

Summary of Product Characteristics

1 NAME OF THE MEDICINAL PRODUCT

Clarithromycin 250 mg film-coated tablets

2 QUALITATIVE AND QUANTITATIVE COMPOSITION

Each film-coated tablet contains Clarithromycin 250 mg.

For the full list of excipients, see section 6.1

3 PHARMACEUTICAL FORM

Film-coated tablet

Light yellow coloured, oval shaped, biconvex, film coated tablets, debossed with 'C1' on one side.

Tablet length is approximately 14.90 mm and width is approximately 7.10 mm.

4 CLINICAL PARTICULARS

4.1 Therapeutic Indications

Clarithromycin are indicated for the treatment of the following bacterial infections in adults and adolescents aged 12 years and older, when caused by clarithromycin-susceptible bacteria in patients with known hypersensitivity to beta-lactam antibiotics or when beta-lactam antibiotics would be inappropriate for other reasons (see sections 4.4 and 5.1).

- Streptococcal pharyngitis
- Acute bacterial sinusitis (adequately diagnosed)
- Acute exacerbation of chronic bronchitis (adequately diagnosed)
- Mild to moderate community acquired bacterial pneumonia
- Skin infections and soft tissue infections of mild to moderate severity (e.g. impetigo, erysipelas, erythrasma)
- In appropriate combination with antibacterial therapeutic regimens and an appropriate ulcer healing agent for the eradication of *Helicobacter pylori* in patients with *Helicobacter pylori* associated ulcers (see section 4.2). This indication is restricted to adults only.

Consideration should be given to official guidance on the appropriate use of antibacterial agents.

4.2 Posology and method of administration

Posology

The dosage of Clarithromycin depends on the type and severity of the infection and has to be defined in any case by the physician.

Adults

- Standard dosage: The usual dose is 250 mg twice daily (in the morning and in the evening).
- High dosage treatment (severe infections): The usual dose may be increased to 500 mg twice daily in severe infections.

Adolescents 12 years and older: As for adults.

Children younger than 12 years

Use of Clarithromycin is not recommended for children younger than 12 years. For children younger than 12 years an appropriate dosage form (Paediatric Suspension) is available.

Eradication of *Helicobacter pylori* in adults

For combination therapy of *H. pylori* infection the common recommendations for *H. pylori* eradication have to be considered.

Elderly

As for adults.

Hepatic impairment

Caution should be exercised when administering clarithromycin in patients with hepatic impairment (see section 4.3. and 4.4).

Renal impairment

Dosage adjustments are not usually required except in patients with severe renal impairment (creatinine clearance < 30 ml/min). If adjustment is necessary, the total daily dosage should be reduced by half, e.g. 250 mg once daily or 250 mg twice daily in more severe infections. Treatment should not be continued beyond 14 days in these patients.

Duration of therapy

The duration of therapy with clarithromycin depends on the clinical condition of the patient and on the type and severity of the infection. In each case the duration of therapy should be determined by the physician.

- The usual duration of treatment is 6 to 14 days.
- Therapy should be continued at least for 2 days after symptoms have subsided.
- In β -haemolytic streptococcal infections the duration of therapy should be at least 10 days in order to prevent complications such as rheumatic fever and glomerulonephritis.

Method of administration

The tablet should be swallowed with a sufficient amount of fluid (eg. one glass of water).

Clarithromycin may be given irrespective of food intake.

4.3 Contraindications

Hypersensitivity to the active substance, to any other macrolide antibiotic drug or to any of the excipients listed in section 6.1.

Concomitant administration of clarithromycin and the following active substances is contraindicated (see section 4.5):

- Ergotamine, dihydroergotamine
- Astemizole, cisapride, pimozone and terfenadine
- Colchicine
- Ticagrelor or ranolazine
- HMG-CoA reductase inhibitors (statins), that are extensively metabolised by CYP3A4 (lovastatin or simvastatin).
- Concomitant administration of clarithromycin and lomitapide is contraindicated (see section 4.5).

Clarithromycin should not be given to patients with history of QT prolongation (congenital or documented acquired QT prolongation) or ventricular cardiac arrhythmia, including torsades de pointe (see sections 4.4 and 4.5).

Clarithromycin should not be given to patients with electrolyte disturbances (hypokalaemia or hypomagnesaemia, due to the risk of prolongation of the QT interval).

Clarithromycin must not be used in patients who suffer from severe hepatic failure in combination with renal impairment.

4.4 Special warnings and precautions for use

The selection of clarithromycin to treat an individual patient should take into account the appropriateness of using a macrolide antibacterial agent based on adequate diagnosis to ascertain the bacterial etiology of the infection in the approved indications and the prevalence of resistance to clarithromycin or other macrolides. In areas with a high incidence of erythromycin A resistance, it is especially important to take into consideration the evolution of the pattern of susceptibility to clarithromycin and other antibiotics. As for other macrolides, high resistance rates of *Streptococcus pneumoniae* have been reported for clarithromycin in some European countries (see section 5.1). This should be taken into account when treating infections caused by *Streptococcus pneumoniae*. In bacterial pharyngitis the use of clarithromycin is recommended only in cases where first line therapy with beta-lactams is not possible.

The physician should not prescribe clarithromycin to pregnant women without carefully weighing the benefits against risk, particularly during the first three months of pregnancy (see section 4.6).

Caution is advised in patients with moderate to severe renal insufficiency (see section 4.2).

Clarithromycin is principally excreted by the liver. Therefore, caution should be exercised in administering this antibiotic to patients with impaired hepatic function.

Cases of fatal hepatic failure (see section 4.8) have been reported. Some patients may have had pre-existing hepatic disease or may have been taking other hepatotoxic medicinal products. Patients should be advised to stop treatment and contact their doctor if signs and symptoms of hepatic disease develop, such as anorexia, jaundice, dark urine, pruritus, or tender abdomen.

