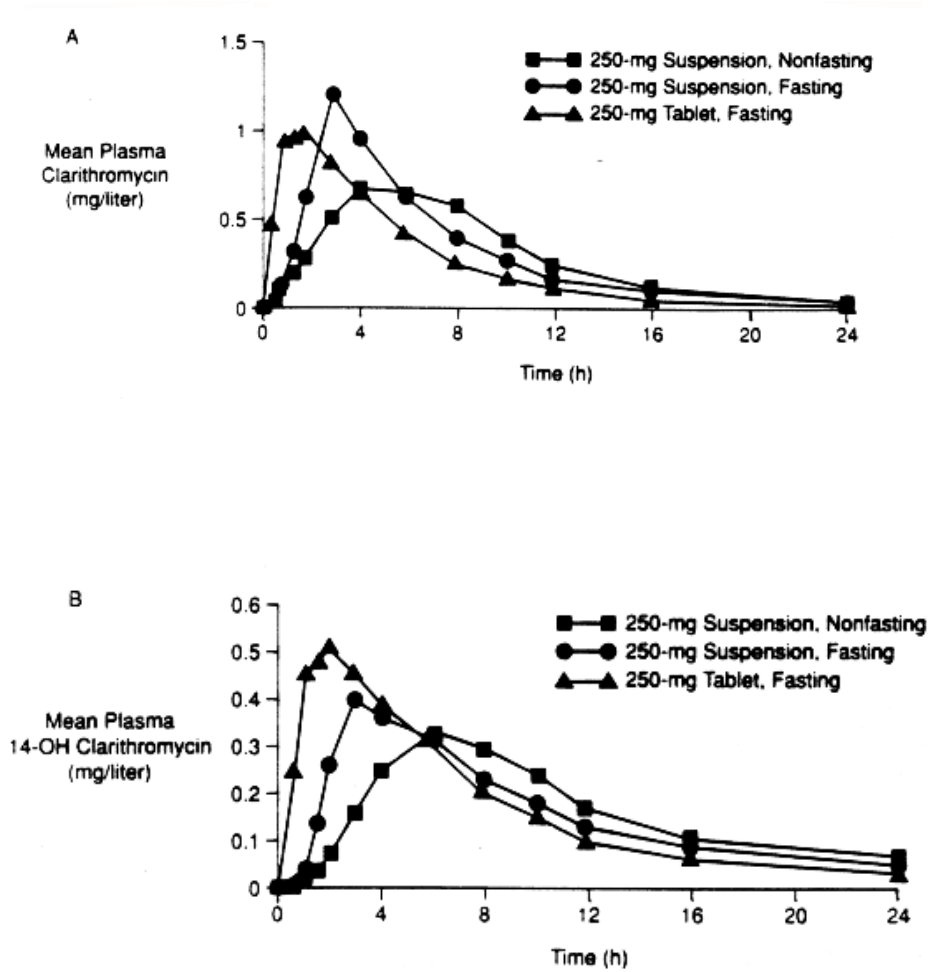


Figure 3: Mean Plasma Clarithromycin (A) and 14-OH-Clarithromycin (B) Concentration vs Time Data After Oral Administration of 250 mg of Clarithromycin

A summary of pharmacokinetic parameters is presented in **Table 57**.

Table 57 Comparative Single-Dose Bioavailability Data for Clarithromycin – BIAVIN® (Clarithromycin for Oral Suspension) versus BIAVIN BID® 250 mg (IR Tablet) under Fasting Conditions and the Effect of Food on the Bioavailability of BIAVIN® (Clarithromycin for Oral Suspension)					
Parameter	Arithmetic Mean (CV%)			Relative Bioavailability	
	Suspension Non-Fasting Regimen A	Suspension Fasting Regimen B	Tablet Fasting Regimen C	Point Estimate (%) ⁺	90% Confidence Interval
Clarithromycin					
AUC _T (mcg·h/mL)	6.52 (57)	7.23 (35)	6.33 (36)	A vs. B: 90.0 B vs. C: 114.0	77.5 – 102.4 99.8 – 128.2
C _{max} (mcg/mL)	0.95 (47)	1.24 (29)	1.10 (30)	A vs. B: 77.8 B vs. C: 112.1	63.8 – 91.8 96.4 – 127.8
C _{min} (mcg/mL)	5.3 (36)	3.3 (35)	1.7 (36)	--	--
T _{max} (hr)	3.7	3.7	3.3	--	--
14(R)-Hydroxy-Clarithromycin					
AUC _T (mcg·h/mL)	4.26 (35)	4.65 (25)	4.92 (29)	A vs. B: 91.1 B vs. C: 93.9	78.5 – 103.7 82.1 – 105.7
C _{max} (mcg/mL)	0.38 (30)	0.42 (34)	0.55 (32)	A vs. B: 90.4 B vs. C: 76.1	77.3 – 103.5 66.1 – 86.0
T _{max} (hr)	5.8 (27)	3.4 (36)	1.9 (30)	--	--
t _{1/2} (hr)	6.7	7.9	6.9	--	--
Regimen A = 250 mg (10 mL) clarithromycin oral suspension under non-fasting conditions (30 min after the start of breakfast). Regimen B = 250 mg (10 mL) clarithromycin oral suspension under fasting conditions (2 hours before breakfast after a minimum 12-hour overnight fast). Regimen C = 250 mg clarithromycin IR tablet under non-fasting conditions (30 min after the start of breakfast). * Harmonic mean half-life. + Antilogarithm of the difference (test minus reference) of the least squares means for logarithms. Legend: IR = immediate-release					

The relative bioavailability of the oral suspension formulation compared with the tablet can be seen by comparing Regimen B versus Regimen C. The difference in clarithromycin T_{max} (3.30 ± 1.20 vs. 1.70 ± 0.60 hr) with the oral suspension and tablet formulations, respectively, shows that the onset and/or rate of absorption from the suspension is slower. A similar trend is seen with the 14-OH metabolite. For clarithromycin, C_{max} was not significantly different between the formulations but for the 14-OH metabolite, C_{max} after suspension administration was significantly lower than after tablet administration. The extent of absorption of clarithromycin was not significantly different from that of the tablet as assessed by AUC, whereas for the 14-OH metabolite, the tablet formulation was associated with a significantly higher extent of metabolite formation than the suspension formulation.

The difference between clarithromycin T_{max} values under non-fasting and fasting conditions (Regimens A and B) was 5.30 ± 1.90 versus 3.30 ± 1.20 hr, respectively, and was similar for 14-OH-clarithromycin (5.80 ± 1.60 vs. 3.40 ± 1.20 hr). Therefore, the onset and/or rate of absorption from the suspension formulation is slowed by the presence of food.

For clarithromycin, C_{max} was significantly higher under fasting than under non-fasting conditions. The extent of absorption of clarithromycin and formation of 14-OH-clarithromycin were not significantly different between fasting and the non-fasting conditions as assessed using AUC.

Single- and multiple-dose adult volunteer studies have established that the suspension and tablet formulations have similar pharmacokinetics.

Relative Bioavailability of Clarithromycin for Oral Suspension (Fruit Punch) and Clarithromycin for Oral Suspension (Fruit-of-the-Forest) Formulations

Single-dose adult volunteer studies show that the reformulated (125 mg/5 mL and 250 mg/5 mL, fruit punch flavor) and the previously-marketed (125 mg/5 mL, fruit -of-the-forest flavor) clarithromycin for oral suspension formulations are bioequivalent under both fasting and non-fasting conditions. The results of the bioavailability comparisons are provided in **Table 58** and **Table 59**.

Parameter	Arithmetic Mean (CV%)				Relative Bioavailability	
	Reform. Fasting Regimen A	Reference Fasting Regimen B	Reform Non-Fasting Regimen C	Reference Non-Fasting Regimen D	Point Estimate (%) ⁺	90% Confidence Interval
AUC_T (mcg·h/mL)	7.95 (35)	8.28 (39)	7.84 (36)	8.37 (37)	A vs. B: 97 C vs. D: 93	93 – 102 89 – 99
AUC_{∞} (mcg·h/mL)	8.14 (36)	8.46 (39)	8.05 (37)	8.60 (38)	A vs. B: 98 C vs. D: 93	93 – 102 89 – 99
C_{max} (mcg/mL)	1.33 (29)	1.35 (39)	1.26 (35)	1.31 (28)	A vs. B: 101 C vs. D: 95	96 – 107 90 – 102
T_{max} (hr)	3.2 (30)	3.3 (30)	4.0 (22)	4.1 (19)	--	--
$t_{1/2}$ (hr)	3.8 (17)	3.8 (15)	4.1 (16)	4.1 (15)	--	--
Regimen A = 250 mg clarithromycin (10 mL reformulated oral suspension) under fasting conditions. Regimen B = 250 mg clarithromycin (10 mL reference oral suspension) under fasting conditions. Regimen C = 250 mg clarithromycin (10 mL reformulated oral suspension) under non-fasting conditions. Regimen D = 250 mg clarithromycin (10 mL reference oral suspension) under non-fasting conditions. + Antilogarithm of the difference (test minus reference) of the least squares means for logarithms.						

Table 59 Comparative Single-Dose Bioavailability Data for Clarithromycin – Reformulated 250 mg/5 mL Clarithromycin for Oral Suspension (Fruit Punch) versus Reference 125 mg/5 mL Clarithromycin for Oral Suspension (Fruit-of-the-Forest) under Fasting and Non-Fasting Conditions						
Parameter	Arithmetic Mean (CV%)				Relative Bioavailability	
	Reform. Fasting Regimen A	Reference Fasting Regimen B	Reform Non-Fasting Regimen C	Reference Non-Fasting Regimen D	Ratio of Geometric Means (%)	90% Confidence Interval
AUC _T (mcg·h/mL)	9.87 (32)	9.62 (32)	9.52 (30)	9.57 (32)	A vs. B: 103 C vs. D: 100	99 – 108 95 – 105
AUC _∞ (mcg·h/mL)	10.15 (32)	9.88 (33)	9.88 (31)	9.93 (33)	A vs. B: 103 C vs. D: 100	99 – 108 96 – 105
C _{max} (mcg/mL)	1.56 (29)	1.53 (27)	1.45 (22)	1.44 (26)	A vs. B: 102 C vs. D: 102	95 – 109 96 – 109
T _{max} (hr)	3.6 (32)	3.4 (28)	4.2 (18)	4.1 (19)	--	--
t _{1/2} (hr)	4.0 (17)	4.0 (16)	4.3 (17)	4.3 (18)	--	--
Regimen A = 250 mg clarithromycin (5 mL reformulated oral suspension) under fasting conditions. Regimen B = 250 mg clarithromycin (10 mL reference oral suspension) under fasting conditions. Regimen C = 250 mg clarithromycin (5 mL reformulated oral suspension) under non-fasting conditions. Regimen D = 250 mg clarithromycin (10 mL reference oral suspension) under non-fasting conditions. + Antilogarithm of the difference (test minus reference) of the least squares means for logarithms.						

DETAILED PHARMACOLOGY

General

Helicobacter pylori

The presence of *H. pylori* may damage the mucosal integrity and defenses so that exposure to acid/pepsin, even in normal concentrations, produces ulceration.

H. pylori displays potent urease activity which may produce an alkaline environment around the organism. Excess ammonia produced by urea hydrolysis is toxic to mucosal cells and may lead to parietal cell failure and/or to a disturbance of the normal negative feedback of acid to the antral G-cells which secrete gastrin. In addition, *H. pylori* produces catalases, lipases, phospholipases, proteases, adhesins and toxins. These enzymes may further degrade the mucous layer and damage the epithelial cell membrane. Also, the presence of *H. pylori* stimulates an active inflammatory response which contributes to mucosal damage.

Gustavson *et al.* (1995) showed that concentrations of 39.3, 23.1 and 25.2 mcg/g clarithromycin were achieved in the gastric mucosa 2, 4, and 6 hours respectively after administering 500 mg clarithromycin three times daily and that corresponding concentrations of the 14-OH metabolite were 3.2, 1.1, and 4.1 mcg/g respectively. Similar results were obtained whether or not clarithromycin was given alone or together with 40 mg omeprazole once daily (Logan *et al.*, 1995). Although the activity of the 14-OH metabolite is about half of the parent drug and its concentrations are lower, it may still contribute antibacterial activity.

Pharmacokinetics

Pharmacokinetics for clarithromycin and 14-OH-clarithromycin metabolite following the oral administration of a single dose or multiple doses of clarithromycin are outlined below.

Clarithromycin Tablets, USP, Film-Coated

Pharmacokinetics for clarithromycin and 14-OH-clarithromycin metabolite was first studied following the oral administration of a single dose of 250 mg or 500 mg or multiple doses of clarithromycin 250 mg tablet.

Single Dose

Plasma levels were determined in 20 subjects following oral administration of a single-dose of 250 mg or 500 mg of clarithromycin under fasting conditions. C_{max} occurred at 1.00 and 1.77 (mg/L) and T_{max} were 1.5 and 2.2 hours, respectively for the 250 mg and 500 mg (**Table 60**, **Figure 4** and **Figure 5**).

