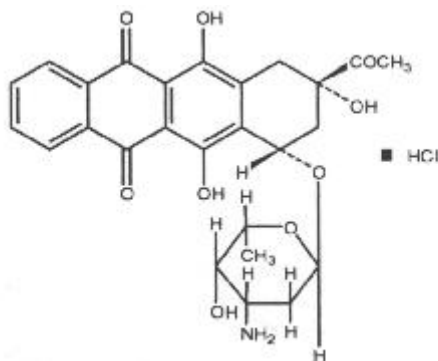


# DATASHEET

## IDARUBICIN EBEWE 1 mg/mL Injection

### NAME OF THE MEDICINE

Idarubicin hydrochloride



*Chemical name:* (7S, 9S) -9-acetyl-7, 8, 9, 10-tetrahydro-6,7,9,11- tetrahydroxy-7-O-(2, 3, 6-trideoxy-3-amino-α-L-lyxo-hexopyranosyl)-5, 12-naphthacenedione hydrochloride

*Molecular formula:* C<sub>26</sub>H<sub>27</sub>NO<sub>9</sub>·HCl

*Molecular weight:* 533.95

*CAS No:* 57852-57-0

### DESCRIPTION

Idarubicin Ebewe is a semi synthetic antineoplastic anthracycline for intravenous use. Idarubicin Ebewe solution for injection is a sterile, pyrogen-free, clear, red to orange, mobile solution in vials for intravenous administration and consists of idarubicin hydrochloride . The excipients included are glycerol, dilute hydrochloric acid, sodium hydroxide and water for injections.

### PHARMACOLOGY

Idarubicin hydrochloride is a cytotoxic agent. It is a DNA intercalating agent which reacts with topoisomerase II and has an inhibitory effect on nucleic acid synthesis. The compound has a high lipophilicity which results in an increased rate of cellular uptake compared with doxorubicin and daunorubicin.

Idarubicin hydrochloride has been shown to have a higher potency with respect to daunorubicin and to be an effective agent against murine leukaemia and lymphomas both by intravenous and oral routes. Studies *in vitro* on human and murine

anthracycline-resistant cells have shown a lower degree of cross-resistance for idarubicin compared with doxorubicin and daunorubicin. Cardiotoxicity studies in animals have indicated that idarubicin has a better therapeutic index than daunorubicin and doxorubicin. The main metabolite idarubicinol, has shown antitumour activities in experimental models both *in vitro* and *in vivo*. In the rat, idarubicinol, administered the same doses as the parent drug, is less cardiotoxic than idarubicin.

### **Pharmacokinetics**

After intravenous administration of idarubicin, there is triphasic disposition in plasma. Estimates of the plasma half-life for the parent compound range from 10 to 35 hours. Idarubicin is extensively metabolised to an active metabolite idarubicinol, which has a plasma half-life ranging from 41 to 69 hours.

The plasma clearance is higher than the expected hepatic plasma flow, indicating extensive extrahepatic metabolism. Protein binding in plasma is 97% for idarubicin and 94% for idarubicinol. For both compounds, the binding is concentration-independent.

Peak cellular idarubicin concentrations are reached a few minutes after injection. Idarubicin and idarubicinol concentrations in nucleated blood and bone marrow cells are more than a hundred times the plasma concentrations. Idarubicin elimination half-life in cells is about 15 hours and is similar to that in plasma. The elimination half-life for idarubicinol in cells is 72 hours.

Excretion takes place via the liver and kidneys, mainly in the form of idarubicinol. After intravenous administration of 13 mg/ m<sup>2</sup> <sup>14</sup>C -idarubicin, 33% of the dose was excreted in urine and 39% in faeces after 14 days. Idarubicin excreted unchanged in urine accounts for 2-7% of the dose, and idarubicinol, 9-13%. In a patient with percutaneous biliary drainage, 17% of the dose was eliminated through the bile (as idarubicin plus idarubicinol) over five days.