Pseudomembranous colitis has been reported with nearly all antibacterial agents, including macrolides, and may range in severity from mild to lifethreatening. Clostridium difficile-associated diarrhoea (CDAD) has been reported with use of nearly all antibacterial agents including clarithromycin, and may range in severity from mild diarrhoea to fatal colitis. Treatment with antibacterial agents alters the normal flora of the colon, which may lead to overgrowth of C. difficile. CDAD must be considered in all patients who present with diarrhoea following antibiotic use. Careful medical history is necessary since CDAD has been reported to occur over two months after the administration of antibacterial agents. Therefore, discontinuation of clarithromycin therapy should be considered regardless of the indication. Microbial testing should be performed and adequate treatment initiated. Drugs inhibiting peristalsis should be avoided.

Exacerbation of symptoms of myasthenia gravis has been reported in patients receiving clarithromycin therapy (see section 4.8).

Caution is advised regarding concomitant administration of clarithromycin and triazolobenzodiazepines, such as triazolam, and midazolam (see section 4.5).

Caution is advised regarding concomitant administration of clarithromycin with other ototoxic drugs, especially with aminoglycosides. Monitoring of vestibular and auditory function should be carried out during and after treatment.

Cardiovascular Events

Prolonged cardiac repolarisation and QT interval, imparting a risk of developing cardiac arrhythmia and torsade de pointes, have been seen in treatment with macrolides including clarithromycin (see section 4.8). Therefore as the following situations may lead to an increased risk for ventricular arrhythmias (including torsade de pointes), clarithromycin should be used with caution in the following patients;

- Patients with coronary artery disease, severe cardiac insufficiency, conduction disturbances or clinically relevant, bradycardia
- Clarithromycin must not be given to patients with hypokalaemia (see section 4.3).
- Patients concomitantly taking other medicinal products associated with QT prolongation (see section 4.5).
- Concomitant administration of clarithromycin with astemizole, cisapride, pimozide and terfenadine is contraindicated (see section 4.3).
- Clarithromycin must not be used in patients with congenital or documented acquired QT prolongation or history of ventricular arrhythmia (see section 4.3).

Epidemiological studies investigating the risk of adverse cardiovascular outcomes with macrolides have shown variable results. Some observational studies have identified a rare short-term risk of arrhythmia, myocardial infarction and cardiovascular mortality associated with macrolides including clarithromycin. Consideration of these findings should be balanced with treatment benefits when prescribing clarithromycin.

Pneumonia: In view of the emerging resistance of Streptococcus pneumoniae to macrolides, it is important that sensitivity testing be performed when prescribing clarithromycin for community-acquired pneumonia. In hospital-acquired pneumonia, clarithromycin should be used in combination with additional appropriate antibiotics.

Skin and soft tissue infections of mild to moderate severity: These infections are most often caused by Staphylococcus aureus and Streptococcus pyogenes, both of which may be resistant to macrolides. Therefore, it is important that sensitivity testing be performed. In cases where beta-lactam antibiotics cannot be used (e.g. allergy), other antibiotics, such as clindamycin, may be the drug of first choice. Currently, macrolides are only considered to play a role in some skin and soft tissue infections, such as

those caused by *Corynebacterium minutissimum* (erythrasma), acne vulgaris, and erysipelas and in situations where penicillin treatment cannot be used.

In the event of severe acute hypersensitivity reactions, such as anaphylaxis, severe cutaneous adverse reactions (SCAR) (e.g. Acute generalised exanthematous pustulosis (AGEP), Stevens-Johnson Syndrome, toxic epidermal necrolysis, DRESS and Henoch-Schonlein purpura, clarithromycin therapy should be discontinued immediately and appropriate treatment should be urgently initiated.

Medications induce cytochrome CYP3A4 enzyme:

Clarithromycin should be used with caution when administered concurrently with medications that induce the cytochrome CYP3A4 enzyme (see section 4.5).

HMG-CoA Reductase Inhibitors (statins): Concomitant use of clarithromycin with lovastatin or simvastatin is contraindicated (see section 4.3). Caution should be exercised when prescribing clarithromycin with other statins. Rhabdomyolysis has been reported in patients taking clarithromycin and statins. Patients should be monitored for signs and symptoms of myopathy.

In situations where the concomitant use of clarithromycin with statins cannot be avoided, it is recommended to prescribe the lowest registered dose of the statin. Use of a statin that is not dependent on CYP3A metabolism (e.g. fluvastatin) can be considered (see section 4.5).

Oral hypoglycemic agents/Insulin: The concomitant use of clarithromycin and oral hypoglycemic agents (such as sulphonylurias) and/or insulin can result in significant hypoglycemia. Careful monitoring of glucose is recommended (see section 4.5).

Oral anticoagulants: There is a risk of serious haemorrhage and significant elevations in International Normalized Ratio (INR) and prothrombin time when clarithromycin is co-administered with warfarin (see section 4.5). INR and prothrombin times should be frequently monitored while patients are receiving clarithromycin and oral anticoagulants concurrently. Caution should be exercised when clarithromycin is co-administered with direct acting oral anticoagulants such as dabigatran, rivaroxaban and apixaban, particularly to patients at high risk of bleeding (see section 4.5).

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

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

Attention should also be paid to the possibility of cross resistance between clarithromycin and other macrolide drugs, as well as lincomycin and clindamycin.

Excipients

This medicine contains less than 1 mmol sodium (23 mg) per tablet, that is to say essentially 'sodium-free'.

