

PRODUCT INFORMATION

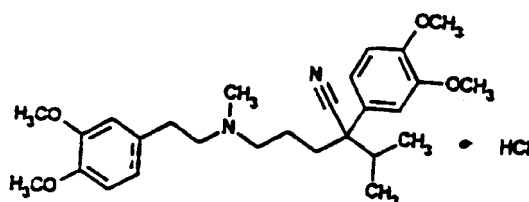
ISOPTIN[®] INJECTION SOLUTION

NAME OF THE MEDICINE

Verapamil Hydrochloride

The chemical name of verapamil hydrochloride is Benzeneacetonitrile, α - [3-[[2-(3,4-dimethoxyphenyl) ethyl]methylamino] propyl]]-3,4-dimethoxy- α -(1-methylethyl)-, monohydrochloride.

The structural formula of verapamil HCl is given below:



It has a molecular weight of 491.07 and the molecular formula is C₂₇H₃₈N₂O₄ • HCl.

The CAS number: 152-11-4.

DESCRIPTION

Verapamil hydrochloride is a white or practically white crystalline powder. It is practically odorless and has a bitter taste. It is soluble in water, freely soluble in chloroform, sparingly soluble in alcohol and practically insoluble in ether.

Verapamil hydrochloride injection is a sterile, nonpyrogenic solution containing verapamil hydrochloride 2.5 mg/mL (equivalent to 2.3 mg/mL verapamil) and sodium chloride 8.5 mg/mL in water for injection. The solution contains no bacteriostat or antimicrobial agent and is intended for single-dose intravenous administration. It may contain hydrochloric acid for pH adjustment; pH is 4.9 (4.0 to 6.5). Inactive ingredients in verapamil hydrochloride injection are sodium chloride and water for injections.

PHARMACOLOGY

Isoptin is a calcium ion influx inhibitor (slow channel blocker or calcium ion antagonist) which exerts its pharmacologic effects by modulating the influx of ionic calcium across the cell membrane of the arterial smooth muscle as well as in conductile and contractile myocardial cells.

Pharmacokinetics

Impaired renal function has no effect on verapamil hydrochloride pharmacokinetics in patients with end-stage renal failure and subjects with healthy kidneys.

CLINICAL DATA

Verapamil has a pronounced antiarrhythmic action particularly in supraventricular cardiac arrhythmias. It prolongs impulse conduction in the AV node and thereby depending on the type of arrhythmia restores the sinus rhythm and/or normalises the ventricular rate.

The calcium antagonist verapamil reduces myocardial oxygen consumption directly by intervening in the energy consuming metabolic processes of the myocardial cell and indirectly by diminishing the peripheral resistance (afterload).

The decrease of the vascular smooth muscle tone moreover prevents coronary spasms and lowers raised blood pressure.

INDICATIONS

- Tachycardias, such as paroxysmal supraventricular tachycardia, atrial fibrillation with rapid ventricular response, (except in WPW syndrome, see “**PRECAUTIONS**”), atrial flutter with rapid conduction, extrasystoles.
- For the prophylaxis and/or therapy of ectopic arrhythmias (predominantly ventricular extrasystoles) in halothane anaesthesia and in the application of adrenaline in halothane anaesthesia, respectively.
- Acute hypertension.
- Acute coronary insufficiency.

CONTRAINDICATIONS

- Cardiogenic shock (except for arrhythmia induced shock), complicated acute myocardial infarction (bradycardia, hypotension, left ventricular failure), second and third degree AV block, sick sinus syndrome (bradycardia-tachycardia syndrome), manifest heart failure.
- In the presence of first degree AV block, sinus bradycardia and hypotension the use of Isoptin should be given critical consideration. In acute coronary insufficiency intravenous administration is only admissible with careful indication and continuous monitoring of the patient. Where heart failure is present, full compensation with cardiac glycosides must be achieved before the administration of Isoptin.
- Patients with atrial fibrillation or atrial fibrillation and an accessory bypass tract (e.g. Wolff-Parkinson-White, Lown-Ganong-Levine syndromes). These patients are at risk

to develop ventricular tachyarrhythmia including ventricular fibrillation if verapamil is administered.