After oral administration to patients with normal renal and hepatic function, idarubicin is rapidly absorbed, reaching maximum concentrations between 2-4 hours post dose. Idarubicin is eliminated from the systemic circulation with an elimination plasma t<sub>1/2</sub> ranging between 10-35 hours and is extensively metabolised to an active metabolite, idarubicinol, which is more slowly eliminated with a plasma t<sub>1/2</sub> ranging between 33 and 60 hours. After oral administration of 46 mg/m<sup>2</sup> <sup>14</sup>C-idarubicin, 30% of the dose was excreted in urine and 61% in faeces after 14 days. Idarubicin excreted unchanged in urine accounts for 1-2% of the dose, and idarubicinol, 5%. In a patient with percutaneous biliary drainage, 8% of the dose was eliminated through the bile (as idarubicin plus idarubicinol) over five days.

The absolute bioavailability of idarubicin has been shown to range between 18 and 39%, whereas that calculated from the data on the active metabolite, idarubicinol, is somewhat higher (29-58%). The effective bioavailability, calculated on the basis of the pharmacological response, is approximately 35%. Studies on cellular (nucleated blood and bone marrow cells) drug concentrations in leukaemic patients have shown that uptake is rapid and most parallels the appearance of the drug in plasma. Idarubicin and idarubicinol concentrations in nucleated blood and bone marrow cells

are more than two hundred times the plasma concentrations. Idarubicin and idarubicinol disappearance rates in plasma and cells were almost comparable.

Only limited information is available regarding the effect of an impaired renal function on the pharmacokinetics of idarubicin. A significant correlation is reported between the plasma clearance of idarubicin after intravenous dosing and creatinine clearance. In a study comparing patients with creatinine clearance <60 mL/min and those with normal creatinine clearance, idarubicin AUC was increased on average by 38% and idarubicinol AUC by 120% in the patients with reduced creatinine clearance; however, there was considerable variability.

There is also limited information on the effect of impaired liver function on the pharmacokinetics of idarubicin. In a study comparing patients with liver metastases and mild liver impairment and those with normal liver function, there were no significant differences in idarubicin and idarubicinol pharmacokinetic parameters. However, in a patient with severe liver impairment, elimination of idarubicin was significantly delayed, the plasma elimination half-life being 112 hours.

## **INDICATIONS**

Idarubicin Ebewe is indicated for use in acute myelogenous leukaemia (AML) in adults for remission induction in untreated patients or for remission induction in relapsed or refractory patients. Idarubicin Ebewe may be used in combination chemotherapy regimens involving other cytotoxic agents.

## **CONTRAINDICATIONS**

Idarubicin therapy is contraindicated in patients with severe renal and liver impairment or patients with uncontrolled infections. It should also not be administered to individuals with hypersensitivity to idarubicin or any other component of the product (see **DESCRIPTION**) and/or other anthracyclines.

Idarubicin therapy is contraindicated in patients with severe myocardial insufficiency, recent myocardial infarction, severe arrhythmias, persistent myelosuppression, or previous treatment with maximum cumulative doses of idarubicin and/or other anthracyclines and anthracenediones.

Idarubicin therapy is contraindicated in pregnant women or women wishing to become pregnant (see **Use in Pregnancy under PRECAUTIONS**).

## **PRECAUTIONS**

**General** Idarubicin is intended for use under the direction of those experienced in leukaemia chemotherapy. Close monitoring for toxicity is mandatory. The medicine should not be given to patients with pre-existing bone marrow depression induced by previous drug therapy or radiotherapy unless the benefit warrants the risk.

Patients should recover from acute toxicities of prior cytotoxic treatment (such as stomatitis, neutropenia, thrombocytopenia, and generalised infections) before beginning treatment with idarubicin.

Pre-existing heart disease and previous therapy with anthracyclines, especially at high cumulative doses, or other potentially cardiotoxic agents are co-factors for increased risk of idarubicin-induced cardiac toxicity: the benefit to risk ratio of idarubicin therapy in such patients should be weighed before starting treatment with idarubicin. Like most other cytotoxic agents, idarubicin has mutagenic properties and is carcinogenic in rats.