4.5 Interaction with other medicinal products and other forms of interactions

The use of the following drugs is strictly contraindicated due to the potential for severe drug interaction effects (see section 4.3):

Cisapride, pimozone, astemizole and terfenadine:

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 torsades de pointes. Similar effects have been observed in patients taking clarithromycin and pimozone concomitantly. Macrolides have been reported to alter the metabolism of terfenadine resulting in increased levels of terfenadine which has occasionally been associated with cardiac arrhythmias, such as QT prolongation, ventricular tachycardia, ventricular fibrillation and torsades de pointes. In one study in 14 healthy volunteers, the concomitant administration of clarithromycin and terfenadine resulted in 2- to 3-fold increase in the serum level of the acid metabolite of terfenadine and in prolongation of the QT interval which did not lead to any clinically detectable effect. Similar effects have been observed with concomitant administration of astemizole and other macrolides.

Ergotamine/dihydroergotamine:

Post-marketing reports indicate that co-administration of clarithromycin with ergotamine or dihydroergotamine has been associated with acute ergot toxicity characterized by vasospasm, and ischaemia of the extremities and other tissues including the central nervous system. Concomitant administration of clarithromycin and these medicinal products is contraindicated (see section 4.3).

Colchicine, since it is a substrate for both CYP3A and the efflux transporter, P-glycoprotein (Pgp). Clarithromycin and other macrolides are known to inhibit CYP3A and Pgp. If administered together with clarithromycin, exposure to colchicine may be increased which increases its adverse events with potentially fatal outcomes, especially in patients with renal or hepatic impairment who also use an inhibitor of P-glycoprotein or a strong CYP3A inhibitor (see section 4.3 and 4.4).

HMG-CoA Reductase Inhibitors (statins)

Concomitant use of clarithromycin with lovastatin or simvastatin is contraindicated (see 4.3) as these statins are extensively metabolized by CYP3A4 and concomitant treatment with clarithromycin increases their plasma concentration, which increases the risk of myopathy, including rhabdomyolysis. Reports of rhabdomyolysis have been received for patients taking clarithromycin concomitantly with these statins. If treatment with clarithromycin cannot be avoided, therapy with lovastatin or simvastatin must be suspended during the course of treatment.

Caution should be exercised when prescribing clarithromycin with statins. In situations where the concomitant use of clarithromycin with statins cannot be avoided, it is recommended to prescribe the lowest registered dose of the statin. Use of a statin that is not dependent on CYP3A metabolism (e.g. fluvastatin) can be considered. Patients should be monitored for signs and symptoms of myopathy.

Effects of Other Medicinal Products on Clarithromycin

Drugs that are inducers of CYP3A (e.g. rifampicin, phenytoin, carbamazepine, phenobarbital, St John's wort) may induce the metabolism of clarithromycin. This may result in sub-therapeutic levels of clarithromycin leading to reduced efficacy. 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). Concomitant administration of rifabutin and clarithromycin resulted in an increase in rifabutin, and decrease in clarithromycin serum levels together with an increased risk of uveitis.

The following drugs are known or suspected to affect circulating concentrations of clarithromycin; clarithromycin dosage adjustment or consideration of alternative treatments may be required.

Efavirenz, nevirapine, rifampicin, rifabutin and rifapentine

Strong inducers of the cytochrome P450 metabolism system such as efavirenz, nevirapine, rifampicin, rifabutin, 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.

Etravirine

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.

Fluconazole

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 minimum clarithromycin concentration (C_{min}) and area under the curve (AUC) of 33% and 18% respectively. Steady state concentrations of the active metabolite 14-OH-clarithromycin were not significantly affected by concomitant administration of fluconazole. No clarithromycin dose adjustment is necessary.

Oral anticoagulants

Simultaneous administration of clarithromycin with warfarin may increase its anticoagulant effects. There have been many reports of increases in oral anti-coagulant activity in patients receiving antibacterial agents, including macrolides. The risk may vary with the underlying infection, age and general status of the patient so that the contribution of the macrolides to the increase in INR (international normalised ratio) is difficult to assess. It is recommended that the INR should be monitored frequently during and shortly after co-administration of macrolides with an oral anticoagulant agent".

Ritonavir

A pharmacokinetic study demonstrated that the concomitant administration of ritonavir 200 mg every eight 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-OH-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 CL_{CR} 30 to 60 mL/min the dose of clarithromycin should be reduced by 50%. For patients with $CL_{CR} < 30$ mL/min the dose of clarithromycin should be decreased by 75%. Doses of clarithromycin greater than 1 gm/day should not be co-administered with ritonavir.

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 (see section below, Bi-directional drug interactions).

Effect of Clarithromycin on Other Medicinal Products

CYP3A-based interactions

Co-administration of clarithromycin, known to inhibit CYP3A, and a drug primarily metabolised by CYP3A may be associated with elevations in drug concentrations that could increase or prolong both therapeutic and adverse effects of the concomitant drug. Clarithromycin should be used with caution in patients receiving treatment with other drugs known to be CYP3A enzyme substrates, especially if the CYP3A substrate has a narrow safety margin (e.g. carbamazepine) and/or the substrate is extensively metabolised by this enzyme.

Dosage adjustments may be considered, and when possible, serum concentrations of drugs primarily metabolised by CYP3A should be monitored closely in patients concurrently receiving clarithromycin.

The following drugs or drug classes are known or suspected to be metabolized by the same CYP3A isozyme: alprazolam, astemizole, carbamazepine, cilostazol, cisapride, ciclosporin, disopyramide, ergot alkaloids, lovastatin, methylprednisolone, midazolam, omeprazole, oral anticoagulants (e.g. warfarin, rivaroxaban, apixaban), atypical antipsychotics (e.g. quetiapine), pimozide, quinidine, rifabutin, sildenafil, simvastatin, sirolimus, tacrolimus, terfenadine, triazolam and vinblastine. Drugs interacting by similar mechanisms through other isozymes within the cytochrome P450 system include phenytoin, theophylline and valproate.

