

Data Sheet

Fluconazole-Clarix

Fluconazole Intravenous Infusion Solution 2mg/mL

Presentation

Fluconazole-Clarix 2mg/mL is a clear, colourless infusion solution containing 2mg Fluconazole per mL. The product comes in bottles of 50mL, 100mL and 200mL which contain 100mg, 200mg and 400mg of Fluconazole respectively.

Uses

Actions

Fluconazole, a member of the triazole class of antifungal agents, is a potent and selective inhibitor of fungal enzymes necessary for the synthesis of ergosterol. Intravenously administered fluconazole is active in a variety of animal fungal infection models. Activity has been demonstrated against opportunistic mycoses, such as infections with *Candida* spp, including systemic candidiasis and in immunocompromised animals; with *Cryptococcus neoformans*, including intracranial infections, with *Microsporum* spp; and with *Trichophyton* spp. Fluconazole has also been shown to be active in animal models of endemic mycoses, including infections with *Blastomyces dermatitidis*; with *Coccidioides immitis*, including intracranial infection; and with *Histoplasma capsulatum* in normal and immunosuppressed animals.

Concurrent administration of fluconazole and amphotericin B in infected normal and immunocompromised mice showed antagonism of the two drugs in systemic infection with *Aspergillus fumigatus*. The clinical significance of results obtained in these studies is unknown.

Fluconazole is a highly selective inhibitor of fungal cytochrome P-450 sterol C-14 alpha demethylation. Mammalian cell demethylation is much less sensitive to fluconazole inhibition. The subsequent loss of normal sterols correlates with the accumulation of 14 alpha-methyl sterols in fungi and may be responsible for the fungistatic activity of fluconazole. Fluconazole 50 mg daily given up to 28 days has been shown not to affect corticosteroid levels or ACTH stimulated response in healthy female volunteers. Plasma oestradiol levels and urinary free cortisol levels were decreased with little effect on plasma testosterone levels. Interaction studies with antipyrine indicate that single or multiple doses of fluconazole 50 mg do not affect its metabolism.

Pharmacokinetics

The pharmacokinetic properties of fluconazole are similar following administration by the intravenous or oral routes. In normal volunteers, the bioavailability of orally administered fluconazole is over 90% compared with intravenous administration. In fasted normal volunteers, peak plasma concentrations occur between 0.5-1.5 hours after the dose with a terminal plasma elimination half-life of approximately 30 hours (range 20-50 hours). Plasma concentrations are proportional to dose and steady-state levels are reached within 4-5 days with oral doses of 50-400mg once daily. Steady-state levels are approximately 2.5 times the levels achieved with single doses. Administration of loading dose (on day 1) of twice the usual daily dose enables plasma levels to approximate to 90% steady-state levels by day 2. The apparent volume of distribution approximates to total body water. Fluconazole has low protein binding of 11-12%.

Fluconazole has been found to achieve good penetration into all tissues and body fluids studied. In cerebrospinal fluid (independent of the degree of meningeal inflammation) the ratio of fluconazole tissue (fluid) to plasma concentration was 0.5-0.9; in saliva, sputum and

blister fluid it was 1; in urine and normal skin it was 10, and in blister skin 2. These were relative to concurrent concentrations in plasma in subjects with normal renal function. The major route of excretion is renal, with approximately 80% of the administered dose appearing in the urine as unchanged drug. Approximately 11% of the dose is excreted in the urine as metabolites. The pharmacokinetics of fluconazole are markedly affected by reduction in renal function. There is an inverse relationship between the elimination half-life and creatinine clearance. The dose of fluconazole may need to be reduced in patients with impaired renal function (see Dosage and Administration). A 3-hour haemodialysis session reduces plasma concentration by about 50%. The long plasma elimination half-life provides the basis for single dose therapy for vaginal candidiasis, once daily and once weekly dosing for all other indications.

Children

There are differences in the pharmacokinetics of fluconazole between adults and children, with children (after the neonatal period) generally having a faster elimination rate and larger volume of distribution than in adults. These differences result in less accumulation on multiple dosing in children with steady-state achieved faster than in adults. Neonates have reduced elimination rates relative to adults and even higher volumes of distribution in comparison with older children. During the first 2 weeks after birth the clearance of fluconazole increases (and the half-life decreases) as renal function develops. The half-life obtained in infants was consistent with that found in older children although the volume of distribution was higher. During the first year of life the pharmacokinetics of fluconazole are similar to older children. No marked sex related differences in pharmacokinetics are evident in children.