**Haematologic Toxicity** Idarubicin is a potent bone marrow suppressant. Myelosuppression, primarily of leukocytes, will therefore occur in all patients given a therapeutic dose of this agent and careful haematological monitoring including granulocytes, red cells and platelets is required.

**Secondary Leukaemia** Secondary leukaemia, with or without a pre-leukaemic phase, has been reported in patients treated with anthracyclines, including idarubicin. Secondary leukaemia is more common when such drugs are given in combination with DNA-damaging antineoplastic agents, when patients have been heavily pre-treated with cytotoxic drugs, or when doses of the anthracyclines have been escalated. These leukaemias can have a 1- to 3-year latency period.

Facilities with laboratory and supportive resources adequate to monitor medicine tolerability and protect and maintain a patient compromised by medicine toxicity should be available. It must be possible to treat a severe haemorrhagic condition and/or severe infection rapidly and effectively.

Myocardial toxicity as manifested by potentially fatal congestive heart failure, acute life-threatening arrhythmias or other cardiomyopathies, may occur during therapy or several weeks after termination of therapy.

Idarubicin-related cardiomyopathy was reported in 5% of patients who received cumulative IV doses of 150 to 290 mg/m<sup>2</sup>. Although cumulative dose limits are yet to be defined, available data on patients treated with oral idarubicin hydrochloride indicate that the total cumulative doses up to at least 400 mg/m<sup>2</sup> have a low probability of cardiotoxicity. Should CHF occur, treatment with digitalis, diuretics, sodium restriction and bed-rest is indicated.

**Cardiac Function** Cardiotoxicity is a risk of anthracycline treatment that may be manifested by early (acute) or late (delayed) events.

*Early (Acute) Events* Early cardiotoxicity of idarubicin consists mainly of sinus tachycardia and/or ECG abnormalities, such as non-specific ST-T wave changes. Tachyarrhythmias, including premature ventricular contractions and ventricular tachycardia, bradycardia, as well as atrioventricular and bundle-branch block have also been reported. These effects do not usually predict subsequent development of delayed cardiotoxicity.

*Late (Delayed) Events* Delayed cardiotoxicity usually develops late in the course of therapy or within 2 to 3 months after completion of treatment, but later events, several months to years after completion of treatment have also been reported. Delayed cardiomyopathy is manifested by reduced left ventricular ejection fraction (LVEF) and/or signs and symptoms of congestive heart failure (CHF) such as dyspnoea, pulmonary oedema, dependent oedema, cardiomegaly and hepatomegaly, oliguria, ascites, pleural effusion, and gallop rhythm. Subacute effects such as pericarditis/myocarditis have also been reported. Life-threatening CHF is the most severe form of anthracycline-induced cardiomyopathy and represents the cumulative dose-limiting toxicity of the medicine.

Cardiac function should be monitored carefully during treatment in order to minimise the risk of cardiac toxicity of the type described for other anthracycline compounds. Risk factors for cardiac toxicity include concomitant or previous radiation to the mediastinal/pericardial area, previous treatment with other anthracyclines or anthracenediones at high cumulative doses, and concomitant use of medicines with the ability to suppress cardiac contractility or other potentially cardiotoxic agents (e.g., trastuzumab). Anthracyclines including idarubicin should not be administered in combination with other cardiotoxic agents unless the patient's cardiac function is closely monitored. Patients receiving anthracyclines after stopping treatment with other cardiotoxic agents, especially those with long half-lives such as trastuzumab, may also be at an increased risk of developing cardiotoxicity. The half-life of trastuzumab is approximately 28.5 days and it may persist in the circulation for up to 24 weeks. Therefore, physicians should avoid anthracycline-based therapy for up to 24 weeks after stopping trastuzumab when possible. If anthracyclines are used before this time, careful monitoring of cardiac function is recommended. The benefit-to-risk ratio of idarubicin therapy in such patients should be weighed before starting treatment. The risk of such myocardial toxicity may also be higher in patients with a pre-existing heart disease or particular clinical situation due to their disease (anaemia, bone marrow depression, infections, leukaemic pericarditis and/or myocarditis).