Table 60 Mean (\pm SD) Pharmacokinetic Parameters for Clarithromycin Administered as a Single Dose in the Absence of Food		
Variable	Clarithromycin Dose	
	250 mg	500 mg
Number of male evaluable patients	20	20
C_{max} (mg/L)	1.00 \pm 0.34	1.77 \pm 0.65
$C_{max}/100 \text{ mg}^1$	0.40	0.35
T_{max} (hr)	1.5 \pm 0.8	2.2 \pm 0.7
AUC (mg.hr/L)	5.47 \pm 1.93 ²	11.66 \pm 3.67 ³
AUC/100 mg ¹	2.19	2.33

¹ $C_{max}/100 \text{ mg} = C_{max} \times \frac{100 \text{ mg}}{\text{dose}}$; $AUC/100 \text{ mg} = AUC \times \frac{100 \text{ mg}}{\text{dose}}$

² $AUC_{0-12 \text{ hr}}$

³ $AUC_{0-14 \text{ hr}}$

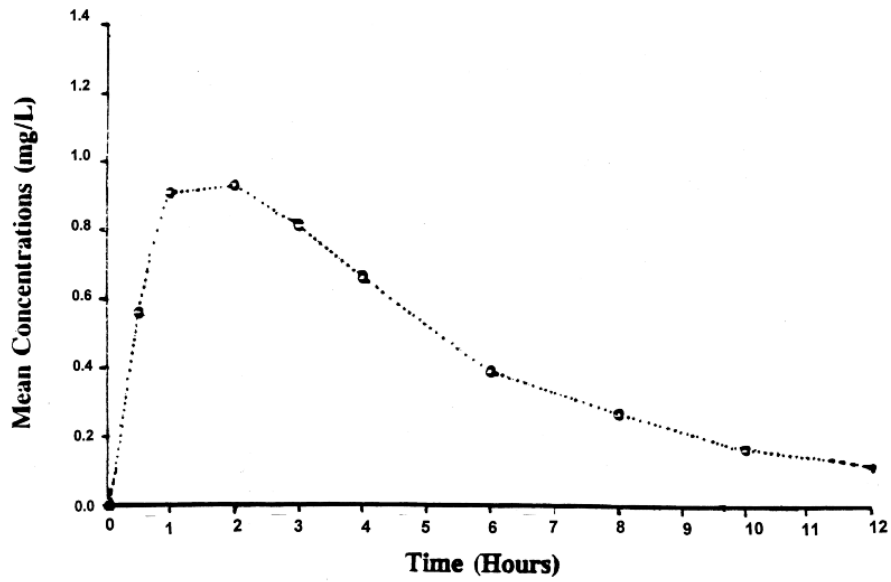


Figure 4: Plasma Clarithromycin Concentration (mg/mL) vs Time Following Oral Administration of a Single Dose of Clarithromycin 250 mg

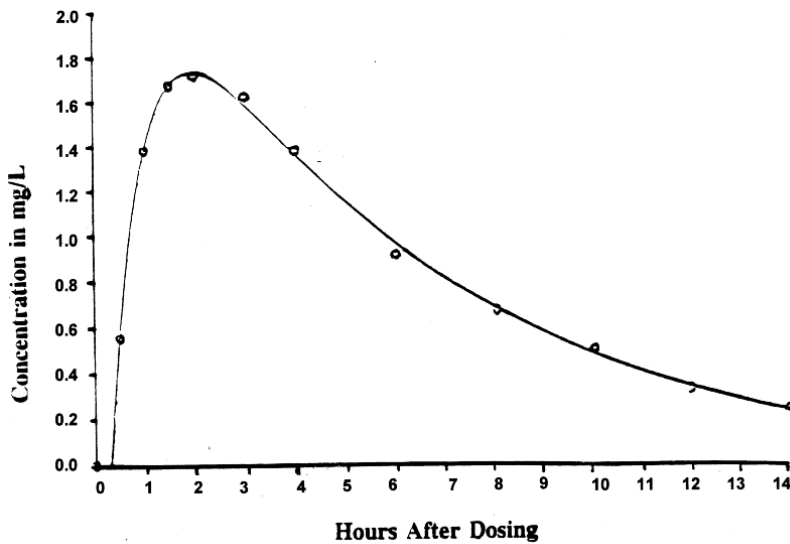


Figure 5: Plasma Clarithromycin Concentration (mg/L) vs Time Following Oral Administration of a Single Dose of Clarithromycin 500 mg

Multiple Dose

Representative estimated pharmacokinetic parameters for clarithromycin and 14-OH-clarithromycin metabolite after a single oral 250 mg dose and after the 5th dose of clarithromycin administered orally at 250 mg twice daily are listed in **Table 61**.

Table 61 Representative Estimated Single and Multiple-Dose Pharmacokinetic Parameters for Clarithromycin and 14-OH-Clarithromycin				
Variables	Single Dose (250 mg)		Multiple Dose after 5th Dose (250 mg b.i.d.)	
	Clari.	14-OH	Clari.	14-OH
C _{max} (mg/L)	0.74 ± 0.24	0.61 ± 0.17	1.00 ± 0.29	0.63 ± 0.19
t _{1/2} (hr)	2.7	4.2	3.5	4.7
AUC ₀₋₁₂ (mg·h/L)	4.27 ± 1.52	4.91 ± 1.12	6.34 ± 1.82	4.72 ± 1.29
Legend: Clari. = clarithromycin; 14-OH = 14-OH-clarithromycin; b.i.d. = twice daily				

The pharmacokinetics of clarithromycin and its 14-OH metabolite indicate that the steady-state concentration is achieved by the 5th dose using 250 mg of clarithromycin twice daily.

The mean plasma concentration-time along the predicted curves for clarithromycin and 14-OH-clarithromycin metabolite are shown in **Figure 6**.

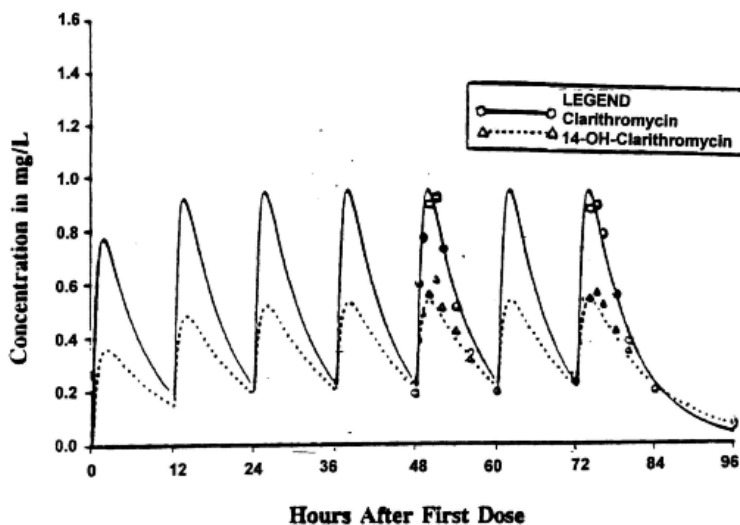


Figure 6: Mean Plasma Concentrations of Clarithromycin and 14-OH-Clarithromycin vs Time Following Seven 250 mg B.I.D. Oral Doses of Clarithromycin

At 250 mg twice daily, approximately 20% of an orally administered dose is excreted in the urine as the unchanged parent drug. The urinary excretion of unchanged clarithromycin is somewhat greater (approximately 30%) with 500 mg twice daily dosing. The renal clearance of clarithromycin is, however, relatively independent of the dose size and approximates the normal glomerular filtration rate. The major metabolite found in urine is 14-OH-clarithromycin which accounts for an additional 10 to 15% of the dose with twice daily dosing at either 250 mg or 500 mg.

Most of the remainder of the dose is eliminated in the feces, primarily via the bile. About 5 to 10% of the parent drug is recovered from the feces. Fecal metabolites are largely products of N-demethylation, 14-hydroxylation or both.

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

The pharmacokinetics of clarithromycin were also altered in subjects with impaired renal function. See (**WARNINGS AND PRECAUTIONS, Renal**) and (**DOSAGE AND ADMINISTRATION, Recommended Dose and Dosage Adjustment**).

Clarithromycin and Omeprazole

A pharmacokinetic study was conducted with clarithromycin 500 mg three times daily and omeprazole 40 mg once daily. When clarithromycin was given alone at 500 mg every 8 hours, the mean steady-state C_{max} value was approximately 31% higher and the mean C_{min} value was approximately 119% higher than when clarithromycin is compared with a previous study at 500 mg every 12 hours. The mean AUC_{0-24} for clarithromycin was 65% greater when 500 mg clarithromycin was given every 8 hours rather than every 12 hours. Neither T_{max} nor half-life values appeared substantially different between the every-8-hour and every-12-hour regimens.

When clarithromycin was administered with omeprazole, increases in omeprazole half-life and AUC_{0-24} were observed. For all subjects combined, the mean omeprazole AUC_{0-24} was 89% greater and the harmonic mean for omeprazole $t_{1/2}$ was 34% greater when omeprazole was administered with clarithromycin than when omeprazole was administered alone. When clarithromycin was administered with omeprazole, the steady-state C_{max} , C_{min} , and AUC_{0-8} of clarithromycin were increased by 10%, 27%, and 15%, respectively over values achieved when clarithromycin was administered with placebo.

At steady-state, clarithromycin gastric mucus concentrations 6 hours post dosing were approximately 25-fold higher in the clarithromycin/omeprazole group compared with the clarithromycin alone group. Six hours post-dosing, mean clarithromycin gastric tissue concentrations were approximately 2-fold higher when clarithromycin was given with omeprazole than when clarithromycin was given with placebo.

Clarithromycin distributes readily into body tissues and fluids, and provides tissue concentrations that are higher than serum concentrations. Examples from tissue and serum concentrations are presented in **Table 62**.

Tissue Type	Concentrations (after 250 mg b.i.d.)	
	Tissue (mcg/g)	Serum (mcg/mL)
Tonsil	1.6	0.8
Lung	8.8	1.7
Leukocytes*	9.2	1.0

* *in vitro* data.
Legend: b.i.d. = twice daily

Clarithromycin for Oral Suspension, USP

Adults

Plasma concentrations of clarithromycin and 14-OH-clarithromycin were studied in 17 healthy male adult volunteers following the administration of clarithromycin granules for suspension. A single phase dose was followed by the multiple dose phase. During the single dose phase, an oral 250 mg (10 mL) dose of clarithromycin granules for suspension was administered. Doses were administered in a fasting state (2 hours before breakfast after an overnight fast and 2 hours after dinner). Mean plasma concentrations of clarithromycin and 14-OH-clarithromycin are illustrated in **Figure 7**.

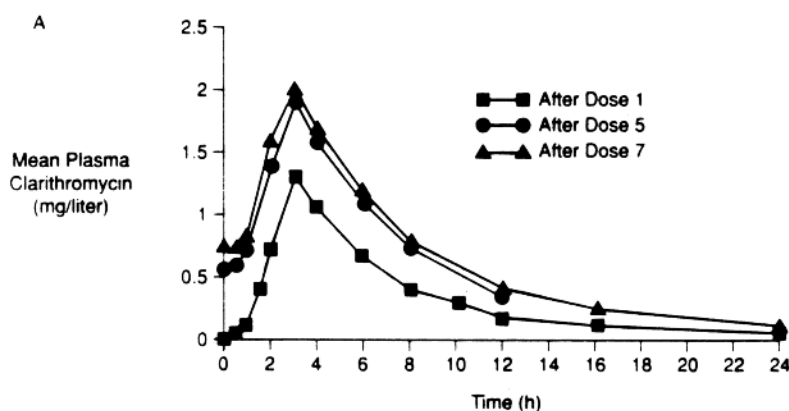


Figure 7: Mean Plasma Clarithromycin (A) and 14-OH-Clarithromycin (B) Concentration of Single and Multiple (Every 12-hours) Dose Administration(s) of 250 mg of Clarithromycin

A summary of pharmacokinetic parameters is presented in **Table 63**. After a single- and multiple-dose administration of clarithromycin as a suspension formulation, times to attain peak plasma clarithromycin and 14-OH-clarithromycin concentrations were prolonged, as evidenced by mean T_{max} values ranging from 2.8 to 3.2 and 2.9 to 3.4 hours, respectively. Steady-state was achieved by Dose 5.