- Patients with ventricular tachycardia. Administration of intravenous verapamil to patients with wide-complex ventricular tachycardia (QRS > 0.12 sec) can result in marked haemodynamic deterioration and ventricular fibrillation. Proper diagnosis and differentiation from wide-complex supraventricular tachycardia is imperative in the emergency room setting.
- Isoptin injection should not be administered intravenously to patients on beta-blockers (except in an intensive care setting).
- In patients with diminished hepatic function (parenchymal loss/reduced blood supply) the effect of Isoptin is intensified and prolonged depending on the severity of the disease due to impaired drug metabolism. In these cases, dosage should be adjusted with special care.
- Known hypersensitivity to verapamil hydrochloride.

PRECAUTIONS

Verapamil should be given as a slow intravenous injection over at least 2 minutes under continuous ECG and blood pressure monitoring (see DOSAGE AND ADMINISTRATION).

Intravenous injection should only be given by the physician.

In atrial fibrillation and simultaneous WPW syndrome there is a risk of inducing ventricular fibrillation.

Hypotension

Severe hypotension has occasionally occurred following intravenous administration of the drug. On rare occasions this has been followed by a loss of consciousness. If severe hypotension develops, verapamil should be promptly discontinued and vasoconstrictor substances used.

In patients using antihypertensive drugs, the additional hypotensive effect should be taken into consideration.

Ventricular Fibrillation

Intravenous administration may precipitate ventricular fibrillation. Patients with atrial flutter/fibrillation and an accessory AV pathway may develop increased antegrade conduction across the aberrant pathway bypassing the AV node, producing a very rapid ventricular response after receiving intravenous verapamil. Its use in these patients is contraindicated. (see **CONTRAINDICATIONS**).

Bradycardia/Asystole

Isoptin slows conduction across the AV node and rarely may produce second or third degree AV block, bradycardia and in extreme cases, asystole. This is more likely to occur in patients with a sick sinus syndrome (SA nodal disease). Asystole in patients other than those

with sick sinus syndrome is usually of short duration (a few seconds or less), with spontaneous return to AV nodal or normal sinus rhythm. If this does not occur promptly, appropriate treatment should be initiated immediately (See Side Effects and Acute Cardiovascular Side Effects).

Heart Failure

Because of the drug's negative inotropic effect, verapamil should not be used in patients with poorly compensated congestive heart failure, unless the failure is complicated by or caused by an arrhythmia. If verapamil is used in such patients, they must be digitalized prior to treatment. Continuous monitoring is mandatory when intravenous verapamil is used in digitalized patients. It has been reported that digoxin plasma levels may increase with chronic oral administration.

Impaired Hepatic or Renal Function

Verapamil should be used with caution in patients with hepatic impairment. Although impaired renal function has been shown to have no effect on verapamil pharmacokinetics in patients with end-stage renal failure, verapamil should be used cautiously and with close monitoring in patients with impaired renal function. Verapamil cannot be removed by haemodialysis.

These patients should be monitored carefully for abnormal prolongation of the PR interval or other signs of excessive pharmacological effects.

Use in Patients with Impaired Neuromuscular Transmission

Verapamil should be used with caution in the presence of diseases in which neuromuscular transmission is affected (myasthenia gravis, Lambert-Eaton syndrome, advanced Duchenne muscular dystrophy).

Intravenous verapamil can precipitate respiratory muscle failure in patients with progressive muscular dystrophy and should, therefore, be used with caution.

Increased Intracranial Pressure

Intravenous verapamil has been seen to increase intracranial pressure in patients with supratentorial tumors at the time of anaesthesia induction. Caution should be taken and appropriate monitoring performed.

Sick Sinus Syndrome

Precaution should be taken when treating any supraventricular arrhythmia on an emergency basis as it may be caused by an undiagnosed Sick Sinus Syndrome (see **CONTRAINDICATIONS**).