Direct acting oral anticoagulants (DOACs)

The DOAC dabigatran is a substrate for the efflux transporter P-gp. Rivaroxaban and apixaban are metabolised via CYP3A4 and are also substrates for P-gp. Caution should be exercised when clarithromycin is co-administered with these agents particularly to patients at high risk of bleeding (see section 4.4).

Oral hypoglycemic agents/Insulin

The concomitant use of clarithromycin and oral hypoglycemic agents and/or insulin can result in significant hypoglycemia. With certain hypoglycemic drugs such as nateglinide, pioglitazone, repaglinide and rosiglitazone, inhibition of CYP3A enzyme by clarithromycin may be involved and could cause hypoglycemia when used concomitantly. Careful monitoring of glucose is recommended.

Antiarrhythmics

There have been post-marketed reports of torsade de points occurring with the concurrent use of clarithromycin and quinidine or disopyramide. Electrocardiograms should be monitored for QTc prolongation during co-administration of clarithromycin with these active substances. Serum levels of quinidine and disopyramide should be monitored during clarithromycin therapy.

Omeprazole

Clarithromycin (500 mg every 8 hours) was given in combination with omeprazole (40 mg daily) to healthy adult subjects. The steady-state plasma concentrations of omeprazole were increased (C_{max} , AUC_{0-24} , and $t_{1/2}$ increased by 30%, 89%, and 34%, respectively), by the concomitant administration of clarithromycin. The mean 24-hour gastric pH value was 5.2 when omeprazole was administered alone and 5.7 when omeprazole was co-administered with clarithromycin.

Sildenafil, tadalafil and vardenafil

Each of these phosphodiesterase inhibitors is metabolised, 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.

Theophylline, carbamazepine

Results of clinical studies indicate that there was a modest but statistically significant ($p \leq 0.05$) increase of circulating theophylline or carbamazepine levels when either of these drugs were administered concomitantly with clarithromycin. Dose reduction may need to be considered.

Tolterodine

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 and with a potential risk for overdose. A reduction in tolterodine dosage may be necessary in the presence of CYP3A inhibitors, such as clarithromycin in the CYP2D6 poor metaboliser population.

Triazolobenzodiazepines (e.g., alprazolam, midazolam, triazolam)

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. The same precautions should also apply to other benzodiazepines that are metabolised 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 drug interactions

Digoxin

Digoxin is thought to be a substrate for the efflux transporter, P-glycoprotein (Pgp). Clarithromycin is known to inhibit Pgp. When clarithromycin and digoxin are administered together, inhibition of Pgp by clarithromycin may lead to increased exposure to digoxin. Elevated digoxin serum concentrations in patients receiving clarithromycin and digoxin concomitantly have also been reported in post marketing surveillance. Some patients have shown clinical signs consistent with digoxin toxicity, including potentially fatal arrhythmias.

Serum digoxin concentrations should be carefully monitored while patients are receiving digoxin and clarithromycin simultaneously.

Zidovudine

Simultaneous oral administration of clarithromycin tablets and zidovudine to HIV-infected adult patients may result in decreased steady-state zidovudine concentrations. Because clarithromycin appears to interfere with the absorption of simultaneously administered oral zidovudine, this interaction can be largely avoided by staggering the doses of clarithromycin and zidovudine to allow for a 4-hour interval between each medication. This interaction does not appear to occur in paediatric HIV-infected patients taking Clarithromycin suspension with zidovudine or dideoxyinosine. This interaction is unlikely when clarithromycin is administered via intravenous infusion.

Phenytoin and Valproate

There have been spontaneous or published reports of interactions of CYP3A inhibitors, including clarithromycin with drugs not thought to be metabolized by CYP3A (e.g. phenytoin and valproate). Serum level determinations are recommended for these drugs when administered concomitantly with clarithromycin. Increased serum levels have been reported.

Bi-directional drug interactions

Atazanavir

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 coadministered with protease inhibitors.

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. Plasma concentrations of clarithromycin as well as calcium channel blockers may increase due to the interaction. Hypotension, bradyarrhythmias and lactic acidosis have been observed in patients taking clarithromycin and verapamil concomitantly.

Itraconazole

Both clarithromycin and itraconazole are substrates and inhibitors of CYP3A, leading to a bidirectional 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 increased or prolonged pharmacologic effect.

Saquinavir

Both clarithromycin and saquinavir are substrates and inhibitors of CYP3A, and there is evidence of a bi-directional drug interaction. 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. No dose adjustment is required when the two drugs are co-administered for a limited time at the doses/formulations studied. 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.

Verapamil

Hypotension, bradyarrhythmias and lactic acidosis have been observed in patients taking clarithromycin and verapamil concomitantly. Clarithromycin has been shown not to interact with oral contraceptives.

Concomitant administration of clarithromycin with lomitapide is contraindicated due to the potential for markedly increased transaminases (see section 4.3).

4.6 Fertility, pregnancy and lactation

Pregnancy

The safety of clarithromycin for use in pregnancy has not been established. Based on variable results obtained from animal studies and experience in humans, the possibility of adverse effects on embryofoetal development cannot be excluded. Some observational studies evaluating exposure to clarithromycin during the first and second trimester have reported an increased risk of miscarriage compared to no antibiotic use or other antibiotic use during the same period. The available epidemiological studies on the risk of major congenital malformations with use of macrolides including clarithromycin during pregnancy provide conflicting results.

Data from animal studies have shown reproductive toxicity (see section 5.3). The risk for humans is unknown. Therefore, use during pregnancy is not advised without carefully weighing the benefits against risks.