Table 63					
Clarithromycin and 14-OH-Clarithromycin Pharmacokinetic Parameters					
Parameters	Single Dose Mean ± SD	5th Dose Mean ± SD	7th Dose Mean ± SD	Comparison¹	
				1 vs 5	5 vs 7
Clarithromycin					
C_{max} (mcg/mL)	1.34 ± 0.37	1.98 ± 0.55	2.15 ± 0.62	*	NS
T_{max} (hr)	3.2 ± 1.1	2.8 ± 0.6	3.1 ± 0.9	--	--
C_{min} (mcg/mL)	0.17 ± 0.10	0.32 ± 0.22	0.39 ± 0.25	*	*
AUC ² (mcg·hr/mL)	7.80 ± 2.87	11.5 ± 4.6	12.7 ± 4.8	*	NS
$t_{1/2}^3$ (hr)	3.6	3.2	3.5	--	--
f_u (% of dose)	--	36.9 ± 11.1	40.0 ± 14.0	--	NS
14-OH-Clarithromycin					
C_{max} (mcg/mL)	0.46 ± 0.16	0.67 ± 0.15	0.72 ± 0.16	*	NS
T_{max} (hr)	3.4 ± 1.2	2.9 ± 1.0	3.0 ± 1.0	--	--
C_{min} (mcg/mL)	0.14 ± 0.04	0.23 ± 0.07	0.27 ± 0.07	*	*
AUC ² (mcg·hr/mL)	4.87 ± 1.24	5.33 ± 1.20	5.85 ± 1.17	*	*
$t_{1/2}^3$ (hr)	7.2	4.9	6.4	--	--
f_u (% of dose)	--	17.1 ± 3.1	18.4 ± 5.0	--	NS
¹ Comparison is based on t-statistics within repeated measures ANOVA framework. Statistical significance is shown as NS if $p > 0.05$ and * if $p < 0.05$ ² AUC _{0-∞} for single dose and AUC ₁₂ for multiple dose data ³ Harmonic Means					

Pediatric Patients

Children with pharyngitis, otitis media or skin infections

Another study was conducted in pediatric patients and included again both a single dose phase (2 groups, non-fasting and fasting) and multiple dose phase (1 group, fasting) design. It was conducted in 28 infants and children ages 6 months to 10 years with pharyngitis, otitis media or skin infections. The single dose phase involved the administration of a single 7.5 mg/kg dose of clarithromycin granules for suspension (125 mg/5 mL) in either a non-fasting or fasting (2 hours before or 1.5 hours after eating) state.

In the multiple dose phase, patients were given multiple 7.5 mg/kg doses (every 12 hours for 4 or 5 days) of clarithromycin granules for suspension in a fasting state.

A summary of pharmacokinetic parameters is presented in **Table 64**.

Table 64			
Clarithromycin and 14-OH-Clarithromycin Pharmacokinetic Parameters			
in Pediatric Patients			
Parameters	Single Dose Fasting Mean ± SD	Single Dose Non-Fasting Mean ± SD	9th Dose b.i.d. Fasting Mean ± SD
	(Group I)	(Group III)	(Group II)
Clarithromycin			
C _{max} (mcg/mL)	3.59 ± 1.47	4.58 ± 2.76	4.60 ± 2.08
T _{max} (hr)	3.1 ± 1.0	2.8 ± 0.7	2.8 ± 1.0
C _{min} (mcg/mL)	--	--	1.67 ± 1.44
Lag (hr)	0.6	0.4	--
AUC ₆ (mcg·hr/mL)	10.0 ± 5.49	14.2 ± 9.39	15.7 ± 6.72
14-OH-Clarithromycin			
C _{max} (mcg/mL)	1.19 ± 0.37	1.26 ± 0.46	1.64 ± 0.75
T _{max} (hr)	3.2 ± 1.0	4.0 ± 1.0	2.7 ± 1.7
C _{min} (mcg/mL)	--	--	1.08 ± 0.84
Lag (hr)	0.6	0.7	--
AUC ₆ (mcg·hr/mL)	3.66 ± 1.49	4.37 ± 1.79	6.69 ± 2.97

Mean peak plasma clarithromycin and 14-OH metabolite concentrations after single dose administration in a fasting state were 3.59 and 1.19 mg/L, respectively. The differences in C_{max} and AUC in the non-fasting and fasting group were not statistically significant. The study shows no deleterious effect of food co-administration on clarithromycin bioavailability in infants and children, similar to results previously noted in adults receiving the tablet formulation.

Mean peak plasma clarithromycin and 14-OH-clarithromycin concentrations after multiple dose (every 12 hours for 4 to 5 days) administration of 7.5 mg/kg of clarithromycin suspension in a fasting state were 4.60 and 1.64 mg/L, respectively. These values compare favourably with those observed in adults after multiple oral dose administration of 250 and 500 mg of clarithromycin. C_{max} and AUC increase after multiple dosing as compared with values after single dose administration which is also comparable with data obtained in adults. This indicates that there is no unusual accumulation in infant and children.

Children with secretory otitis media

Multiple oral doses of clarithromycin (7.5 mg/kg every 12 hours for 7 days) were administered to 31 children ages 2 to 12 years with a diagnosis of secretory otitis media. Clarithromycin serum and middle ear effusion (MEE) concentrations were 1.73 ± 1.21 (range 0.16 to 4.96) mg/L and 2.53 ± 2.31 (range 0.39 to 10.62) mg/kg, respectively. In 16 of 24 patients MEE concentrations equalled or exceeded those in serum. The ratio of MEE to serum concentration was 2.48 ± 3.57 (range 0.19 to 15.31).

14-OH-clarithromycin serum and MEE concentrations were 0.82 ± 0.32 (range 0.26 to 1.53) mg/L and 1.27 ± 0.99 (range 0.24 to 4.20) mg/kg, respectively (**Table 65**). In 14 of 24 patients MEE concentrations equalled or exceeded those in serum. The ratio of MEE to serum concentration was 1.73 ± 1.4 (range 0.25 to 5.87).

Table 65 Clarithromycin Serum and Middle Ear Effusion Concentrations after clarithromycin 7.5 mg/kg q12 h for 5 doses		
Analyte	Serum (mcg/mL)	Middle Ear Fluid (mcg/mL)
Clarithromycin	1.7	2.5
14-OH-Clarithromycin	0.8	1.3

When children (n=10) were administered a single oral dose of 7.5 mg/kg suspension, food increased mean plasma clarithromycin concentration from 3.6 (\pm 1.5) mcg/mL to 4.6 (\pm 2.8) mcg/mL and the extent of absorption from 10.0 (\pm 5.5) mcg•hr/mL to 14.2 (\pm 9.4) mcg•hr/mL.

Although the onset and/or rate of absorption from the suspension formulation is significantly slower than that of the tablet formulation, this is of little clinical relevance.

MICROBIOLOGY

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

Clarithromycin is active *in vitro* against various aerobic and anaerobic gram-positive and gram-negative organisms as well as most MAC microorganisms. The *in vitro* activity of clarithromycin is presented in **Table 66**.

Additionally, the 14-OH-clarithromycin metabolite also has significant antimicrobial activity which may be additive to the activity of the parent compound. Against *Haemophilus influenzae*, 14-OH clarithromycin is twice as active as the parent compound *in vitro*. However, for MAC isolates, the 14-OH metabolite was 4 to 7 times less active than clarithromycin. The clinical significance of this activity against MAC is unknown.

Clarithromycin is bactericidal to *H. pylori*; this activity is greater at neutral pH than at acid pH.

The ranges of MICs of clarithromycin, 14-OH-clarithromycin metabolite and the MICs required to inhibit 50% (MIC₅₀) and 90% (MIC₉₀) of bacteria are presented in **Table 67** and **Table 68**. Beta-lactamase production should not have any effect on clarithromycin activity.

Cross-resistance to azithromycin has been documented. Attention should be paid to the possibility of cross resistance between clarithromycin and other macrolide drugs, as well as lincomycin and clindamycin.

The *in vitro* data indicate enterobacteriaceae, pseudomonas species and other non-lactose fermenting gram negative bacilli are not sensitive to clarithromycin.

Table 66
In Vitro Susceptibility® of Strains
of Gram-Positive and Gram-Negative Bacteria to Clarithromycin

Microorganisms	Number of Strains	Cumulative % of Strains Inhibited at MIC (mg/L)											
		.031	.062	.125	.250	.500	1.00	2.00	4.00	8.00	16.0	32.0	64.0
<u>Gram Positive</u>													
<i>Staphylococcus aureus</i> methicillin resistant	25	-	4	4	8	8	12	12	12	12	12	12	100
<i>Staphylococcus aureus</i> methicillin susceptible	126	-	20	75	84	86	87	87	87	88	88	88	100
All <i>Staphylococcus aureus</i>	151	-	17	63	72	73	74	74	74	75	75	75	100
<i>Staphylococcus epidermidis</i>	59	-	18	37	42	44	45	47	50	50	54	54	100
Other coagulase negative staphylococcus	27	-	14	44	44	48	48	48	55	55	59	59	100
<i>Streptococcus pyogenes</i> (GrA)	48	89	91	93	97	97	97	100	-	-	-	-	-
<i>Enterococcus</i>	97	1	4	8	25	59	61	63	63	64	64	68	100
<i>Streptococcus pneumoniae</i>	26	38	84	84	84	100	-	-	-	-	-	-	-
<i>Streptococcus agalactiae</i> (GrB)	41	95	95	95	95	95	97	100	-	-	-	-	-
<i>Streptococcus viridans</i>	15	86	86	86	93	93	93	93	93	93	93	93	100
Other β-hemolytic Streptococcus	19	78	78	78	84	84	84	89	89	94	94	94	100
<i>Corynebacterium species</i>	11	27	45	54	63	63	63	81	81	90	100	-	-
<i>Listeria monocytogenes</i>	7	28	100	-	-	-	-	-	-	-	-	-	-
<u>Gram Negative</u>													
<i>Neisseria gonorrhoeae</i>	39	23	35	64	100	-	-	-	-	-	-	-	-
<i>Haemophilus influenzae</i>	56	3	3	3	7	16	37	80	100	-	-	-	-
<i>Neisseria meningitidis</i>	6	-	33	50	83	100	-	-	-	-	-	-	-
<i>Campylobacter species</i>	30	-	10	10	43	80	93	100	-	-	-	-	-

* MICs do not take into account the antimicrobial activity of the 14-OH-clarithromycin metabolite.

Table 67
***In vitro* Susceptibility of Different Bacteria to Clarithromycin**

<u>Microorganisms</u>	<u>Number of strains</u>	<u>Range</u>	<u>MIC (mg/L)</u>	
			<u>50%</u>	<u>90%</u>
<i>Mycoplasma pneumoniae</i>	30	≤0.004-0.125	≤0.004	≤0.031
<i>Bordetella pertussis</i>	18	≤0.008-0.06	≤0.008	0.03
<i>Legionella pneumophila</i>	14	0.12-0.25	0.12	0.25
<i>Haemophilus influenzae</i>	22	2-8	4	8
<i>Moraxella catarrhalis</i>	17	0.03-0.25	0.06	0.25
<i>Chlamydia trachomatis</i>	11	0.002-0.008	0.004	0.008
<i>Neisseria gonorrhoea</i>	26	0.0625-4	0.125	0.5
<i>Mycobacterium avium</i>	30	4-32	8	16
<i>Mycobacterium avium-intracellulare</i>	124	< 0.25-4	1	2
<i>Mycobacterium chelonae</i>	137	--	--	0.25
<i>Mycobacterium fortuitum</i>	86	--	2.0	>8.0
<i>Mycobacterium kansasii</i>	24	≤0.125-0.25	≤0.125	0.25
<i>Pasteurella multocida</i>	10	1.0-4	1.0	2.0
<i>Bacteriodes melaninogenicus</i>	12	≤0.125-0.2	≤0.125	≤0.125
<i>Clostridium perfringens</i>	10	0.25-0.5	0.5	0.5
<i>Staphylococcus aureus</i> (methicillin sensitive)	20	0.06-0.25	0.17	0.24
<i>Streptococcus pyogenes</i>	10	≤0.06	≤0.06	≤0.06
<i>Chlamydia pneumoniae</i>	49	0.004-0.025	0.016	0.031
<i>Helicobacter pylori</i> †	13	0.03-0.06	0.03	0.03

† Hardy DJ, Hanson CW, Hensey DM, Beyer JM, Fernandes PB. Susceptibility of *Campylobacter pylori* to macrolides and fluoroquinolones. *J Antimicrob Chemother* 1988;22:631-636.

Table 68
***In vitro* Susceptibility of Different Bacteria to 14-OH-Clarithromycin**

<u>Microorganisms</u>	<u>Number of strains</u>	<u>Range</u>	<u>MIC (mg/L)</u>	
			<u>50%</u>	<u>90%</u>
<i>Streptococcus pyogenes</i>	15	0.015-0.03	0.015	0.03
<i>Streptococcus pneumoniae</i>	13	≤0.004-0.015	0.008	0.015
<i>Streptococcus agalactiae</i>	15	0.03-0.06	0.06	0.06
<i>Listeria monocytogenes</i>	14	0.25-0.5	0.5	0.5
<i>Moraxella catarrhalis</i>	17	0.03-0.12	0.06	0.12
<i>Neisseria gonorrhoeae</i>	15	0.06-1	0.25	0.5
<i>Campylobacter jejuni</i>	12	0.25-2	0.5	2
<i>Legionella pneumophila</i>	14	0.12-0.5	0.25	0.5
<i>Haemophilus influenzae</i>	22	1-4	2	4
<i>Bordetella pertussis</i>	18	≤0.008-0.06	0.015	0.06
<i>Bacteroides fragilis</i>	10	0.5->128	1	1
<i>Clostridium perfringens</i>	10	0.5-0.5	0.5	0.5
<i>Propionibacterium acnes</i>	12	0.03->128	0.03	0.06

Clarithromycin Kill Kinetics Against *Helicobacter pylori*

Figure 8 illustrates the kill kinetics of clarithromycin and 14-OH-clarithromycin against *H. pylori* at 8 x MIC and at pH 8.0; and **Figure 9** illustrates the kill kinetics of clarithromycin and amoxicillin against *H. pylori* at pH 6.5.