Heart Block

Development of second or third degree AV block or unifascicular, bifascicular or trifascicular bundle branch block requires reduction in subsequent doses or discontinuation of verapamil and institution of appropriate therapy, if needed. (See Treatment of Acute Cardiovascular Side Effects).

Use in Pregnancy (Category C)

Verapamil carries the potential to produce fetal hypoxia associated with maternal hypotension.

Verapamil should not be administered intravenously during the first six months of pregnancy. There are no data on use in the first and second trimester. Verapamil should not be used in the final trimester unless the benefits clearly outweigh the risks.

Use in Lactation

Verapamil hydrochloride is excreted in human breast milk. There are currently no reports of verapamil injection or infusion use during breastfeeding. Due to the potential for serious adverse reactions in nursing infants, intravenous verapamil is not recommended during lactation.

Paediatric Use

There have been rare cases of severe haemodynamic events – some fatal – after intravenous administration of verapamil to neonates and infants. Intravenous verapamil should not be administered to this group of patients unless it is absolutely necessary and there is no alternative.

Interactions with other Medicines

During the simultaneous administration of Isoptin and drugs with cardiodepressive action and/or inhibitory effect on AV conduction watch should be kept for additive effects. Above all Isoptin should not be administered intravenously without compelling reason if the patient is on β -adrenergic blockers.

The concomitant administration of intravenous beta blockers and intravenous verapamil has resulted in serious adverse reactions, especially in patients with severe cardiomyopathy, congestive heart failure or recent myocardial infarction (see **CONTRAINDICATIONS**).

The additional hypotensive effect of Isoptin should be borne in mind particularly in patients on antihypertensive drugs.

Diuretics, Vasodilators

Potential of the antihypertensive effect.

Digoxin

Elevation of digoxin plasma levels because of diminished renal excretion. However since both drugs slow AV conduction, patients should be monitored for AV block or excessive bradycardia.

Quinidine

Enhanced blood pressure lowering is possible. Pulmonary oedema may occur in patients with hypertrophic obstructive cardiomyopathy. Elevation of quinidine plasma level.

Flecainide

May result in an additive negative inotropic effect and prolongation of atrioventricular conduction.

Disopyramide

Possible additive effects and impairment of left ventricular function. Pending further accumulation of data, disopyramide should be discontinued 48 hours prior to initiating

verapamil therapy and should not be reinstated until 24 hours after verapamil has been discontinued.

HMG-CoA Reductase Inhibitors

Treatment with HMG CoA reductase inhibitors (e.g., simvastatin or atorvastatin) in a patient taking verapamil should be started at the lowest possible dose and titrated upwards. If verapamil treatment is to be added to patients already taking an HMG CoA reductase inhibitor (e.g., simvastatin or atorvastatin) consider a reduction in the statin dose and retitrate against serum cholesterol concentrations.

Verapamil hydrochloride may increase the serum levels of HMG CoA reductase inhibitors primarily metabolised by CYP3A enzymes (e.g., atorvastatin and simvastatin). An interaction in healthy subjects demonstrated a 43% increase in verapamil AUC in combination with atorvastatin. Consider using caution when these HMG CoA reductase inhibitors and verapamil are concomitantly administered.

Fluvastatin, pravastatin and rosuvastatin are not metabolized by CYP3A4 and are less likely to interact with verapamil.

Inhalation Anaesthetics

Mutual potentiation of cardiovascular effects (higher-grade AV block, higher-grade lowering of heart rate, induction of heart failure, enhanced blood pressure lowering).

Carbamazepine

Potentiation of carbamazepine effect, enhanced neurotoxicity.

Cimetidine

Cimetidine reduces verapamil clearance following intravenous verapamil administration.

Lithium

Increased sensitivity to the effects of lithium (neurotoxicity) has been reported during concomitant verapamil hydrochloride-lithium therapy with either no change or an increase in serum lithium levels. The addition of verapamil hydrochloride, however, has also resulted in the lowering of the serum lithium levels in patients receiving chronic stable oral lithium. Patients receiving both drugs should be monitored carefully.