While there is no reliable method for predicting acute congestive heart failure, cardiomyopathy induced by anthracyclines is usually associated with persistent QRS voltage reduction, increase beyond normal limits of the systolic time interval (PEP/LET) and decrease of the left ventricular ejection fraction (LVEF) from pre-treatment baseline values.

Assessment of cardiac function (evaluation of LVEF) with an electrocardiogram (ECG) and either a multiple-gated acquisition (MUGA) scan or an echocardiogram (ECHO) should be performed prior to starting therapy with idarubicin. Repeated MUGA or ECHO determinations of LVEF should be performed, particularly with higher, cumulative anthracycline doses. The technique used for assessment should be consistent throughout follow-up. Early clinical diagnosis of drug-induced myocardial damage appears to be important for pharmacological treatment to be useful.

### **Gastrointestinal System**

Severe enterocolitis with perforation has been reported rarely. The risk of perforation may be increased by instrumental intervention. The possibility of perforation should be considered in patients who develop severe abdominal pain and appropriate steps for diagnosis and management should be taken.

## Paediatric Use

In infants and children there appears to be a greater susceptibility to anthracycline-induced cardiac toxicity, and a long-term periodic evaluation of cardiac function has to be performed.

**Hepatic and/or Renal Function** Since impairment of hepatic or renal function may affect the disposition of idarubicin, liver and kidney function should be evaluated with conventional clinical laboratory tests (using serum bilirubin and serum creatinine as indicators) prior to and during treatment. Idarubicin is contraindicated in severe hepatic and renal impairment.

**Tumour Lysis Syndrome** Idarubicin may induce hyperuricaemia as a consequence of the extensive purine catabolism that accompanies medicine-induced rapid lysis of neoplastic cells ('tumour lysis syndrome'). Blood uric acid levels, potassium, calcium, phosphate, and creatinine should be evaluated after initial treatment. Hydration, urine alkalinisation, and prophylaxis with allopurinol to prevent hyperuricaemia may minimise potential complications of tumour lysis syndrome. Appropriate measures must be taken to control any systemic infection before beginning therapy.

**Effects at Site of Injection** With intravenous-administered idarubicin, extravasation at the site of injection can cause severe local tissue necrosis. Extravasation may occur with or without accompanying stinging or burning sensation, even if blood returns well on aspiration of the infusion needle. If signs or symptoms of extravasation occur, the injection or infusion should be terminated immediately and restarted in another vein (see **DOSAGE AND ADMINISTRATION**).

Phlebosclerosis may result from an injection into a small vessel or from previous injections into the same vein.

**Immunosuppressant Effects/Increased Susceptibility to Infections** Administration of live or live-attenuated vaccines in patients immunocompromised by chemotherapeutic agents including idarubicin, may result in serious or fatal infections. Vaccination with a live vaccine should be avoided in patients receiving idarubicin. Killed or inactivated vaccines may be administered; however, the response to such vaccines may be diminished.

**Other** Thrombophlebitis and thromboembolic phenomena, including pulmonary embolism have been coincidentally reported with the use of idarubicin. The risk of thrombophlebitis at the injection site may be minimised by following the recommended procedure for administration.

## Use In Pregnancy (Category D)

**Category D** Medicines which have caused, are suspected to have caused or may be expected to cause, an increased incidence of human foetal malformations or irreversible damage. These medicines may also have adverse pharmacological effects. Accompanying texts should be consulted for further details.

There is no information as to whether idarubicin adversely affects fertility or causes teratogenesis in humans. However, it is teratogenic and embryotoxic in rats at intravenous doses of 0.7-1.4 mg/m<sup>2</sup>/day. In rabbits, no evidence of teratogenicity was

seen at the highest dose tested (2.2 mg/m<sup>2</sup>/day, or one-fifth of the human intravenous dose), which caused some maternal deaths. Idarubicin should not be used during pregnancy (see **CONTRAINDICATIONS**), and women of child-bearing potential should be advised to avoid pregnancy. If the patient becomes pregnant during therapy, the patient should be informed of the potential hazard to the foetus.

### **Use in Lactation**

It is not known whether idarubicin or its metabolites are excreted in human breast milk. Mothers should be advised not to breast-feed while undergoing chemotherapy with idarubicin.