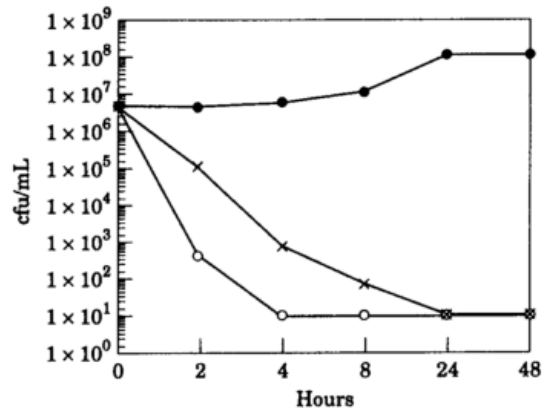


Figure 8: Kill kinetics of clarithromycin and 14-OH-clarithromycin against *H. pylori* strain 2597 at 8 x MIC and at pH 8.0. A flask was inoculated to produce a starting inoculum of approximately 10⁶ cfu/mL. The flask was then incubated in an anaerobe jar with CampyPak[®] and shaken gently at 37^oC. Counts were done at 0, 2, 4, 8, 24, and 48 h in physiological saline after 72 h incubation. ●, No antimicrobial; ○, clarithromycin (0.12 mg/L); x, 14-OH-clarithromycin (0.24 mg/L).

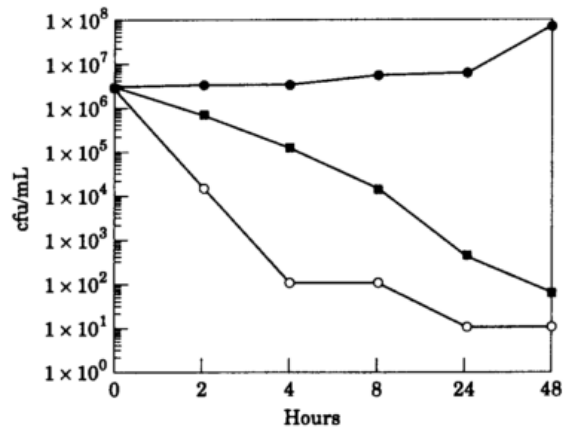


Figure 9: Kill kinetics of clarithromycin and amoxicillin against *H. pylori* strain 2597 at pH 6.5. Counts were done at 0, 2, 4, 8, 24, and 48 h in physiological saline after 72 h incubation. ●, No antimicrobial; ○, clarithromycin (3 mg/L); ■, amoxicillin (3 mg/L)

Susceptibility Testing excluding *Mycobacteria* and *Helicobacter*

Dilution Techniques

Quantitative methods are used to determine antimicrobial minimal inhibitory concentrations (MICs). These MICs provide estimates of the susceptibility of bacteria to antimicrobial compounds. The MICs should be determined using a standardized procedure. Standardized procedures are based on a dilution method⁴³ (broth or agar) or equivalent with standardized inoculum concentrations and standardized concentrations of clarithromycin powder.

The standard single disc susceptibility test (using the 15 mcg clarithromycin disc) and the dilution susceptibility test should be interpreted according to the criteria in **Table 69**.

Table 69 Criteria for the Interpretation of Standard Single Disc and Dilution Susceptibility Tests except for <i>H. influenzae</i> and <i>H. pylori</i>		
	Zone Diameter (mm)	Appropriate MIC Correlate (mg/L)
Susceptible	≥ 18	≤ 2
Intermediate*	14 to 17	4
Resistant	≤ 13	≥ 8
* Indicates that the test results are equivocal; therefore, dilution tests may be indicated. N.B. These criteria and the definition are in agreement with NCCLS Documents M2-A6 ⁴⁴ and M100-S8 ⁴⁵ .		

The standard single disc susceptibility test (using the 15 mcg clarithromycin disc) for *H. influenzae* should be interpreted according to the criteria in **Table 70**.

Table 70 Criteria for the Interpretation of Standard Single Disc and Dilution Susceptibility Tests for <i>H. influenzae</i>		
	Zone Diameter (mm)	Appropriate MIC Correlate (mg/L)
Susceptible	≥ 13	≤ 8
Intermediate*	11 to 12	16
Resistant	≤ 10	≥ 32
* Indicates that the test results are equivocal; therefore, dilution tests may be indicated. N.B. According to the revised NCCLS 1997 and 1998 Guidelines, the zone diameter and MIC values reflect both the activities of the parent compound and 14-OH metabolite.		

A report of "Susceptible" indicates that the pathogen is likely to respond to monotherapy with clarithromycin.

A report of "Intermediate" indicates that the result be considered equivocal, and if the microorganism is not fully susceptible to alternative clinically feasible drugs, the test should be repeated. This category implies possible clinical applicability in body sites where clarithromycin is physiologically concentrated or in situations where high clarithromycin dosages can be used. This category provides a buffer zone which prevents small uncontrolled technical factors from causing major discrepancies in interpretations.

A report of "Resistant" indicates that achievable drug concentrations are unlikely to be inhibitory, and other therapy should be selected.

Diffusion Techniques

Quantitative methods that require measurement of zone diameters also provide reproducible estimates of the susceptibility of bacteria to antimicrobial compounds. One such standardized procedure⁴⁴ requires the use of standardized inoculum concentrations. This procedure uses paper disks impregnated with 15-mcg clarithromycin to test the susceptibility of microorganisms to clarithromycin.

Reports from the laboratory providing results of the standard single-disk susceptibility test with a 15-mcg clarithromycin disk should be interpreted according to the criteria in **Table 69**.

Standardized Dilution Techniques

Standardized susceptibility test procedures require the use of laboratory control microorganisms to control the technical aspects of the laboratory procedures. Standard clarithromycin powder should provide the following MIC values for *S. aureus* and *H. influenzae* (**Table 71**).

Table 71		
Standard Clarithromycin Powder MIC Values		
Microorganisms		MIC (mcg/mL)
<i>S. aureus</i>	ATCC 29213	0.12 to 0.5
<i>H. influenzae</i>	ATCC 49247	4 to 16

Standardized Diffusion Techniques

As with standardized dilution techniques, diffusion methods require the use of laboratory control microorganisms that are used to control the technical aspects of the laboratory procedures. For the diffusion technique, the 15-mcg clarithromycin disk should provide the following zone diameters for *S. aureus* and *H. influenzae* (**Table 72**).

Table 72		
Zone Diameter for the 15 mcg Clarithromycin Disc		
Microorganisms		Zone Diameter (mm)
<i>S. aureus</i>	ATCC 25923	26 to 32
<i>H. influenzae</i>	ATCC 49247	11 to 17

In vitro Activity of Clarithromycin against Mycobacteria

Clarithromycin has demonstrated *in vitro* activity against MAC microorganisms isolated from both AIDS and non-AIDS patients. While gene probe techniques may be used to distinguish *M. avium* species from *M. intracellulare*, many studies only reported results on MAC isolates.

Various *in vitro* methodologies employing broth or solid media at different pH's, with and without oleic acid-albumin-dextrose-catalase (OADC), have been used to determine clarithromycin MIC values for mycobacterial species. In general, MIC values decrease more than 16-fold as the pH of Middlebrook 7H12 broth increases from 5.0 to 7.4. At pH 7.4, MIC values determined with Mueller-Hinton agar were 4- to 8-fold higher than those observed with Middlebrook 7H12 media. Utilization of OADC in these assays has been shown to further alter MIC values.

Clarithromycin activity against 80 MAC isolates from AIDS patients and 211 MAC isolates from non-AIDS patients was evaluated using a microdilution method with Middlebrook 7H9 broth. Results showed MIC values of ≤ 4.0 mcg/mL in 81% and 89% of the AIDS and non-AIDS MAC isolates, respectively. Twelve percent of the non-AIDS isolates had an MIC value ≤ 0.5 mcg/mL. Clarithromycin activity was evaluated against phagocytized MAC in mouse and human macrophage cell cultures as well as in the beige mouse infection model.

Clarithromycin activity was evaluated against *Mycobacterium tuberculosis* microorganisms. In 1 study utilizing the agar dilution method with Middlebrook 7H10 media, 3 of 30 clinical isolates had an MIC of 2.5 mcg/mL. Clarithromycin inhibited all isolates at > 10.0 mcg/mL.

Susceptibility Testing for *Mycobacterium avium* Complex

The disk diffusion and dilution techniques for susceptibility testing against gram-positive and gram-negative bacteria should not be used for determining clarithromycin MIC values against mycobacteria. *In vitro* susceptibility testing methods and diagnostic products currently available for determining MIC values against MAC organisms have not been standardized nor validated. Clarithromycin MIC values will vary depending on the susceptibility testing method employed, composition and pH of the media, and the utilization of nutritional supplements. Breakpoints to determine whether clinical isolates of *M. avium* or *M. intracellulare* are susceptible or resistant to clarithromycin have not been established.

In vitro* Activity of Clarithromycin against *Helicobacter pylori

Clarithromycin has demonstrated *in vitro* activity against *H. pylori* isolated from patients with duodenal ulcers. *In vitro* susceptibility testing methods (broth microdilution, agar dilution, E-test, and disk diffusion) and diagnostic products currently available for determining MICs and zone sizes have not been standardized, validated, or approved for testing *H. pylori*. The clarithromycin MIC values and zone sizes will vary depending on the susceptibility testing methodology employed, media, growth additives, pH, inoculum concentration tested, growth phase, incubation atmosphere, and time.

Susceptibility Test for *Helicobacter pylori*

In vitro susceptibility testing methods and diagnostic products currently available for determining MICs and zone sizes have not been standardized, validated, or approved for testing *H. pylori* microorganisms. MIC values for *H. pylori* isolates collected during 2 U.S. clinical trials evaluating clarithromycin plus omeprazole were determined by broth microdilution MIC methodology (Hachem CY et al., 1996). Results obtained during the clarithromycin plus omeprazole clinical trials fell into a distinct bimodal distribution of susceptible and resistant clarithromycin MICs.

If the broth microdilution MIC methodology published in Hachem CY *et al.*, 1996 is used and the following tentative breakpoints are employed, there should be reasonable correlation between MIC results and clinical and microbiological outcomes for patients treated with clarithromycin plus omeprazole (**Table 73**).

MIC (mcg/mL)	Interpretation
≤ 0.06	Susceptible (S)
0.12 to 2.0	Intermediate (I)
≥ 4	Resistant (R)

These breakpoints should not be used to interpret results obtained using alternative methods.

TOXICOLOGY

Acute Toxicity

Clarithromycin Tablets, USP, Film-Coated

The acute toxicity of clarithromycin administered by a variety of routes, was studied in mice and rats. The median lethal dose by the oral route ranged from 2.7 to > 5.0 g/kg. Acute toxicity did not differ markedly between sexes (**Table 74**).

Table 74			
Acute LD₅₀ values of Clarithromycin			
Species	Sex	Route	LD₅₀ value (g/kg)
Mice	M	p.o.	2.74
	F	p.o.	2.7
	M	s.c.	> 5.0
	F	s.c.	> 5.0
	M	i.p.	1.03
	F	i.p.	0.85
	M	i.v.	0.17
	F	i.v.	0.2
Rats	M	p.o.	3.47
	F	p.o.	2.7
	M	s.c.	> 5.0
	F	s.c.	> 5.0
	M	i.p.	6.69
	F	i.p.	7.58

Legend: i.p. = intraperitoneal; i.v. = intravenous; p.o. = oral; s.c. = subcutaneous

The primary signs of toxicity included reduction in activities, behaviours, weight gains, respiration rates and sedation. The emetic activity of clarithromycin prevented the determination of the lethal dose in dog.

The acute oral toxicity of clarithromycin in very young mice and rats was determined. The median lethal dose (1.2 g/kg) was about 2-fold that seen in the older rodents.

Clarithromycin for Oral Suspension, USP

Clarithromycin was administered orally to rats and mice 3 days after birth. The study design was 10M/10F animals in the dose groups, 20M/20F in the control group. The animals were dosed by gavage with a single dose of a suspension of clarithromycin in 5% gum arabic; control animals received a solution of 5% gum arabic. The recovery period was 14 days.

Mice

The mice were dosed at 714, 857, 1028, 1233, 1480 and 1776 mg/kg; the rats at 769, 1000, 1300, 1690, 2197 and 3713 mg/kg.

LD₅₀ (95% confidence limits) in mice was 1290 mg/kg (1170 to 1420 mg/kg) in males and 1230 mg/kg (1130 to 1340 mg/kg) in females; the sex difference was considered to be negligible. LD₅₀ of clarithromycin orally administered to adult mice is about 2700 mg/kg; acute toxicity was more notable in juvenile animals than in adults. The LD₅₀ of antibiotics of the penicillin group, cephalosporin group and macrolide group is generally lower in juvenile animals than in adults; clarithromycin showed similar results.

Body weight was reduced or its increase was suppressed in both males and females of each dosing group from 1 to 4, 7 or 9 days after the administration, but its changes thereafter were comparable to those in the control group.

Some animals died from 1 to 7 days after the administration. The general condition, suckling behaviour and spontaneous movements were depressed in some of the mice administered 1028 mg/kg or more clarithromycin from 1 day after the administration, but these changes disappeared by 7 days after the administration in those that survived the observation period.