Breast-feeding

Clarithromycin and its active metabolite are excreted in breast milk in small amounts. It has been estimated that an exclusively breastfed infant would receive about 1.7% of the maternal weight-adjusted dose of clarithromycin. Diarrhoea and fungus infection of the mucous membranes could occur in the breast-fed infant, so that nursing might have to be discontinued. The possibility of sensitisation should be considered. The benefit of treatment of the mother should be weighed against the potential risk for the infant.

Fertility

There is no data available on the effect of clarithromycin on fertility in humans. In rats, the limited data available do not indicate any effects on fertility.

4.7 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.

4.8 Undesirable effects**a. Summary of the safety profile**

The most frequent and common adverse reactions related to clarithromycin therapy for both adult and paediatric populations are abdominal pain, diarrhoea, nausea, vomiting and taste perversion. These adverse reactions are usually mild in intensity and are consistent with the known safety profile of macrolide antibiotics (see section b of section 4.8).

There was no significant difference in the incidence of these gastrointestinal adverse reactions during clinical trials between the patient population with or without pre-existing mycobacterial infections.

b. Tabulated summary of adverse reactions

The following table displays adverse reactions reported in clinical trials and from post-marketing experience with clarithromycin immediate-release tablets, granules for oral suspension, powder for solution for injection, extended-release tablets and modified-release tablets.

The reactions considered at least possibly related to clarithromycin are displayed by system organ class and frequency using the following convention: very common ($\geq 1/10$), common ($\geq 1/100$ to $< 1/10$), uncommon ($\geq 1/1,000$ to $< 1/100$) and not known (adverse reactions from post-marketing experience; cannot be estimated from the available data). Within each frequency grouping, adverse reactions are presented in order of decreasing seriousness when the seriousness could be assessed.

System Organ Class	Very common $\geq 1/10$	Common $\geq 1/100$ to $< 1/10$	Uncommon $\geq 1/1,000$ to $< 1/100$	Not Known* (cannot be estimated from the available data)
Infections and infestations			Cellulitis ¹ , candidiasis, gastroenteritis ² , infection ³ , vaginal infection	Pseudomembranous colitis, erysipelas, erythrasma
Blood and lymphatic system			Leukopenia, neutropenia ⁴ , thrombocythaemia ³ , eosinophilia ⁴	Agranulocytosis, thrombocytopenia
Immune system disorders ⁵			Anaphylactoid reaction ¹ , hypersensitivity	Anaphylactic reaction
Metabolism and nutrition disorders			Anorexia, decreased appetite	Hypoglycaemia ⁶
Psychiatric disorders		Insomnia	Anxiety, nervousness ³	Psychotic disorder, confusional state, depersonalisation, depression, disorientation, hallucination, abnormal dreams
Nervous system disorders		Dysgeusia, headache, taste perversion	Loss of consciousness ¹ , dyskinesia ¹ , dizziness, somnolence ⁷ , tremor	Convulsion, ageusia, parosmia, anosmia, Myasthenia gravis (see section 4.4)
Ear and labyrinth disorders			Vertigo, hearing impaired, tinnitus	Deafness

Cardiac disorders			Cardiac arrest ¹ , atrial fibrillation ¹ , electrocardiogram QT prolonged ⁸ , extrasystoles ¹ , palpitations	Torsade de pointes ⁸ , ventricular tachycardia ⁸ , ventricular fibrillation
Vascular disorders		Vasodilation ¹		Haemorrhage ⁹
Respiratory, thoracic and mediastinal disorder			Asthma ¹ , epistaxis ² , pulmonary embolism ¹	
Gastrointestinal disorders		Diarrhoea ¹⁰ , vomiting, dyspepsia, nausea, abdominal pain	Oesophagitis ¹ , gastrooesophageal reflux disease ² , gastritis, proctalgia ² , stomatitis, glossitis, abdominal distension ⁴ , constipation, dry mouth, eructation, flatulence,	Pancreatitis acute, tongue discolouration, tooth discolouration ¹³
Hepatobiliary disorders		Liver function test abnormal	Cholestasis ⁴ , hepatitis ⁴ , alanine aminotransferase increased, aspartate aminotransferase increased, gamma-glutamyltransferase increased ⁴	Hepatic failure ¹¹ , jaundice hepatocellular
Skin and subcutaneous tissue disorders		Rash, hyperhidrosis	Dermatitis bullous ¹ , pruritus, urticaria, rash maculo-papular ³	Stevens-Johnson syndrome ⁵ , toxic epidermal necrolysis ⁵ , drug rash with eosinophilia and systemic symptoms (DRESS), acne, Henoch-Schönleins purpura, acute generalised exanthematous pustulosis (AGEP)
Musculoskeletal and connective tissue disorders			Muscle spasms ³ , musculoskeletal stiffness ¹ , myalgia ²	Rhabdomyolysis ^{2,12} , myopathy
Renal and urinary disorders			Blood creatinine increased ¹ , blood urea increased ¹	Renal failure, nephritis interstitial
General disorders and administration site conditions	Injection site phlebitis ¹	Injection site pain ¹ , injection site inflammation ¹	Malaise ⁴ , pyrexia ³ , asthenia, chest pain ⁴ , chills ⁴ , fatigue ⁴	
Investigations			Albumin globulin ratio abnormal ¹ , blood alkaline phosphatase increased ⁴ , blood lactate dehydrogenase increased ⁴	International normalised ratio increased ⁹ , prothrombin time prolonged ⁹ , urine color abnormal

¹ ADRs reported only for the Powder for Solution for Injection formulation² ADRs reported only for the Extended-Release Tablets formulation³ ADRs reported only for the Granules for Oral Suspension formulation⁴ ADRs reported only for the Immediate-Release Tablets formulation

^{5,8,10,11,12} See section 4.8 a)

^{6,7,9} See section 4.8 c)¹³ Tooth discolouration is usually reversible through professional dental cleaning assistance.

c. Description of selected adverse reactions

Injection site phlebitis, injection site pain, vessel puncture site pain, and injection site inflammation are specific to the clarithromycin intravenous formulation.