### **Carcinogenesis, Mutagenesis, Impairment of Fertility**

Long-term carcinogenicity studies have not been conducted with idarubicin, but like most other cytotoxic agents, idarubicin has mutagenic properties and is carcinogenic in rats. In male dogs, testicular atrophy with inhibition of spermatogenesis and sperm maturation was observed at threshold idarubicin doses 1.8 mg/m<sup>2</sup> i.v. or 3 mg/m<sup>2</sup> po. (3 days/week for 13 weeks). These effects were not readily reversible after an eight-week recovery period.

Given the mutagenic potential of idarubicin, the medicine could induce chromosomal damage in human spermatozoa, for this reason, males undergoing idarubicin treatment should use contraceptive measures.

### **Effects on Ability to Drive and Use Machines**

The effect of idarubicin on the ability to drive or use machinery has not been systematically evaluated. Special care should be taken if it is essential that patients drive or operate machinery while undergoing treatment with idarubicin, especially if in a debilitated condition.

### **Interactions with Other Medicines**

Idarubicin is a potent myelosuppressant and combination chemotherapy regimens which contain other agents having a similar action may be expected to lead to additive myelosuppressive effects, especially with regard to bone marrow/haematologic and gastrointestinal effects. The use of idarubicin in combination chemotherapy with other potentially cardiotoxic drugs, as well as the concomitant use of other cardioactive compounds (e.g., calcium channel blockers), requires monitoring of cardiac function throughout treatment. Changes in hepatic or renal function induced by concomitant therapies may affect idarubicin metabolism, pharmacokinetics, and therapeutic efficacy and/or toxicity.

An additive myelosuppressant effect may occur when radiotherapy is given concomitantly or within 2-3 weeks prior to treatment with idarubicin.

## **ADVERSE EFFECTS**

Severe myelosuppression and cardiac toxicity are the two major adverse effects. Most side effects are dose-dependent e.g. bone marrow depression and cardiotoxicity. All side effects except cardiomyopathy are reversible.

Adverse reactions that occur more frequently than 1% include:

General - fever, infection.

Blood - bone marrow depression.

Circulation - cardiomyopathy, ECG changes.

Gastrointestinal - acute nausea and vomiting, stomatitis, oesophagitis, diarrhoea.

Skin - alopecia, skin rash.

Liver - bilirubin and liver enzyme elevation.

### **Myelosuppression**

Haematological toxicity occurs in all patients receiving therapeutic doses of idarubicin and severe myelosuppression is the major toxicity associated with idarubicin therapy. Leucopenia is usually severe, with neutrophils as the white blood cell most significantly affected; thrombocytopenia and anaemia may also occur. During the period of myelosuppression, patients are at risk of developing infection and bleeding which may be life-threatening or fatal.

Leucocyte and platelet nadirs are usually reached 10 to 14 days following administration of the medicine, however cell counts generally return to normal levels during the third week.

Clinical consequences of bone marrow/haematological toxicity may be fever, infections, sepsis/septicaemia, septic shock, haemorrhages, tissue hypoxia, death. Intravenous antibiotics should be given in the presence of febrile neutropenia.

### **Gastrointestinal**

Nausea and/or vomiting, mucositis (usually involving the oral mucosa and appearing 3-10 days after starting treatment), abdominal pain, diarrhoea and oesophagitis may occur but severe (WHO Grade 4) gastrointestinal toxicity is reported in less than 5% of patients.

Severe vomiting and diarrhoea may cause dehydration. Nausea and vomiting may be prevented or alleviated by the administration of appropriate antiemetic therapy.

Severe enterocolitis (neutropenic enterocolitis) with perforation has been reported. The possibility of perforation should be considered in patients who develop severe abdominal pain and appropriate steps for diagnosis and management should be taken.

Anorexia, burning sensation, erosions/ulceration, gastrointestinal tract bleeding and colitis have also been reported.