Phenytoin, Phenobarbital

Lowering of the plasma level and attenuation of the effects of verapamil.

Erythromycin, clarithromycin and telithromycin

Erythromycin, clarithromycin and telithromycin therapy may increase serum levels of verapamil.

Rifampicin

Blood pressure lowering effect may be reduced.

Sulfinpyrazone

Blood pressure lowering effect may be reduced.

Theophylline

Elevation of theophylline plasma levels.

Prazosin, Terazosin

Additive hypotensive effect.

HIV Antiviral Agents

Due to the metabolic inhibitory potential of some of the HIV antiviral agents, such as ritonavir, plasma concentrations of verapamil may increase. Caution should be used or the dose of verapamil may be decreased.

Cyclosporin

Elevation of cyclosporin plasma levels

Everolimus, sirolimus and tacrolimus.

Verapamil therapy may increase serum levels of everolimus, sirolimus and tacrolimus.

Buspirone

Verapamil therapy may increase plasma levels of buspirone

Midazolam

Elevation of midazolam

Muscle Relaxants

Possible potentiation by verapamil.

Protein Bound Drugs

As verapamil is highly protein bound, it should be administered with caution to patients receiving other highly protein bound drugs.

Dantrolene

Animal studies suggest that concomitant use of IV verapamil and IV dantrolene may result in cardiovascular collapse.

Aspirin

Increased tendency to bleed.

Ethanol (alcohol)

Delayed ethanol breakdown and elevation of ethanol plasma levels, resulting in enhancement of the alcoholic effect through verapamil.

Grapefruit Juice

Increase in verapamil serum level has been reported. Therefore grapefruit and its juice should not be taken with verapamil.

Doxorubicin

Caution should be used when oral verapamil is administered in combination with doxorubicin due to the potential for increased doxorubicin levels.

Colchicine

Colchicine is a substrate for both CYP3A and the efflux transporter, P-glycoprotein (P-gp). Verapamil is known to inhibit CYP3A and P-gp. When verapamil and colchicines are administered together, inhibition of P-gp and/or CYP3A by verapamil may lead to increased exposure to colchicine. Combined use is not recommended.

Imipramine

Verapamil therapy may increase serum levels of imipramine.

Glibenclamide

Verapamil therapy may increase serum levels of glibenclamide.

ADVERSE EFFECTS

As with all drugs which inhibit AV conduction, Isoptin can produce first or second degree AV block; in extreme cases there may be complete block with or without subsequent asystole. Occasionally, heart failure may develop or existing heart failure may be exacerbated.

The risk of inducing ventricular fibrillation is minute, as Isoptin has no effect on the conduction velocity and refractory period in either atria or ventricles. By diminishing the peripheral resistance, the intravenous administration of Isoptin may lead to a slight and transient decrease of blood pressure even in normotensive patients. If the heart is no longer able to increase cardiac output for maintaining normal blood pressure, a critical blood pressure fall may occur. There are rare reports of symptoms such as palpitations and rapid heart beat (tachycardia) in patients receiving verapamil.

Elevation of the pacing and sensing threshold cannot be ruled out in pacemaker wearers on verapamil hydrochloride.

Frequently, nausea (rarely, vomiting), bloating or constipation - in isolated cases to the point of ileus, abdominal discomfort and pain.

Occasionally, there may be headache, nervousness, dizziness or lightheadedness, fatigue, sensory disturbances such as tingling, numbness (paraesthesia, neuropathy), shakiness (tremor), and vertigo.

Flush has been observed occasionally.

Occasionally, allergic reactions such as erythema, pruritus, urticaria, maculopapular exanthema and erythromelalgia may occur. Rarely bronchospasm may occur.

Rarely – tinnitus. Peripheral oedema may occur as a result of local arteriole dilation.

Rarely, reversible elevation of liver enzymes has been observed, probably as a manifestation of allergic hepatitis.

Relevant lowering of glucose tolerance is rare.

There are rare reports of impotence.