Necropsy of those that died spontaneously disclosed dark reddish lungs in more than half the animals. This finding suggests that the death in these animals was due to debilitation resulting from reduced suckling behaviour.

In the survivors, necropsy showed dilation of renal pelvis in 1 male of the 1028 mg/kg group and hypoplasia of the kidney in 1 female of the 1233 mg/kg group, but these uncommon conditions are considered to be incidental.

Rats

LD₅₀ (95% confidence limits) in rats was 1330 mg/kg (1210 to 1470 mg/kg) in males and 1270 mg/kg (1150 to 1400 mg/kg) in females, the sex difference was considered to be negligible.

LD₅₀ of the agent administered orally to adult rats is about 3000 mg/kg; the acute toxicity was more notable in juvenile animals than in adult animals. LD₅₀ of antibiotics of the penicillin group, cephalosporin group, and macrolide group is generally lower in juvenile animals than in adult animals; clarithromycin showed similar results.

The body weight was reduced or its increase was suppressed in both males and females of each dosing group from 1 to 4 or 7 days after the administration, but body weight changes thereafter were comparable to those of the control group.

Some of the animals of both sexes died from 2 to 5 days after the administration. The general condition, suckling behaviour and spontaneous movements were depressed in some animals from 1 or 2 days after the administration, but in survivors these changes disappeared by 13 days after the administration. In the control group, 1 male and female of the same litter showed depressed suckling behaviour and spontaneous movements from 13 days after the administration, and the female was cannibalised by its mother 14 days after the administration. This is considered to be due to the death of all the other animals of the litter and a resultant reduction in the nursing activity of the mother.

Necropsy of those that died spontaneously showed dark-reddish lungs in about 25%. A reddish-black substance was noted in the intestines of a few males and females of each group administered 2197 mg/kg or more clarithromycin, probably because of bleeding from the intestines. From these findings, the deaths were considered to be due to debilitation resulting from depressed suckling behaviour or bleeding from the intestines.

Necropsy of the survivors revealed nodulated ribs in 1 male of the control group. Since this animal showed a reduction in body weight from 11 days after the administration, these nodules are considered to have been caused by suppressed development of the ribs associated with a delay in the growth. White spots in the liver surface of the 769 mg/kg and 1300 mg/kg groups, and a bulging mass on the surface of the liver and adhesion of the liver to the diaphragm were observed in 1 female of the 769 mg/kg group. Since these changes were infrequent and were not observed in the animals that died during the observation period, they are considered to be incidental.

Three clarithromycin pediatric formulations under consideration for development, a carbopol complex, a hot melt sprayed coating form and a spray-congealed dosage form, were evaluated for acute oral toxicity in rats. Five male and 5 females were administered a single oral dose of 1 of 3 clarithromycin pediatric formulations at a concentration of 250 mg/mL. The dose for all rats was 20 mL/kg (i.e., 5 g/kg). Except for one rat considered to have been misdosed with the spray congealed dosage form, none of the rats died and no signs of toxicity were observed.

No gross morphologic changes were found when the rats were killed and necropsied 2 weeks after treatment.

Doses greater than 5 g/kg were considered to be excessive (5 g/kg is generally employed as the highest test dose for test materials with toxicity too low to determine the minimum lethal dose). Thus, clarithromycin pediatric formulations were found to be non-toxic to rats at the applicable maximum dose of 5 g/kg.

Subchronic Toxicity

Clarithromycin Tablets, USP, Film-Coated

Studies were conducted in rats, dogs and monkeys with clarithromycin administered orally. The duration of administration ranged from 14 days to 42 days.

Rats

One study in rats (with oral doses up to 800 mg/kg/day) failed to show adverse effects in rats exposed to 50 mg/kg/day for 4 weeks. The clinical signs observed at toxic doses were reduced motility, piloerection, hypothermia and perineal urine staining. Changes occurred in biochemical parameters at 200 and 800 mg/kg/day indicative of hepatotoxicity which was confirmed by histopathologic findings of hepatocyte necrosis.

Other pathologic findings at the top 2 dose levels included swelling of the renal cortical tubular epithelia and atrophic changes to the lymphatic and genital systems. The same toxicity profile was observed in immature rats following the daily administration of oral doses up to 150 mg/kg/day of clarithromycin for 6 weeks. At 150 mg/kg/day, there was an increase in relative weights of liver and kidneys.

Dogs

Dogs were dosed orally with 0, 6.25, 25, 100 or 400 mg/kg/day of clarithromycin daily for 28 days. Emesis occurred sporadically in the treated dogs. No other adverse effects were seen in dogs exposed to 6.25 mg/kg/day. The clinical signs at higher dosages included loose stools, lacrimation and conjunctivitis.

Slight anorexia was noted in dogs receiving 100 mg/kg/day or more. Dogs at 400 mg/kg/day exhibited reduced red blood cell count, hematocrit, hemoglobin concentration, serum albumin, and mean urine pH and specific gravity. Increases were seen in serum transaminase, alkaline phosphatase, and total bilirubin concentrations.

Bilirubin was detected in the urine. Other pathologic changes at 400 mg/kg/day included biliary hyperplasia, gastric glandular atrophy, renal tubule epithelial atrophy, edema of the iris, ciliary body and choroid, capillary proliferation in the cornea, suppression of spermatogenesis, and adrenal medullary degeneration.

Monkeys

Monkeys were treated daily for 1 month with oral doses of 0, 25, 100 or 400 mg/kg/day. Two animals out of 10 receiving 400 mg/kg/day died. Salivation was recorded at all dosage levels. No other adverse effects were seen in animals treated daily with 25 mg/kg/day.

The clinical signs observed at higher doses and most frequently at 400 mg/kg/day were vomiting, emesis, sunken eyes, dehydration, emaciation, low rectal temperature, body weight loss, reduced food consumption, cloudiness of the cornea and reduction in intra-ocular pressure. Yellow discoloured feces were passed on a few isolated occasions by some animals given a dose of 400 mg/kg/day. As with the other species, the liver was the primary target at toxic doses as shown by early elevation of serum concentration of glucose, BUN, creatinine, ALT, AST, LDH, amylase and/or triglyceride; an electrolyte imbalance and low levels of protein, cholesterol, phospholipid; elevated leucine aminopeptidase (LAP).

Principal histopathologic changes were seen mainly in high dose monkeys, but some mid-dose monkeys exhibited similar alterations. Changes included necrosis and vacuolation of hepatocytes, vacuolation of renal cortical tubules, no spermatogenesis, thymic regression and single cell necrosis of the stomach. In man the recommended dose is 500 to 1000 mg/day or 7.1 to 14.3 mg/kg/day (70 kg person).

Clarithromycin for Oral Suspension, USP

Rats

Two-week toxicity study was done with clarithromycin granules administered orally to preweaning rats. CrI:CD*(SD)BR pups, 5 days old at the start of treatment, were dosed by oral gavage with suspension for 17 to 20 days (**Table 75**).

Treatment Group	Test Material	Dosages ^a (mg/kg/day)	Concentration ^b (mg/mL)	No/Group	
				M	F
T ₀	Vehicle ^c	0	0	10	10
T ₁	Clarithromycin Granule for Suspension	15	2.46	10	10
T ₂	Clarithromycin Granule for Suspension	55	9.02	10	10
T ₃	Clarithromycin Granule for Suspension	200	32.79	10	10

^a Dosages are expressed in terms of the free base.
^b In terms of bulk granule (a potency of 610 mcg/mg).
^c 0.2% hydroxypropylmethylcellulose (HPMC).

One female pup in the vehicle Control group was found dead on day 18. Sporadic incidence of reddish spots on the skin or skin erythema occurred in some T₃ pups. The mean weight gains from days 0 to 17 for T₃ males and females were approximately 20 and 10% less than those of T₀ males and females, respectively. There were no ophthalmic effects. Statistically significant decreases occurred in the values of mean hemoglobin, mean cell hemoglobin and mean cell volume of T₃ male pups (200 mg/kg/day); T₃ female pups (200 mg/kg/day) had lower hemoglobin and hematocrit values when compared to controls, but the differences were not significant; similarly the mean hematocrit value of the T₃ male pups was also lower than that of the controls. A statistically significant increase was observed in the mean relative kidney weights of T₃ pups when compared to controls. Treatment-related minimal to mild multifocal vacuolar degeneration of the intrahepatic bile duct epithelium and an increased incidence of nephritic lesions were observed in the T₃ pups (200 mg/kg/day).

A dosage of 200 mg/kg/day for 2 weeks produced decreased body weight gain, decreased mean hemoglobin and hematocrit values as well as histopathologic changes in the livers and kidneys of preweaning rats. The "no-toxic-effect" dosage in this 2-week preweaning rat study was judged to be 55 mg/kg/day. This finding is similar to that reported following administration to adult rats for 1 month. Prewaning rats did not therefore appear to be more susceptible than mature rats.

Crl:CD*(SD)BR immature rats, aged 15 days at the start of treatment, were dosed daily orally by gavage for 6 weeks. The rats were dosed at 0, 15, 50 and 150 mg/kg clarithromycin, with 10 male and 10 female animals allocated to each treatment group. The control group was treated with 0.2% hydroxypropylmethylcellulose (HPMC) vehicle only.

No deaths occurred during the study. No drug-induced signs were observed. Male T₃ pups had a consistently lower mean body weight than male T₀ pups on the growth curves. This is considered to be a drug-related effect. Male T₃ rats had lower mean food consumption than male T₀ rats; male and female T₂ rats appear to have consistently higher mean food consumption than male and female T₀ rats (not statistically significant). The following increases in relative mean organ weights were observed: liver and kidney of male and female T₃ rats, kidney of male T₁ rats and spleen of female T₃ rats. The increases in liver and kidney relative weights of male and female T₃ rats were considered to be drug induced, but no concurrent drug-related micropathology was observed.

Renal hydronephrosis occurred in 1 female T₂ rat, which was not considered to be drug-related. A small number of microscopic alterations was distributed randomly through control and treatment groups. None were drug-related.

The "no-toxic effect" level was considered to be 50 mg/kg/day. This finding is similar to administration of clarithromycin to adult rats for 1 month. Immature rats did not, therefore, appear to be more susceptible to clarithromycin than mature rats.

Crl:CD*(SD)BR juvenile rats, 16 days old at the start of treatment, were dosed by oral gavage for 42 to 44 treatment days (**Table 76**).

Table 76					
Subchronic Toxicity Study with Clarithromycin Granules					
Administered Orally to Crl:CD*(SD)BR Juvenile Rats (42 to 44 treatment days)					
Treatment Group	Test Material	Dosages^a (mg/kg/day)	Concentration^b (mg/mL)	No/Group	
				M	F
T ₀	Vehicle ^c	0	0	10	10
T ₁	Clarithromycin Granule for Suspension	15	2.44	10	10
T ₂	Clarithromycin Granule for Suspension	50	8.13	10	10
T ₃	Clarithromycin Granule for Suspension	150	24.4	10	10
a	Dosages are expressed in terms of the free base.				
b	In terms of bulk granule, Clarithromycin Granule for Suspension with a potency of 615 mcg/mg.				
c	0.2% hydroxypropylmethylcellulose (HPMC).				

There were no deaths in the study. Excessive salivation occurred in some T₃ rats (1 to 2 hours after dosing) during the last 3 weeks of treatment. Male and female pups given 150 mg/kg/day (T₃) consistently had lower mean body weights than controls throughout the treatment period. The differences were statistically significant during the first 3 weeks of treatment. The mean weight gains from days 0 to 40 for T₃ males and females were 9.4 and 6.9% less than those of T₀ males and females, respectively. There were no significant differences between control and drug-treatment groups in food consumption. There were no treatment-related ophthalmic effects.

No meaningful differences were found in urinalyses and hematology parameters for the drug-treated and control rats.

There was a statistically significant decrease in the mean albumin values of T₃ male and female rats when compared to controls and a statistically significant increase in the mean relative liver weights for T₃ rats when compared to controls. No treatment-related gross or microscopic observations were found. A dosage of 150 mg/kg/day produced slight toxicity in the treated rats. Therefore the no-effect dosage was judged to be 50 mg/kg/day.

Wistar rats, 4 days old at the start of treatment, were dosed by oral gavage for 28 treatment days followed by a 28-day recovery period (**Table 77**).

Table 77				
Subchronic Toxicity Study with Clarithromycin Granules				
Administered Orally to Wistar Rats (28 treatment days)				
Treatment Group	Test Material	Dosages^a (mg/kg/day)	No/Group	
			M	M
T ₀	Vehicle ^b	0	20	20
T ₁	Clarithromycin	12.5	12	12
T ₂	Clarithromycin	50	20	20
T ₃	Clarithromycin	200	20	20
^a Dosages are expressed in terms of the free base. ^b 5% Gum Arabic.				

No deaths or abnormalities in the general condition of the animals occurred during the administration or recovery periods in all treated groups.

Body weight gain was suppressed in males and females of the 200 mg/kg group from the 4th day of administration, but normal body weight gain was restored by the discontinuation of the administration. Urinalysis showed slight elevation in pH of the groups administered 50 mg/kg or more clarithromycin, but it was normalized after discontinuation of the administration.