### **Dermatological**

Alopecia is reported frequently and dermatological reactions including rash/itch, urticaria and a bullous erythrodermatous rash of the palms and soles can occur. The dermatological reactions are usually attributable to concomitant antibiotic therapy, skin changes, skin and nail hyperpigmentation, hypersensitivity of irradiated skin ('radiation-recall reaction'), acral erythema, local toxicity (see **PRECAUTIONS**) and local reactions including hives at the injection site have been reported.

## **Hepatic and Renal**

Changes in hepatic and renal function tests are severe (Grade 4) in less than 5% of patients, are usually transient and occur in the setting of sepsis and while patients are receiving potentially hepatotoxic and nephrotoxic antibiotics and antifungal agents.

Idarubicin may impart a red colour to the urine for 1-2 days after administration and patients should be advised that this is no cause for alarm.

## **Cardiac**

As in the case of other anthracyclines, cardiac toxicity, as manifested by congestive heart failure (frequently attributed to fluid overload), serious life-threatening arrhythmias including atrial fibrillation, chest pain, myocardial infarction and asymptomatic declines in LVEF, have been reported in patients undergoing induction therapy for AML (see **PRECAUTIONS**). Myocardial insufficiency and arrhythmias are usually reversible and occur in the setting of sepsis, anaemia and aggressive intravenous fluid administration. The events were reported more frequently in patients over age 60 years and in those with pre-existing cardiac disease. Serious cardiac impairment may be prevented through regular surveillance during the course of treatment (see **PRECAUTIONS**).

Subacute effects such as pericarditis/myocarditis have also been reported.

Sinus tachycardia, tachyarrhythmias, atrio-ventricular and bundle branch block have also been reported.

## **Endocrine**

Vasomotor instability (hot flushes) has been reported.

## **Vascular**

Phlebitis, thrombophlebitis and thromboembolism have been reported.

## **Other**

Anaphylaxis, sepsis/septicaemia, secondary leukaemias (acute myeloid leukaemia and myelodysplastic syndrome), shock, fever, chills and hyperuricaemia have been reported.

## **DOSAGE AND ADMINISTRATION**

For induction therapy in adult patients with AML, the following dose schedules are recommended:

### **Intravenous Formulation**

Idarubicin Ebewe 12 mg/m<sup>2</sup> daily for three days by slow (10-15 min) intravenous injection in combination with Ara-C, 100 mg/m<sup>2</sup> daily given by continuous infusion for seven days. In patients with unequivocal evidence of leukaemia after the first induction course, a second course may be administered. Administration of the second course should be delayed in patients who experienced severe mucositis, until recovery from this toxicity has occurred, and a dose reduction of 25% is recommended.

## **Liver and renal impairment**

Idarubicin Ebewe should not be administered in patients with severe renal and liver impairment (see **CONTRAINDICATIONS**). Dose adjustment should be considered in patients with moderate impairment of the liver. With anthracyclines a 50% dose reduction is generally employed if bilirubin levels are in the range 20.4-51.0 µmoles/L.

In case of moderate renal impairment, caution is recommended in the dosage administration, (refer to Pharmacokinetics under **PHARMACOLOGY**).

All dosage schedules should take into account the haematological status of the patient and all the doses of other cytotoxic medicines when used in combination.

## **Incompatibilities**

Idarubicin Ebewe is not to be mixed with heparin since this causes precipitation, not to be mixed with alkaline solutions since this causes rapid degradation of Idarubicin Ebewe and it is not recommended that it be mixed with other medicines.

## Administration

Idarubicin Ebewe for injection contains no antimicrobial preservative. Idarubicin Ebewe is for single use in one patient only. Discard any residue.

Idarubicin Ebewe injection must be administered only by the intravenous route and the solution should be given via tubing of a freely running intravenous infusion of 0.9% Sodium Chloride Injection, taking 10-15 minutes over the injection.

The tubing should be attached to a butterfly needle or other suitable device and inserted preferably into a large vein. This technique minimises the risk of thrombosis or perivenous extravasation, which can lead to severe cellulitis and necrosis. Venous sclerosis may result from injection into small veins or repeated injections in the same vein.

Care in the administration of Idarubicin Ebewe will reduce the chance of perivenous infiltration. It may also decrease the chance of local reactions such as urticaria and erythematous streaking.