Gynaecomastia has been observed very rarely in elderly patients on long term treatment. In the cases reported to date, the condition was reversible upon discontinuation of the drug. Elevated prolactin levels has been described, with isolated cases of milk (galactorrhoea).

Very rarely, there have been cases of purpura in the skin or mucous. There are isolated reports of photodermatitis.

Very rarely, muscular weakness or muscle and joint pain may occur.

There are isolated reports of angioneurotic oedema and Stevens-Johnson syndrome.

There may be isolated cases of gingival hyperplasia which is reversible when the drug is discontinued.

Adverse Effects from Post-marketing Surveillance:

There has been a single post marketing report of paralysis (tetraparesis) associated with the combined use of verapamil and colchicine. This may have been caused by colchicine crossing the blood-brain barrier due to CYP3A and P-gp inhibition by verapamil. Combined use of verapamil and colchicine is not recommended.

Other adverse effects reported from post-marketing surveillance include erythema multiforme and extrapyramidal syndrome.

Treatment Of Acute Cardiovascular Side Effects

Cardiac Arrest

External cardiac massage, artificial respiration, ECG for differentiating between asystole and ventricular fibrillation; then appropriate intensive measures, such as defibrillation or pacemaker therapy, as required.

Second Or Third Degree Av Block

Atropine, isoprenaline, if necessary, pacemaker therapy.

Development Of Myocardial Insufficiency

Dopamine, dobutamine, cardiac glycosides or calcium.

Blood Pressure Fall

Proper positioning, dopamine, dobutamine, noradrenaline (norepinephrine).

DOSAGE AND ADMINISTRATION

Adults

5mg slowly intravenously, in tachycardias and hypertensive crises repeated, if necessary, after 5 to 10 minutes. Drip infusion to maintain the therapeutic effect: 5-10 mg/hour in physiological saline, glucose, laevulose or similar solutions, on average up to a total dose of 100mg/day.

Children

Newborn	0.75-1mg (= 0.3-0.4mL)
Infants	0.75-2mg (= 0.3-0.8mL)
Children (aged 1-5 years)	2-3mg (= 0.8-1.2mL)
(aged 6-14 years)	2.5-5mg (= 1-2mL)

of Isoptin, given intravenously, depending on age and action. The injection should be made slowly under electrocardiographic control and only until onset of the effect. Intravenous infusion in hypertensive crises; initially 0.05-0.1mg/kg/hour; if the effect proves to be insufficient, the dose is increased at 30-60 minute intervals until twice the dose or more is reached. Average total dose up to 1.5mg/kg/day.

OVERDOSAGE

Symptoms

Hypotension, bradycardia up to high degree AV block and sinus arrest, hyperglycemia, stupor and metabolic acidosis. Fatalities have occurred as a result of overdose.

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Treatment

Treatment of overdose should be supportive and individualized. Beta-adrenergic stimulation and/or parenteral administration of calcium injection (calcium chloride) have been effectively used in treatment of deliberate overdose with oral verapamil hydrochloride. Verapamil hydrochloride cannot be removed by hemodialysis. Clinically significant hypotensive reactions or high-degree AV block should be treated with vasopressor agents or cardiac pacing, respectively. Asystole should be handled by the usual measures including isoproterenol hydrochloride, other vasopressor agents or cardiopulmonary resuscitation.

For advice on the management of overdose please contact the Poisons Information Centre. In Australia please call 13 11 26 and in New Zealand 0800 764 766.

PRESENTATION AND STORAGE CONDITIONS

Ampoules, 5mg/2mL
5 x 2mL ampoules

Store below 25°C

NAME AND ADDRESS OF THE SPONSOR

Abbott Australasia Pty Ltd
32-34 Lord Street
Botany NSW 2019
AUSTRALIA

Abbott Laboratories (NZ) Ltd
4 Pacific Rise
Mt Wellington
Auckland
New Zealand

POISON SCHEDULE OF THE MEDICINE

Prescription Only Medicine

DATE OF APPROVAL

Date of TGA Approval: 11 August 2010

Date Of Most Recent Amendment: 8 June 2010

Version 16