Hematological examinations showed a reduction in haematocrit and a reduction in hemoglobin in both sexes, a reduction in MCHC in males, and a reduction in MCH in females of the 200 mg/kg group. Platelets were reduced in males of the 200 mg/kg group and females of all dosing groups, and white blood cells were reduced in both sexes of the 200 mg/kg group. These changes, however, were reversed or reduced by discontinuation of the administration.

Serum biochemical analyses revealed reduction in AST, ALP, total protein, and albumin in both sexes, a reduction in the calcium level in males, and an elevation in the blood glucose level and reduction in the creatinine level in females of the 200 mg/kg group. These changes, however, could be reversed by discontinuation of the administration.

Necropsy revealed no abnormalities in any of the groups. Concerning organ weights, the absolute and relative weights of the thymus were reduced in males and females of the 200 mg/kg group, but normal weights were restored by discontinuation of the administration.

Changes considered to be related to suppression of body weight gains were observed in the brain, lungs, heart (males only), liver, spleen, kidneys, caecum, and testes (males only) in both sexes of the 200 mg/kg/group. The weight of these organs recovered after discontinuation of the administration. Histopathological studies showed no changes considered to be related to the administration of clarithromycin.

Dogs

Clarithromycin was administered to juvenile beagles by oral catheter daily for 4 weeks at doses of 0 (Control), 30, 100 and 300 mg/kg, followed by a 4-week withdrawal period to evaluate recovery. At the start of the study the beagles were 3 weeks old; each group consisted of 3 males and 3 females; and 1 female and male were added to the control and high-dose groups for the recovery study.

None of the animals died during the administration or recovery period, and no changes in the general condition of the animals were observed.

No changes considered to be due to the administration of clarithromycin were observed in the food consumption, body weight, or the results of ophthalmological, hematological, or serum biochemical examinations. Urinalysis indicated very slight occult blood in 1 female of the high-dose (300 mg/kg) group at the end of the administration period, but it was considered to be unrelated to the administration.

Pathological examinations showed dose-associated reductions in the relative weight of the kidneys in females, but these changes were considered to be unrelated to the administration because individual values were not abnormal. Necropsy revealed no abnormalities. During histological examination, fatty deposition of centrilobular hepatocytes and cell infiltration of portal areas was observed by the light microscopy, and an increase in hepatocellular fat droplets was noted by electron microscopy in the 300 mg/kg group.

In this group, also, increased fat deposition was noted relatively frequently in the kidneys. Other findings, which were considered to be unrelated to the administration, included congestion and megakaryocytic proliferation in the spleen, regional atelectasis and localised lesions of pneumonia in the lungs, leukocytic infiltration around the intrapulmonary bronchi, microfollicular formation of the thyroid glands and reduced stainability (degeneration) of Purkinje cells.

From these findings, the no-effect dose of clarithromycin in a 4-week subacute oral toxicity and a 4-week recovery study in juvenile beagles was considered to be 100 mg/kg for both males and females. The toxic dose was considered to be above 300 mg/kg.

Chronic Toxicity

Clarithromycin Tablets, USP, Film-Coated

Rats (20/sex/group) were treated daily with oral doses of 0, 15, 37.5, 75 or 150 mg/kg/day for 3 months. There were 8 incidental deaths, but none of them were considered treatment related. Clinical signs included increased salivation, dehydration, hyperactivity and were observed in a dose-related manner. The only toxic effect noted, was some variation in body weight gain. No toxicologically significant changes occurred in hematology, biochemistry or urinalysis results.

Post mortem, there was an increase in mean relative liver and kidney weights at the top dose level. No microscopic changes were detected in the kidneys, but in the liver, there was a sex/dose-related increase in multinucleated hepatocytes. Effects were only seen in females at 150 mg/kg/day but in males occurred as low as 37.5 mg/kg/day.

A 6-month oral study was performed in rats (20 to 27/sex/group) at dosages of 0, 1 to 6, 8, 40 or 200 mg/kg/day. Seven male and female rats from the control group and the 40 and 200 mg/kg/day groups were allowed a 63-day non-dosed recovery period. No mortalities occurred. Body weight and food intake were reduced at high doses during the dosing phase but normalized during recovery.

Water intake and urine volume increased in males and females of the 40 and 200 mg/kg/day groups. Dose-related hematological changes included reduced erythrocytes and HCT with increased MCV, MCH and MCHC and relative eosinophil counts. Biochemical changes were mainly restricted to the high dose group and included increased ALP and decreased phospholipids; decreased total cholesterol and triglycerides, and increased AST and ALT in males only and decreased albumin in females only.

Organ weight increases were found to include cecum, adrenals, liver, and spleen. Histopathological examinations showed drug-related, recovery-reversible increases in multinucleated hepatocytes associated with minimal and focal necrosis in livers of both sexes at the top 2 dose levels. No relevant pathology was found in the cecum, adrenals or spleen to account for the increased weights. After recovery only the 200 mg/kg/day group had increased multinucleated hepatocytes.

Dogs (7/sex/group) were administered daily with oral doses of 0, 10, 30, or 100 mg/kg/day of clarithromycin for 3 months. Emesis occurred at levels of 30 mg/kg and above. One male high-dose dog was killed *in extremis* on day 69. Drug-related lesions were seen in the liver, gall bladder, thymus and stomach.

Hematological and biochemical changes at the high dose level included, decreased RBC and HCT, increased ALT, ALP, GGT, and decreased total protein and albumin. No significant organ weight changes were recorded, but treatment-related microscopic alterations in the liver and stomach of mild- and high-dose dogs were seen, as well as changes in gall bladder, spleen and thymus of high-dose animals.

A 6-month oral study was also performed in dogs (4 to 5/sex/group) at dosages of 0, 0.8, 4, 20 or 100 mg/kg/day. At the 0 and 100 mg/kg levels, 1 male and 1 female dog were allowed a 1-month, non-dosed, recovery period. One male-high dose dog died on day 174. This death was considered to be as a direct result of clarithromycin administration. Histopathologic examination revealed hepatic parenchymal damage, identifying the cause of clinical jaundice. Clinical signs during the dosing phase of the study were restricted to the top 2 dose levels and included emesis and ocular signs. Food consumption and water intake were reduced at 20 and 100 mg/kg/day.

Hematologic changes at 100 mg/kg were indicative of subclinical anemia. Biochemical alterations at the same level were associated with liver damage. Ocular changes were only apparent at the top dose level.

Increase in the weights of lung, liver, spleen, adrenals and kidneys were found at 100 mg/kg/day. Histopathologic examination of these organs showed degeneration of liver parenchyma, and toxic effects in adrenals. The thymus weight was reduced at 100 mg/kg/day. At the end of the recovery period all findings had regressed or reduced.

Monkeys (5 to 6/sex/group) were similarly administered clarithromycin at levels of 0, 25, 50 or 100 mg/kg/day for 6 months. At the 0 and 100 mg/kg levels, 1 male and 1 female monkey were allowed a one-month recovery period. One high-dose female died in week 25. Inhalation of vomit was considered to be the cause of death. Clinical signs were restricted to a dose-related incidence of emesis and salivation. No treatment-related effects were found in food consumption, ophthalmoscopy or hematology. Weight loss was restricted to 1 high-dose female. Minor serum chemistry changes were seen at the 100 mg/kg level, particularly in plasma proteins. Urinalysis revealed a dose-related lowering of pH and SG at 13 weeks only. Organ weight increases in liver, adrenal and kidneys were seen at high doses, but pathology was restricted to minimal liver changes consisting of cytoplasmic rarefaction of centrilobular hepatocytes. All changes were reversed during the recovery period.

Carcinogenicity

Long-term studies in animals have not been performed to evaluate the carcinogenic potential of clarithromycin.

Mutagenicity

The following *in vitro* mutagenicity tests have been conducted with clarithromycin: *Salmonella*/mammalian microsome test, bacterial induced mutation frequency test, *in vitro* chromosome aberration test, rat hepatocyte DNA synthesis assay, mouse lymphoma assay, mouse dominant lethal study, mouse micronucleus test.

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

Reproduction and Teratology

Fertility and reproduction studies have shown that daily doses of 150 to 160 mg/kg/day to male and female rats caused no adverse effects on the estrous cycle, fertility, parturition, or number and viability of offspring. Plasma levels in rats after 150 mg/kg/day were 2 times the human serum levels.

In the 150 mg/kg/day monkey studies, plasma levels were 3 times the human serum levels. When given orally after 150 mg/kg/day, clarithromycin was shown to produce embryonic loss in monkeys. This effect has been attributed to marked maternal toxicity of the drug at this high dose.

In rabbits, *in utero* fetal loss occurred at an intravenous dose of 33 mg/m², which is 17 times less than the maximum proposed human oral daily dose of 618 mg/m².

Special Studies

Acute Renal Toxicity

There was no evidence of nephrotoxicity of clarithromycin in the rat at doses up to 500 mg/kg/day.

Hepatotoxicity

In the *in vitro* and *in vivo* hepatotoxicity studies comparing clarithromycin with erythromycin, it was found that clarithromycin caused no greater cytotoxicity than erythromycin stearate and much less toxicity than erythromycin estolate. Hepatic enzyme induction was not found in doses below 500 mg/kg/day. In cynomolgus monkeys, the closest metabolic model for humans, elevations of ALT and LDH were identified at 200 mg/kg/day.

In dogs, a rise of ALT has been seen at 100 mg/kg/day, and in Wistar rats, a similar elevation of enzymes was seen at 200 mg/kg/day. Morphologic lesions related to prolonged exposure to clarithromycin (up to 6 months) have been consistent with reportedly reversible changes in rat, dog and monkey studies. Such doses are many times beyond the therapeutic range in humans, which is within 8 to 10 mg/kg/day.

Ocular Toxicity

Ocular lesions appear confined to dogs and monkeys receiving lethal doses, which were large multiples of the human therapeutic dose. Radiolabelled clarithromycin studies indicate the eye is not selectively burdened by drug deposits and that clearance from this tissue follows that seen in other tissues. Opacities occur in the cornea following widespread extraocular tissue changes which are detectable via numerous diagnostic methods. Reduced intraocular pressure precedes corneal opacity in a relatively predictive manner. Some evidence for transient opacity and at least partial resolution was noted in animal studies, but most animals succumbed to other organ dysfunctions shortly after opacities were observed.

Animals given doses close to the therapeutic dose had no ocular changes. No ophthalmologic effects were noted in rabbits treated at doses of 40 and 160 mg/kg/day for 28 days.

Ototoxicity

No effects on pinna reflex were seen in guinea pigs at a dose of 400 mg/kg/day but inner and outer hair cells disappeared suggesting toxic damage. No evidence of damage was reported at 200 mg/kg/day.

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PART III: CONSUMER INFORMATION

PrBIAXIN BID[®] clarithromycin tablets, USP, film-coated

This leaflet is Part III of a three-part "Product Monograph" published when BIAXIN BID[®] was approved for sale in Canada and is designed specifically for consumers. This leaflet is a summary and will not tell you everything about BIAXIN BID[®]. Contact your doctor or pharmacist if you have any questions about the drug.

ABOUT THIS MEDICATION

What the medication is used for:

BIAXIN BID[®] is used to treat certain infections caused by bacteria, such as pneumonia, bronchitis, infections of the sinuses, skin, and throat.

When used with other medications, it can treat infection caused by a bacterium called *Helicobacter pylori* (*H. pylori*) and reduce the risk of duodenal ulcer recurrence. A duodenal ulcer is a sore on the lining of the duodenum, which is the beginning of the small intestine.

It can also be prescribed to prevent and combat MAC disease in patients with HIV. MAC is a short word for *Mycobacterium avium* complex, the germs that cause MAC disease.

What it does:

BIAXIN BID[®] is an antibiotic that kills bacteria in your body.

When it should not be used:

Do not take BIAXIN BID[®] if you have ever had an allergic reaction to it, or if you are sensitive to it or erythromycin, or other antibacterial agents of the same family or to any ingredient in the formulation. See (**What the important non-medicinal ingredients are**).

Do not take BIAXIN BID[®] if you are taking astemizole*, cisapride*, colchicine, pimozone, terfenadine*, ergotamine, dihydroergotamine, lovastatin or simvastatin. Astemizole*, cisapride*, pimozone, terfenadine*, ergotamine, dihydroergotamine and colchicine can interact with BIAXIN BID[®], possibly leading to an irregular heartbeat pattern; deaths have occurred.

* no longer marketed in Canada.

Do not take BIAXIN BID[®] if you have ever developed liver problems after using BIAXIN BID[®].

Do not use BIAXIN BID[®] if you have a history of heart disturbance or irregular heart beat (arrhythmias, QT prolongation, torsade de pointes).

What the medicinal ingredient is:

The medicinal ingredient is clarithromycin.

What the important non-medicinal ingredients are:

The non-medicinal ingredients are the following: cellulosic polymers, croscarmellose sodium, D&C Yellow No. 10, magnesium stearate, povidone, pregelatinized starch (250 mg only), propylene glycol, silicon dioxide, sorbic acid, sorbitan monooleate, stearic acid, talc, titanium dioxide and vanillin.

What dosage forms it comes in:

This medicine comes in:

- regular tablets (BIAXIN BID[®], 250 mg and 500 mg),
- extended-release tablets (BIAXIN[®] XL, 500 mg)
- liquid form (BIAXIN[®], 125 mg/5mL and 250 mg/5mL).