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 (see section 4.4).

A special attention to diarrhoea should be paid as *Clostridium difficile*-associated diarrhoea (CDAD) has been reported with use of nearly all antibacterial agents including clarithromycin, and may range in severity from mild diarrhoea to fatal colitis. (see section 4.4)

In the event of severe acute hypersensitivity reactions, such as anaphylaxis, Stevens-Johnson Syndrome and toxic epidermal necrolysis, clarithromycin therapy should be discontinued immediately and appropriate treatment should be urgently initiated (see section 4.4).

As with other macrolides, QT prolongation, ventricular tachycardia, and *torsade de pointes* have rarely been reported with clarithromycin (see section 4.4 and 4.5).

Pseudomembranous colitis has been reported with nearly all antibacterial agents, including clarithromycin, and may range in severity from mild to life threatening. Therefore, it is important to consider this diagnosis in patients who present with diarrhoea subsequent to the administration of antibacterial agents (see section 4.4).

In some of the reports of rhabdomyolysis, clarithromycin was administered concomitantly with statins, fibrates, colchicine or allopurinol (see section 4.3 and 4.4).

There have been postmarketing reports of colchicine toxicity with concomitant use of clarithromycin and colchicine, especially in elderly and/or patients with renal insufficiency, some with a fatal outcome (see sections 4.4 and 4.5).

There have been rare reports of hypoglycaemia, some of which have occurred in patients on concomitant oral hypoglycaemic agents or insulin (see section 4.4 and 4.5).

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 (see section 4.5).

There is a risk of serious haemorrhage and significant elevations in 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 section 4.4 and 4.5).

There have been rare reports of clarithromycin ER 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 diarrhoea. 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.

Special population: Adverse Reactions in Immunocompromised Patients (see section e).

d. Paediatric populations

Clinical trials have been conducted using clarithromycin paediatric suspension in children 6 months to 12 years of age. Therefore, children under 12 years of age should use clarithromycin paediatric suspension.

e. Other special populations

Immunocompromised patients

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

In adult patients, the most frequently reported adverse reactions by patients treated with total daily doses of 1000mg and 2000mg of clarithromycin were: nausea, vomiting, taste perversion, abdominal pain, diarrhoea, rash, flatulence, headache, constipation, hearing disturbance, Serum Glutamic Oxaloacetic Transaminase (SGOT) and Serum Glutamic Pyruvate Transaminase (SGPT) elevations. Additional low-frequency events included dyspnoea, insomnia and dry mouth. The incidences were comparable for patients treated with 1000mg and 2000mg, but were generally about 3 to 4 times as frequent for those patients who received total daily doses of 4000mg of clarithromycin.

In these immunocompromised patients, 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. On the basis of these criteria, about 2% to 3% of those patients who received 1000mg or 2000mg of clarithromycin daily had seriously abnormal elevated levels of SGOT and SGPT, and abnormally low white blood cell and platelet counts. A lower percentage of patients in these two dosage groups also had elevated Blood Urea Nitrogen levels. Slightly higher incidences of abnormal values were noted for patients who received 4000 mg daily for all parameters except White Blood Cell.

Reporting of suspected adverse reactions

Reporting suspected adverse reactions after authorisation of the medicinal product is important. It allows continued monitoring of the benefit/risk balance of the medicinal product. Healthcare professionals are asked to report any suspected adverse reactions via

HPRA Pharmacovigilance

Website: www.hpra.ie

4.9 Overdose

Symptoms of intoxication

Reports indicate that the ingestion of large amounts of clarithromycin can be expected to produce gastro-intestinal symptoms. One patient who had a history of bipolar disorder ingested 8 grams of clarithromycin and showed altered mental status, paranoid behaviour, hypokalemia and hypoxemia.

Therapy of intoxication

There is no specific antidote on overdose. Serum levels of clarithromycin can not be reduced by haemodialysis or peritoneal dialysis.

Adverse reactions accompanying overdosage should be treated by gastric lavage and supportive measures.

5 PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: Antibacterial for systemic use, macrolide

ATC code: J01FA09

Mechanism of action

Clarithromycin is a semi-synthetic derivative of erythromycin A. It exerts its antibacterial action by binding to the 50s ribosomal sub-unit of susceptible bacteria and suppresses protein synthesis. It is highly potent against a wide variety of aerobic and anaerobic gram-positive and gram-negative organisms. The minimum inhibitory concentrations (MICs) of clarithromycin are generally two-fold lower than the MICs of erythromycin.

The 14-hydroxy metabolite of clarithromycin also has antimicrobial activity. The MICs of this metabolite are equal or two-fold higher than the MICs of the parent compound, except for *H. influenzae* where the 14-hydroxy metabolite is two-fold more active than the parent compound.

PK/PD Relationship

Clarithromycin is extensively distributed in body tissues and fluids. Because of high tissue penetration, intracellular concentrations are higher than serum concentrations.

The most important pharmacodynamic parameters for predicting macrolide activity are not conclusively established. The time above MIC (T/MIC) may correlate best with efficacy for clarithromycin, however since clarithromycin concentrations achieved in respiratory tissues and epithelial lining fluids exceed those in plasma, using parameters based on plasma concentrations may fail to predict accurately the response for respiratory tract infections.

Mechanisms of resistance

Resistance mechanisms against macrolide antibiotics include alteration of the target site of the antibiotic or are based on modification and/or the active efflux of the antibiotic. Resistance development can be mediated via chromosomes or plasmids, be induced or exist constitutively. Macrolide-resistant bacteria generate enzymes which lead to methylation of residual adenine at ribosomal RNA and consequently to inhibition of the antibiotic binding to the ribosome. Macrolide-resistant organisms are generally cross-resistant to lincosamides and streptogramin B based on methylation of the ribosomal binding site. Clarithromycin ranks among the strong inducers of this enzyme as well. Furthermore, macrolides have a bacteriostatic action by inhibiting the peptidyl transferase of ribosomes.