During intravenous administration of Idarubicin Ebewe, extravasation may occur with or without an accompanying stinging or burning sensation, even if blood returns well on aspiration of the infusion needle. If any signs or symptoms of extravasation have occurred, the injection or infusion should be immediately terminated and restarted in another vein. If it is known or suspected that subcutaneous extravasation has occurred, it is recommended that intermittent ice packs (½ hour immediately, then ½ hour 4 times per day for 3 days) be placed on the area of extravasation and that the affected extremity be elevated.

Because of the progressive nature of extravasation reactions, the area of injection should be frequently examined and plastic surgery consultations obtained early if there is any sign of local reaction such as pain, erythema, oedema or vesication. If ulceration begins or there is persistent pain at the site of extravasation, early wide excision of the involved area should be considered.

## **Instructions for use and handling and disposal**

Caution in handling the solution must be exercised, as skin reactions associated with Idarubicin Ebewe may occur. Skin exposed accidentally to Idarubicin Ebewe should be washed thoroughly with water, soap and water or sodium bicarbonate solution and, if the eyes are involved, standard irrigation techniques should be used immediately. Medical attention should be sought. The following protective recommendations are given due to the toxic nature of the substance:

- Personnel should be trained in good technique for handling.
- Pregnant staff should be excluded from working with Idarubicin Ebewe.
- The use of goggles, disposable masks and gloves and protective gowns are recommended during preparation and administration of the medicine.
- All items used for administration or cleaning, including gloves should be placed in high-risk, waste-disposal bags for high temperature incineration.

Spillage or leakage should be treated with dilute sodium hypochlorite (1% available chlorine) solution, preferably by soaking, and then water. All cleaning materials should be disposed of as indicated previously.

## **OVERDOSAGE**

Contact the Poisons Information Centre on telephone 131126 for advice on management of overdose.

Very high doses of idarubicin may be expected to cause acute myocardial toxicity within 24 hours and severe myelosuppression within one or two weeks. Delayed cardiac failure has been seen with the anthracyclines up to several months after an overdose.

Two cases of fatal overdose in patients receiving therapy for AML have been reported. The doses were  $135 \text{ mg/m}^2$  over 3 days, and  $45 \text{ mg/m}^2$  of idarubicin and  $90 \text{ mg/m}^2$  of daunorubicin over a 3-day period.

There is no known antidote to idarubicin . Treatment should aim to support the patient and should utilise such measures as blood transfusions, reverse-barrier nursing, antibiotics and symptomatic treatment of mucositis. Patients should be observed carefully and if signs of cardiac failure arise, should be treated along conventional lines.

Disposition studies with idarubicin in patients with severe renal failure or in those undergoing dialysis have not been carried out. The profound multi-compartment behaviour, extensive extravascular distribution and tissue binding, coupled with the low unbound fraction available in the plasma pool make it unlikely that therapeutic efficacy or toxicity would be altered by conventional peritoneal haemodialysis.

## **PRESENTATION AND STORAGE CONDITIONS**

Idarubicin Ebewe is available in the following presentations:

Idarubicin Ebewe 5mg/5mL injection, concentrated – glass vial. Pack of 1 vial and 5 vials.

Idarubicin Ebewe 10mg/10mL injection, concentrated – glass vial. Pack of 1 vial and 5 vials.

Idarubicin Ebewe 20mg/20mL injection, concentrated – glass vial. Pack of 1 vial and 5 vials.

Store at 2°C to 8°C (Refrigerate. Do not freeze). Protect from light.

**NAME AND ADDRESS OF THE SPONSOR.**

In Australia:

Sandoz Pty Ltd  
ABN 60 075 449 553  
19 Harris Street  
Pymont NSW 2009  
Tel: 1800 634 500

In New Zealand:

Pharmaco (NZ) Ltd  
4 Fisher Crescent  
Mt Wellington,  
AUCKLAND

**POISON SCHEDULE**

Schedule 4 – Prescription Only Medicine

**DATE OF PREPARATION**

10 Dec 2011