WARNINGS AND PRECAUTIONS

Serious Warnings and Precautions

BIAXIN BID[®] should not be used in pregnancy unless advised by your doctor due to potential hazards to the fetus. Do not take BIAXIN BID[®] without first talking to your doctor if you are breast-feeding a baby.

Before taking BIAXIN BID[®], tell your doctor if you have liver or kidney disease. You may not be able to take clarithromycin, or you may require a lower dose and special monitoring during therapy. Talk to your doctor if BIAXIN BID[®] gives you prolonged and severe diarrhea.

The development of antibiotic resistance has been seen in patients with HIV receiving clarithromycin. To avoid failure of the treatment with a potential for developing antimicrobial resistance and a risk of failure with subsequent therapy, you/your child should follow closely the prescribed regimen.

BEFORE you use BIAXIN BID[®] talk to your doctor or pharmacist:

- about all health problems you have now or have had in the past;
- about all other medicines you are taking, including non-prescription medicines, nutritional supplements, or herbal products. See (**INTERACTIONS WITH THIS MEDICATION**);
- if you have or develop severe diarrhea as this may be a sign of a more serious condition;
- if you have kidney problems;
- if you have liver problems;
- if you are taking astemizole, terfenadine, cisapride, pimozone, ergotamine, dihydroergotamine, digoxin, colchicine, lovastatin or simvastatin.
- if you have any unusual or allergic reaction (rash, difficulty breathing) to clarithromycin or any of the non-medicinal ingredients in BIAXIN BID[®] (see **What the important non-medicinal ingredients are**), other medicines, foods, dyes, or preservatives;

- if you are pregnant, trying to get pregnant or are breast-feeding because clarithromycin has been detected in human breast milk.
- if you are elderly with a history of liver or kidney problems and taking colchicine.

WHILE taking BIAXIN BID[®], contact your doctor if:

- You develop symptoms of myasthenia gravis or the symptoms of your existing myasthenia gravis worsen. These symptoms could include muscle weakness that gets worse with activity and gets better with rest, drooping eyelid, blurred or double vision, difficulty chewing and swallowing, or trouble breathing.
- You develop symptoms of hepatitis (liver inflammation) such as abdominal pain, nausea, vomiting, yellowing of skin and eyes, dark urine etc. Stop taking the drug immediately.

INTERACTIONS WITH THIS MEDICATION

Drugs that may interact with BIAXIN BID[®] includes:

Alfentanil, alprazolam, amlodipine, astemizole*/terfenadine*, atazanavir, atorvastatin, bromocriptine, carbamazepine, cilostazol, cisapride*/pimozide, colchicine, cyclosporine, digoxin, diltiazem, disopyramide/quinidine, efavirenz, ergotamine/dihydroergotamine, etravirine, fluconazole, hexobarbital, insulin, itraconazole, lansoprazole/omeprazole, lovastatin/simvastatin, methylprednisolone, midazolam/triazolam, nateglinide, nevirapine, phenobarbital, phenytoin, pioglitazone, repaglinide, rifabutin/rifampin, rifapentine*, ritonavir/indinavir, rosiglitazone, rosuvastatin, saquinavir, sildenafil, St. John's Wort (*Hypericum perforatum*), tacrolimus, tadalafil, theophylline, tolterodine, valproic acid, vardenafil, verapamil, vinblastine, warfarin/acenocoumarol, zidovudine and drugs metabolized by cytochrome P450 system.

*not marketed in Canada.

PROPER USE OF THIS MEDICATION

Usual Adult Dose:

BIAXIN BID[®] may be taken with or without meals.

Respiratory Tract or Skin Infections:

The usual dosage of BIAXIN BID[®] is 250 mg to 500 mg every 12 hours for 7 to 14 days.

Infections with *H. pylori*:

Triple Therapy: BIAXIN BID[®] + Omeprazole + Amoxicillin

The recommended dose is the following for 10 days:

- BIAXIN BID[®]: 500 mg every 12 hours
- Omeprazole: 20 mg once daily
- Amoxicillin: 1 g every 12 hours

Dual Therapy: BIAXIN BID[®] + Omeprazole

The recommended dose is the following for 14 days:

- BIAXIN BID[®]: 500 mg every 8 hours
- Omeprazole: 40 mg once daily followed by 20 mg omeprazole once daily for 14 days

MAC disease:

The recommended dose of BIAXIN BID[®] for prevention and treatment of MAC disease is 500 mg every 12 hours.

Treatment of disseminated MAC infection (MAC infection spread through your whole body) in patients with HIV should continue for life if improvement of symptoms is observed.

Overdose:

In case of overdose, contact your healthcare professional, hospital emergency department or regional poison control centre, even if there are no symptoms. Symptoms of BIAXIN BID[®] overdose are abdominal pain, vomiting, nausea, and diarrhea.

Missed Dose:

If you miss a dose, take it as soon as you remember unless it is almost time for the next dose. In that case, skip the missed dose and take the next one as directed. Do not take double or extra doses.

SIDE EFFECTS AND WHAT TO DO ABOUT THEM

Like all medicines, BIAXIN BID[®] can cause side effects. The majority of side effects observed in clinical trials with BIAXIN BID[®] were of a mild and transient nature.

The following adverse reactions were reported during the clinical studies with clarithromycin, the medicinal ingredient (occurring between 1% and 10% in clinical trials) or during post-marketing surveillance: abdominal pain, abnormal taste, diarrhea, ear disorder, flatulence, indigestion, headache, nausea, rash, vomiting. Talk to your doctor or pharmacist if any of these side effects persist or become bothersome.

Serious side effects from BIAXIN BID[®] are not common.

If dizziness, confusion or disorientation occur while taking BIAXIN BID[®], do not drive or operate machinery.

SERIOUS SIDE EFFECTS, HOW OFTEN THEY HAPPEN AND WHAT TO DO ABOUT THEM

Symptom/effect		Talk with your doctor or pharmacist		Stop taking drug and call your doctor or pharmacist
		Only if severe	In all cases	
Uncommon	Allergic reactions*			✓
	Severe diarrhea		✓	
	Severe abdominal cramps		✓	
	Irregular heart beat			✓

*Allergic reactions, with symptoms such as itching, skin eruptions, rash, sore throat, fever, swelling, skin rash, itchiness, difficulty breathing, lightheadedness/dizziness.

This is not a complete list of side effects. For any unexpected effects while taking BIAXIN BID[®], contact your doctor or pharmacist.

HOW TO STORE IT

Keep BIAXIN BID[®] and all other medicines out of reach of children.

Store at room temperature (15 to 25°C) in a tightly closed container. Protect from light. Do not use beyond the expiration date.

REPORTING SUSPECTED SIDE EFFECTS

You can report any suspected adverse reactions associated with the use of health products to the Canada Vigilance Program by one of the following 3 ways:

- Report on line at: www.healthcanada.gc.ca/medeffect
- Call toll-free at 1-866-234-2345
- Complete a Canada Vigilance Reporting Form and:
 - Fax toll-free to 1-866-678-6789
 - Mail to: Canada Vigilance Program
Health Canada
Postal Locator 0701D
Ottawa, ON K1A 0K9

Postage paid labels, Canada Vigilance Reporting Form and the adverse reaction reporting guidelines are available on the MedEffect[™] Canada Web site at <http://www.healthcanada.gc.ca/medeffect>

NOTE: Should you require information related to the management of side effects, contact your health professional. The Canada Vigilance Program does not provide medical advice.

MORE INFORMATION

This document plus the full Product Monograph, prepared for health professionals can be found at:

<http://www.abbott.ca>

or by contacting the sponsor, Abbott Laboratories, Limited, Saint-Laurent, Qc H4S 1Z1 at: 1-800-699-9948

This leaflet was prepared by Abbott Laboratories, Limited.

Last revised: July 20, 2011

PART III: CONSUMER INFORMATION

Pr BIAXIN® XL

clarithromycin extended-release tablets, Abbott Standard

This leaflet is Part III of a three-part "Product Monograph" published when BIAXIN® XL was approved for sale in Canada and is designed specifically for consumers. This leaflet is a summary and will not tell you everything about BIAXIN® XL. Contact your doctor or pharmacist if you have any questions about the drug.

ABOUT THIS MEDICATION

What the medication is used for:

BIAXIN® XL is used to treat certain infections caused by bacteria, such as pneumonia, bronchitis and infections of the sinuses.

The efficacy and safety of BIAXIN® XL in treating other infections for which BIAXIN BID® and BIAXIN® are approved have not been established.

What it does:

BIAXIN® XL is an antibiotic that kills bacteria in your body.

When it should not be used:

Do not take BIAXIN® XL if you have ever had an allergic reaction to it, or if you are sensitive to it or erythromycin, or other antibacterial agents of the same family or to any ingredient in the formulation. See (**What the important non-medicinal ingredients are**).

Do not take BIAXIN® XL if you are taking astemizole*, cisapride*, colchicine, pimozone, terfenadine*, ergotamine, dihydroergotamine, lovastatin or simvastatin. Astemizole*, cisapride*, pimozone, terfenadine*, ergotamine, dihydroergotamine and colchicine can interact with BIAXIN® XL, possibly leading to an irregular heartbeat pattern; deaths have occurred.

* no longer marketed in Canada.

Do not take BIAXIN® XL if you have ever developed liver problems after using BIAXIN® XL.

Do not use BIAXIN® XL if you have a history of heart disturbance or irregular heart beat (arrhythmias, QT prolongation, torsade de points).

What the medicinal ingredient is:

The medicinal ingredient is clarithromycin.

What the important non-medicinal ingredients are:

The non-medicinal ingredients are the following: cellulosic polymers, lactose monohydrate, magnesium stearate, propylene

glycol, Quinoline Yellow Lake E104, sorbitan monooleate, talc, titanium dioxide and vanillin.

What dosage forms it comes in:

This medicine comes in:

- extended-release tablets (BIAXIN® XL, 500 mg),
- regular tablets (BIAXIN BID®, 250 mg and 500 mg),
- liquid forms (BIAXIN®, 125 mg/5mL and 250 mg/5mL).

WARNINGS AND PRECAUTIONS

Serious Warnings and Precautions

BIAXIN® XL should not be used in pregnancy unless advised by your doctor due to potential hazards to the fetus. Do not take BIAXIN® XL without first talking to your doctor if you are breast-feeding a baby.

Before taking BIAXIN® XL, tell your doctor if you have liver or kidney disease. You may not be able to take clarithromycin, or you may require a lower dose and special monitoring during therapy. Talk to your doctor if BIAXIN® XL gives you prolonged and severe diarrhea.

The development of antibiotic resistance has been seen in patients with HIV receiving clarithromycin. To avoid failure of the treatment with a potential for developing antimicrobial resistance and a risk of failure with subsequent therapy, you/your child should follow closely the prescribed regimen.

BEFORE you use BIAXIN® XL talk to your doctor or pharmacist:

- about all health problems you have now or have had in the past;
- about all other medicines you are taking, including non-prescription medicines, nutritional supplements, or herbal products. See (**INTERACTIONS WITH THIS MEDICATION**);
- if you have or develop severe diarrhea as this may be a sign of a more serious condition;
- if you have kidney problems;
- if you have liver problems;
- if you are taking astemizole, terfenadine, cisapride, pimozone, ergotamine, dihydroergotamine, digoxin, colchicine, lovastatin or simvastatin.
- if you have any unusual or allergic reaction (rash, difficulty breathing) to clarithromycin or any of the non-medicinal ingredients in BIAXIN® XL (see **What the important non-medicinal ingredients are**), other medicines, foods, dyes, or preservatives;
- if you are pregnant, trying to get pregnant or are breast-feeding because clarithromycin has been detected in human breast milk.

- if you are elderly with a history of liver or kidney problems and taking colchicine.

WHILE taking BIAXIN® XL, contact your doctor if:

- You develop symptoms of myasthenia gravis or the symptoms of your existing myasthenia gravis worsen. These symptoms could include muscle weakness that gets worse with activity and gets better with rest, drooping eyelid, blurred or double vision, difficulty chewing and swallowing, or trouble breathing.
- You develop symptoms of hepatitis (liver inflammation) such as abdominal pain, nausea, vomiting, yellowing of skin and eyes, dark urine etc. Stop taking the drug immediately.

INTERACTIONS WITH THIS MEDICATION

Drugs that may interact with BIAXIN® XL includes:

Alfentanil, alprazolam, amlodipine, astemizole*/terfenadine*, atazanavir, atorvastatin, bromocriptine, carbamazepine, cilostazol, cisapride*/pimozide, colchicine, cyclosporine, digoxin, diltiazem, disopyramide/quinidine, efavirenz, ergotamine/dihydroergotamine, etravirine, fluconazole, hexobarbital, insulin, itraconazole, lansoprazole/omeprazole, lovastatin/simvastatin, methylprednisolone, midazolam/triazolam, nateglinide, nevirapine, phenobarbital, phenytoin, pioglitazone, repaglinide, rifabutin/rifampin, rifapentine*, ritonavir/indinavir, rosiglitazone, rosuvastatin, saquinavir, sildenafil, St. John’s Wort (*Hypericum perforatum*), tacrolimus, tadalafil, theophylline, tolterodine, valproic acid, vardenafil, verapamil, vinblastine, warfarin/acenocoumarol, zidovudine and drugs metabolized by cytochrome P450 system.