A complete cross-resistance exists among clarithromycin, erythromycin and azithromycin. Methicillin-resistant staphylococci and penicillin-resistant *Streptococcus pneumoniae* are resistant to macrolides such as clarithromycin.

Breakpoints

The following breakpoints for clarithromycin, separating susceptible organisms from resistant organisms, have been established by the European Committee for Antimicrobial Susceptibility Testing (EUCAST) 2010-04-27 (v 1.1).

Species-related breakpoints for clarithromycin^{B,C}		
Pathogens	Susceptible (\leq) (mg/L)	Resistant ($>$) (mg/L)
<i>Enterobacteriaceae</i>	-	-
<i>Pseudomonas spp.</i>	-	-
<i>Acinetobacter spp.</i>	-	-
<i>Staphylococcus spp.</i>	1	2
<i>Enterococcus spp.</i>	-	-
<i>Streptococcus groups A, B, C and G</i>	0.25	0.5
<i>Streptococcus pneumoniae D</i>	0.25	0.5
<i>Other streptococci</i>	IE	IE
<i>Haemophilus influenzae</i>	1	32
<i>Moraxella catarrhalis</i>	0.25	0.5
<i>Neisseria gonorrhoeae</i>	-	-
<i>Neisseria meningitidis</i>	-	-
<i>Gram-positive anaerobes (except Clostridium difficile)</i>	-	-
<i>Gram-negative anaerobes</i>	-	-
<i>Non-species related break-points A</i>	IE	IE

A. Non-species related breakpoints have been determined mainly on the basis of PK/PD data and are independent of MIC distributions of specific species. They are for use only for species not mentioned in the table or footnotes. However, pharmacodynamic data for calculation of macrolide, lincosamines and streptogramins non-species related breakpoints are not robust, hence IE.

B. Erythromycin can be used to determine the susceptibility of the listed bacteria to the other macrolides (azithromycin, clarithromycin and roxithromycin).

C. Clarithromycin is used for the eradication of *H. pylori* (MIC \leq 0.25 mg/L for wild type isolates).

D. The correlation between *H. influenzae* macrolide MICs and clinical outcome is weak. Therefore, breakpoints for macrolides and related antibiotics were set to categorise wild type *H. influenzae* as intermediate.

IE – Insufficient evidence that the species in question is a good target for therapy with the drug.

Clarithromycin is used for the eradication of *H. pylori*; minimum inhibitory concentration (MIC) \leq 0.25 microgram/ml which has been established as the susceptible breakpoint by the Clinical and Laboratory Standards Institute (CLSI).

Susceptibility

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

Commonly susceptible species
Aerobic Gram-positive microorganisms
<i>Corynebacterium diphtheriae</i>
<i>Streptococcus</i> Group F
Aerobic Gram-negative microorganisms
<i>Bordetella pertussis</i>
<i>Legionella</i> spp.
<i>Moraxella catarrhalis</i>
<i>Pasteurella multocida</i>
Anaerobes
<i>Clostridium</i> spp. other than <i>C.difficile</i>
Other microorganisms
<i>Chlamydia trachomatis</i>
<i>Chlamydia pneumoniae</i>
<i>Clamydophilapsitacci</i>
<i>Mycoplasma pneumoniae</i>
<i>Mycobacterium</i> spp.
Species for which acquired resistance may be a problem
Aerobic Gram-positive microorganisms
<i>Enterococcus</i> spp.+
<i>Staphylococcus aureus</i> (methicillin-susceptible and methicillin-resistant+)
<i>Staphylococcus epidermidis</i> +
<i>Streptococcus</i> Group A*, B, C, G
<i>Streptococcus viridans</i>
<i>Streptococcus pneumoniae</i> *+
Aerobic Gram-negative microorganisms
<i>Haemophilus influenzae</i> §
<i>Helicobacter pylori</i>
Anaerobes
<i>Bacteroides</i> spp.
<i>Peptococcus/Peptostreptococcus</i> spp.
Inherently resistant organisms
Aerobic Gram-negative microorganisms
<i>Acinetobacter</i>
Enterobacteriaceae
<i>Pseudomonas aeruginosa</i>
Anaerobes
<i>Fusobacterium</i> spp.
Other microorganisms
<i>Mycobacterium tuberculosis</i>

≥ 10% resistance in at least one country of the European Union

* Species against efficacy has been demonstrated in clinical investigations (if susceptible)

+ Indicates species for which a high rate of resistance (i.e. greater than 50%) have been observed in one or more area/country/region(s) of the EU

§ Breakpoints for macrolides and related antibiotics were set to categorise wild type *H.influenzae* as *intermediate*

Other information

Susceptibility and resistance of *Streptococcus pneumoniae* and *Streptococcus* spp. to clarithromycin can be predicted by testing erythromycin.

Most available clinical experience from controlled randomised clinical trials indicate that clarithromycin 500 mg twice daily in combination with another antibiotic e.g. amoxicillin or metronidazole and e.g. omeprazole (given at approved levels) for 7 days achieve > 80% *H. pylori* eradication rate in patients with gastro-doudenal ulcers. As expected, significantly lower eradication rates were observed in patients with baseline metronidazole-resistant *H. pylori* isolates. Hence, local information on the prevalence of resistance and local therapeutic guidelines should be taken into account in the choice of an appropriate combination regimen for *H. pylori* eradication therapy. Furthermore, in patients with persistent infection, potential development of secondary resistance (in patients with primary susceptible strains) to an antimicrobial agent should be taken into the considerations for a new treatment regimen.