*not marketed in Canada.

PROPER USE OF THIS MEDICATION

Usual Dose:

BIAXIN® XL must be taken with food.

Adults with Respiratory Tract Infection:

The usual adult dosage is 1000 mg every 24 hours for 5 to 14 days.

BIAXIN® XL should be swallowed whole, with a glass of water and not chewed, broken or crushed.

Overdose:

In case of overdose, contact your healthcare professional, hospital emergency department or regional poison control centre, even if there are no symptoms. Symptoms of BIAXIN® XL overdose are abdominal pain, vomiting, nausea, and diarrhea.

Missed Dose:

If you miss a dose, take it as soon as you remember unless it is almost time for the next dose. In that case, skip the missed dose and take the next one as directed. Do not take double or extra doses.

SIDE EFFECTS AND WHAT TO DO ABOUT THEM

Like all medicines, BIAXIN® XL can cause side effects. The majority of side effects observed in clinical trials with BIAXIN® XL were of a mild and transient nature.

The following adverse reactions were reported during the clinical studies with clarithromycin, the medicinal ingredient (occurring between 1% and 10% in clinical trials) or during post-marketing surveillance: abdominal pain, abnormal taste, diarrhea, ear disorder, flatulence, indigestion, headache, nausea, rash, vomiting. Talk to your doctor or pharmacist if any of these side effects persist or become bothersome.

If you see tablet residue in your stool, contact your doctor as your doctor may recommend a different clarithromycin formulation, especially if you have certain bowel conditions.

Serious side effects from BIAXIN® XL are not common.

If dizziness, confusion or disorientation occur while taking BIAXIN® XL, do not drive or operate machinery.

SERIOUS SIDE EFFECTS, HOW OFTEN THEY HAPPEN AND WHAT TO DO ABOUT THEM

Symptom/effect		Talk with your doctor or pharmacist		Stop taking drug and call your doctor or pharmacist
		Only if severe	In all cases	
Uncommon	Allergic reactions*			✓
	Severe diarrhea		✓	
	Severe abdominal cramps		✓	
	Irregular heart beat			✓

*Allergic reactions, with symptoms such as itching, skin eruptions, rash, sore throat, fever, swelling, skin rash, itchiness, difficulty breathing, lightheadedness/dizziness.

This is not a complete list of side effects. For any unexpected effects while taking BIAXIN® XL, contact your doctor or pharmacist.

HOW TO STORE IT

Keep BIAXIN[®] XL and all other medicines out of reach of children.

Store at room temperature (15 to 25°C) in a tightly closed container. Protect from light. Do not use beyond the expiration date.

REPORTING SUSPECTED SIDE EFFECTS

You can report any suspected adverse reactions associated with the use of health products to the Canada Vigilance Program by one of the following 3 ways:

- **Report on line at:**
www.healthcanada.gc.ca/medeffect
- **Call toll-free at 1-866-234-2345**
- **Complete a Canada Vigilance Reporting Form and:**
 - **Fax toll-free to 1-866-678-6789**
 - **Mail to: Canada Vigilance Program**
Health Canada
Postal Locator 0701D
Ottawa, ON K1A 0K9

Postage paid labels, Canada Vigilance Reporting Form and the adverse reaction reporting guidelines are available on the MedEffect[™] Canada Web site at
<http://www.healthcanada.gc.ca/medeffect>

NOTE: Should you require information related to the management of side effects, contact your health professional. The Canada Vigilance Program does not provide medical advice.

MORE INFORMATION

This document plus the full Product Monograph, prepared for health professionals, can be found at:

<http://www.abbott.ca>

or by contacting the sponsor, Abbott Laboratories, Limited, Saint-Laurent, Qc H4S 1Z1 at:
1-800-699-9948

This leaflet was prepared by Abbott Laboratories, Limited.

Last revised: July 20, 2011

PART III: CONSUMER INFORMATION

Pr **BIAXIN**[®] clarithromycin for oral suspension, USP

This leaflet is Part III of a three-part "Product Monograph" published when BIAXIN[®] was approved for sale in Canada and is designed specifically for consumers. This leaflet is a summary and will not tell you everything about BIAXIN[®]. Contact your doctor or pharmacist if you have any questions about the drug.

ABOUT THIS MEDICATION

What the medication is used for:

BIAXIN[®] is used to treat certain infections caused by bacteria, such as pneumonia, otitis, and infections of the skin and throat (pharyngitis).

It can also be prescribed to combat mycobacterial infections. Mycobacteria are a group of bacteria that cause several diseases.

What it does:

BIAXIN[®] is an antibiotic that kills bacteria in your body.

When it should not be used:

Do not take BIAXIN[®] if you/your child have ever had an allergic reaction to it, or if you/your child are sensitive to it or erythromycin, or other antibacterial agents of the same family or to any ingredient in the formulation. See (**What the important non-medicinal ingredients are:**).

Do not take BIAXIN[®] if you/your child are taking astemizole*, cisapride*, colchicine, pimozone, terfenadine*, ergotamine, dihydroergotamine, lovastatin or simvastatin. Astemizole*, cisapride*, pimozone, terfenadine*, ergotamine, dihydroergotamine and colchicine can interact with BIAXIN[®], possibly leading to an irregular heartbeat pattern; deaths have occurred.

* no longer marketed in Canada.

Do not take BIAXIN[®] if you have ever developed liver problems after using BIAXIN[®].

Do not use BIAXIN[®] if you have a history of heart disturbance or irregular heart beat (arrhythmias, QT prolongation, torsade de points).

What the medicinal ingredient is:

The medicinal ingredient is clarithromycin.

What the important non-medicinal ingredients are:

The non-medicinal ingredients are the following: carbopol, povidone, polymer, sucrose or sugar, maltodextrin, xanthan gum, silicon dioxide, potassium sorbate, citric acid, artificial and natural fruit flavour, castor oil, and titanium dioxide.

What dosage forms it comes in:

This medicine comes in:

- liquid forms (BIAXIN[®], 125 mg/5mL and 250 mg/5mL).
- extended-release tablets (BIAXIN[®] XL, 500 mg),
- regular tablets (BIAXIN BID[®], 250 mg and 500 mg).

WARNINGS AND PRECAUTIONS

Serious Warnings and Precautions

BIAXIN[®] should not be used in pregnancy unless advised by your doctor due to potential hazards to the fetus. Do not take BIAXIN[®] without first talking to your doctor if you are breast-feeding a baby.

Before taking BIAXIN[®], tell your doctor if you/your child have liver or kidney disease. You may not be able to take clarithromycin, or you/your child may require a lower dose and special monitoring during therapy. Talk to your doctor if BIAXIN[®] gives you/your child prolonged and severe diarrhea.

The development of antibiotic resistance has been seen in patients with HIV receiving clarithromycin. To avoid failure of the treatment with a potential for developing antimicrobial resistance and a risk of failure with subsequent therapy, you/your child should follow closely the prescribed regimen.

BEFORE you/your child use BIAXIN[®] talk to your doctor or pharmacist:

- about all health problems you/your child have now or have had in the past;
- about all other medicines you/your child are taking, including non-prescription medicines, nutritional supplements, or herbal products. See (**INTERACTIONS WITH THIS MEDICATION**);
- if you/your have or develop severe diarrhea as this may be a sign of a more serious condition;
- if you/your child have kidney problems;
- if you/your child have liver problems;
- if you/your child are taking astemizole, terfenadine, cisapride, pimozone, ergotamine, dihydroergotamine, digoxin, colchicine, lovastatin or simvastatin.
- if you/your child have any unusual or allergic reaction (rash, difficulty breathing) to clarithromycin or any of the non-medicinal ingredients in BIAXIN[®] (see **What the important non-medicinal ingredients are**), other medicines, foods, dyes, or preservatives;
- if you are pregnant, trying to get pregnant or are breast-feeding because clarithromycin has been detected in human breast milk.
- if you are elderly with a history of liver or kidney problems and taking colchicine.

WHILE taking BIAXIN[®], contact your doctor if:

- You develop symptoms of myasthenia gravis or the symptoms of your existing myasthenia gravis worsen. These symptoms could include muscle weakness that gets worse with activity and gets better with rest, drooping eyelid, blurred or double vision, difficulty chewing and swallowing, or trouble breathing.
- You develop symptoms of hepatitis (liver inflammation) such as abdominal pain, nausea, vomiting, yellowing of skin and eyes, dark urine etc. Stop taking the drug immediately.

SIDE EFFECTS AND WHAT TO DO ABOUT THEM

Like all medicines, BIAXIN[®] can cause side effects. The majority of side effects observed in clinical trials with BIAXIN[®] were of a mild and transient nature.

The following adverse reactions were reported during the clinical studies with clarithromycin, the medicinal ingredient (occurring between 1% and 10% in clinical trials) or during post-marketing surveillance: abdominal pain, abnormal taste, diarrhea, ear disorder, flatulence, indigestion, headache, nausea, rash, vomiting. Talk to your doctor or pharmacist if any of these side effects persist or become bothersome.

Serious side effects from BIAXIN[®] are not common.

If dizziness, confusion or disorientation occur while taking BIAXIN[®], do not drive or operate machinery.

INTERACTIONS WITH THIS MEDICATION

Drugs that may interact with BIAXIN[®] includes:

Alfentanil, alprazolam, amlodipine, astemizole*/terfenadine*, atazanavir, atorvastatin, bromocriptine, carbamazepine, cilostazol, cisapride*/pimozide, colchicine, cyclosporine, digoxin, diltiazem, disopyramide/quinidine, efavirenz, ergotamine/dihydroergotamine, etravirine, fluconazole, hexobarbital, insulin, itraconazole, lansoprazole/omeprazole, lovastatin/simvastatin, methylprednisolone, midazolam/triazolam, nateglinide, nevirapine, phenobarbital, phenytoin, pioglitazone, repaglinide, rifabutin/rifampin, rifapentine*, ritonavir/indinavir, rosiglitazone, rosuvastatin, saquinavir, sildenafil, St. John's Wort (*Hypericum perforatum*), tacrolimus, tadalafil, theophylline, tolterodine, valproic acid, vardenafil, verapamil, vinblastine, warfarin/acenocoumarol, zidovudine and drugs metabolized by cytochrome P450 system.

*not marketed in Canada.

SERIOUS SIDE EFFECTS, HOW OFTEN THEY HAPPEN AND WHAT TO DO ABOUT THEM

Symptom/effect		Talk with your doctor or pharmacist		Stop taking drug and call your doctor or pharmacist
		Only if severe	In all cases	
Uncommon	Allergic reactions*			✓
	Severe diarrhea		✓	
	Severe abdominal cramps		✓	
	Irregular heart beat			✓

*Allergic reactions, with symptoms such as itching, skin eruptions, rash, sore throat, fever, swelling, skin rash, itchiness, difficulty breathing, lightheadedness/dizziness.

This is not a complete list of side effects. For any unexpected effects while taking BIAXIN[®], contact your doctor or pharmacist.

PROPER USE OF THIS MEDICATION

Usual Dose:

BIAXIN[®] must be taken with food.

The recommended daily dosage of BIAXIN[®] is 15 mg/kg/day, in divided doses every 12 hours, not to exceed 1000 mg/day. The usual duration of treatment is for 5 to 10 days. Ask your pharmacist to prepare BIAXIN[®] in liquid form.

Overdose:

In case of overdose, contact your healthcare professional, hospital emergency department or regional poison control centre, even if there are no symptoms. Symptoms of BIAXIN[®] overdose are abdominal pain, vomiting, nausea, and diarrhea.

HOW TO STORE IT

Keep BIAXIN[®] and all other medicines out of reach of children.

Store at room temperature (15 to 25°C) in a tightly closed container. Protect from light. Do not use beyond the expiration date.

Missed Dose:

If you/your child miss a dose of BIAXIN[®], take/give to your child the missed dose as soon as you remember. If it is almost time for your/your child's next dose, wait and take/give to your child the next dose at the regular time. Do not take/give to your child double or extra doses.

REPORTING SUSPECTED SIDE EFFECTS

You can report any suspected adverse reactions associated with the use of health products to the Canada Vigilance Program by one of the following 3 ways:

- **Report on line at:**
www.healthcanada.gc.ca/medeffect
- **Call toll-free at 1-866-234-2345**
- **Complete a Canada Vigilance Reporting Form and:**
 - **Fax toll-free to 1-866-678-6789**
 - **Mail to: Canada Vigilance Program**
Health Canada
Postal Locator 0701D
Ottawa, ON K1A 0K9

Postage paid labels, Canada Vigilance Reporting Form and the adverse reaction reporting guidelines are available on the MedEffect™ Canada Web site at <http://www.healthcanada.gc.ca/medeffect>

NOTE: Should you require information related to the management of side effects, contact your health professional. The Canada Vigilance Program does not provide medical advice.

MORE INFORMATION

This document plus the full Product Monograph, prepared for health professionals, can be found at:

<http://www.abbott.ca>

or by contacting the sponsor, Abbott Laboratories, Limited, Saint-Laurent, Qc H4S 1Z1 at:
1-800-699-9948

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