5.2 Pharmacokinetic properties

Absorption

Clarithromycin is rapidly and well absorbed from the gastrointestinal tract - primarily in the jejunum - but undergoes extensive first-pass metabolism after oral administration. The absolute bioavailability of a 250 mg clarithromycin tablet is approximately 50%. Food slightly delays the absorption but does not affect the extent of bioavailability. Therefore, clarithromycin tablets may be given without regard to food. Due to its chemical structure (6-O-methylerythromycin) clarithromycin is quite resistant to degradation by stomach acid. Peak plasma levels of 1-2 microgram/ml clarithromycin were observed in adults after oral administration of 250 mg twice daily. After administration of 500 mg clarithromycin twice daily the peak plasma level was 2.8 microgram/ml.

After administration of 250 mg clarithromycin twice daily the microbiologically active 14-hydroxy metabolite attains peak plasma concentrations of 0.6 microgram/ml. Steady state is attained within 2 days of dosing.

Distribution

Clarithromycin penetrates well into different compartments, with an estimated volume of distribution of 200-400 l. Clarithromycin provides concentrations in some tissues that are several times higher than the circulating substance levels. Increased levels have been found in both tonsils and lung tissue. Clarithromycin also penetrates the gastric mucus.

Clarithromycin is approximately 80% bound to plasma proteins at therapeutic levels.

Biotransformation and elimination

Clarithromycin is rapidly and extensively metabolised in the liver involving the P450 cytochrome system. Metabolism involves mainly N-dealkylation, oxidation and stereospecific hydroxylation at position C 14.

The pharmacokinetics of clarithromycin is non-linear due to saturation of hepatic metabolism at high doses. The elimination half-life increased from 2-4 hours following administration of 250 mg clarithromycin twice daily to 5 hours following administration of 500 mg clarithromycin twice daily. The half-life of the active 14-hydroxy metabolite ranges between 5 to 6 hours following administration of 250 mg clarithromycin twice daily.

After oral administration of radioactive clarithromycin 70-80% of the radioactivity was found in the faeces. Approximately 20-30% of clarithromycin is collected as the unchanged active substance in the urine. This proportion is increased when the dose is increased. Renal insufficiency increases clarithromycin levels in plasma, if the dose is not decreased.

Total plasma clearance has been estimated to approximately 700 ml/min, with a renal clearance of approximately 170 ml/min.

Special populations

Renal impairment: Reduced renal function results in increased plasma levels of clarithromycin and the active metabolite levels in plasma.

5.3 Preclinical safety data

In 4-week-studies in animals, toxicity of clarithromycin was found to be related to the dose and to the duration of the treatment. In all species, the first signs of toxicity were observed in the liver, in which lesions were seen within 14 days in dogs and monkeys. The systemic levels of exposure, related to this toxicity, are not known in detail, but toxic doses (300 mg/kg/day) were clearly higher than the therapeutic doses recommended for humans. Other tissues affected included the stomach, thymus and other lymphoid tissues as well as the kidneys. At near therapeutic doses conjunctival injection and lacrimation occurred only in dogs. At a dose of 400mg/kg/day some dogs and monkeys developed corneal opacities and/or oedema. In vitro and in vivo studies showed that clarithromycin did not have genotoxic potential. No mutagenic effects were found in in vitro- and in vivo -studies with clarithromycin.

Studies on reproduction toxicity showed that administration of clarithromycin at doses 2x the clinical dose in rabbit (iv) and 10x the clinical dose in monkey (po) resulted in an increased incidence of spontaneous abortions. These doses were related to maternal toxicity. No embryotoxicity or teratogenicity was generally noted in rat studies. However, cardiovascular malformations were observed in two studies in rats treated with doses of 150 mg/kg/d. In mice at doses 70x the clinical dose, cleft palate occurred at varying incidence (3-30%). Clarithromycin has been found in the milk of lactating animals.

In 3-day old mice and rats, the LD50 values were approximately half those in adult animals. Juvenile animals presented similar toxicity profiles to mature animals although enhanced nephrotoxicity in neonatal rats has been reported in some studies. Slight reductions in erythrocytes, platelets and leukocytes have also been found in juvenile animals.

Clarithromycin has not been tested for carcinogenicity.

6 PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Tablet core:

Cellulose, microcrystalline(E460)

Croscarmellose sodium

Povidone K30

Talc (E553b)

Colloidal anhydrous silica

Magnesium stearate (E470b)

Stearic acid 50

Film-coating:

Opadry Yellow containing:

Hypromellose 2910 (5mPa.s) (E464)

Propylene glycol (E1520)

Titanium dioxide (E171)

Vanillin

Hydroxypropylcellulose (E463)

Talc (E553b)

Quinoline yellow (E104)

6.2 Incompatibilities

Not applicable.

6.3 Shelf life

3 years

6.4 Special precautions for storage

This medicinal product does not require any special temperature storage conditions. Store in the original package in order to protect from moisture.

6.5 Nature and contents of container

Tablets are packed in clear PVC/PVdC-Alu blister pack of 10, 12, 14, 16, 20, 21, 30, 250 or 500 tablets.

Not all pack sizes may be marketed.

6.6 Special precautions for disposal and other handling

Any unused medicinal product or waste material should be disposed of in accordance with local requirements.

7 MARKETING AUTHORISATION HOLDER

Accord Healthcare Ireland Ltd.

Euro House

Euro Business Park

Little Island

Cork T45 K857

Ireland

8 MARKETING AUTHORISATION NUMBER

PA2315/197/001

9 DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUTHORISATION

Date of first authorisation: 21st April 2017

Date of last renewal: 17th February 2022

10 DATE OF REVISION OF THE TEXT

April 2022