In children the following mean pharmacokinetic data have been reported:

Age	Dose (mg/kg)	Clearance (mL/min/kg)	Half-life (hours)	C _{max} (µg/mL)	V _{diss} (L/kg)
9 months – 13 years	Single oral				
	2 mg/kg	0.40	25.0	2.9	-
5 – 15 years	8 mg/kg	0.51	19.5	9.8	-
	Multiple I.V.				
	2 mg/kg	0.49	17.4	5.5	0.722
	4 mg/kg	0.59	15.2	11.4	0.729
	8 mg/kg	0.66	17.6	14.1	1.069

Clearance corrected for bodyweight was not affected by age in these studies. Mean body clearance in adults is reported to be 0.23 mL/min/kg.

In premature newborn infants (gestational age 26-29 weeks) the mean clearance within 36 hours of birth was 0.180 mL/min/kg, which increased with time to a mean of 0.218 mL/min/kg 6 days later and 0.333 mL/min/kg 12 days later. Similarly the half-life was 73.6 hours which decreased to a mean of 53.2 hours 6 days later and 46.6 hours 12 days later.

Indications

Fluconazole-Claris Intravenous Infusion should be used only when fluconazole cannot be administered orally.

- Cryptococcosis, including cryptococcal meningitis and infections of other sites (e.g. pulmonary, cutaneous). Normal hosts, and patients with AIDS, organ transplants or other causes of immunosuppression may be treated. Fluconazole-Claris can be used as maintenance therapy to prevent relapse of cryptococcal disease in patients with AIDS.
- Systemic candidiasis including candidaemia, disseminated candidiasis and other forms of invasive candidal infection including infections of the peritoneum, endocardium and pulmonary and urinary tracts. Patients with malignancy, in intensive care units, receiving cytotoxic or immunosuppressive therapy, or with other factors predisposing to candidal infection may be treated.
- Mucosal candidiasis. These include oropharyngeal, oesophageal, non-invasive bronchopulmonary infections, candiduria, mucocutaneous and chronic oral atrophic candidiasis (denture sore mouth). Normal hosts and patients with compromised immune function may be treated.
- Vaginal candidiasis, acute or recurrent.
- Prevention of fungal infection in immunocompromised patients considered at risk as a consequence of HIV infections or neutropenia following cytotoxic chemotherapy, radiotherapy or bone marrow transplant

Dosage and Administration

The daily dose of Fluconazole-Claris should be based on the nature and severity of the fungal infection. Most cases of vaginal candidiasis respond to single dose therapy. Therapy for those types of infections requiring multiple dose treatment should be continued until clinical parameters or laboratory tests indicate that active fungal infection has subsided. An inadequate period of treatment may lead to recurrence of active infection. Patients with AIDS and cryptococcal meningitis or recurrent oropharyngeal candidiasis usually require maintenance therapy to prevent relapse.

Adults

Cryptococcal meningitis and cryptococcal infections at other sites:

The usual dose is 400 mg on the first day followed by 200 to 400 mg once daily. Duration of treatment for cryptococcal infections will depend on the clinical and mycological response, but is usually at least 6-8 weeks for cryptococcal meningitis.

Prevention of relapse of cryptococcal meningitis in AIDS patients:

After the patient receives a full course of primary therapy, DIFLUCAN may be administered indefinitely at a single daily dose of 200 mg.

Candidaemia, disseminated candidiasis and other invasive candidal infections:

The usual dose is 400 mg on the first day followed by 200 mg once daily. Depending on the clinical response, the dose may be increased to 400 mg once daily. Duration of treatment is based upon the clinical response.

Oropharyngeal candidiasis:

The usual dose is 50 mg once daily for 7-14 days. If necessary, treatment can be continued for longer periods in patients with severely compromised immune function. For atrophic oral candidiasis associated with dentures the usual dose is 50 mg once daily for 14 days administered concurrently with local antiseptic measures to the denture.

For other candidal infections of mucosa (except vaginal candidiasis which is normally treated using oral therapy), e.g. oesophagitis, candiduria, mucocutaneous candidiasis etc., the usual effective dose is 50 mg daily, given for 14-30 days.

In unusually difficult cases of mucosal candidal infections the dose may be increased to 100 mg daily.

Prevention of fungal infections in immunocompromised patients:

The dose should be 50 mg once daily while the patient is at risk as a consequence of receiving cytotoxic chemotherapy, radiotherapy or bone marrow transplant. A higher dose of 100 mg/day may be used in patients at risk of severe recurrent infections.

Dermatomycoses:

The usual dosage is 50 mg once daily or 150mg once weekly for two to four weeks. Tinea pedis may require treatment for up to six weeks.

Children

As with similar infections in adults, the duration of treatment is based on the clinical and mycological response. Fluconazole is administered as a single dose each day.

Mucosal candidiasis:

3 mg/kg daily. A loading dose of 6 mg/kg may be used on the first day to achieve steady state levels more rapidly.

Systemic candidiasis and cryptococcal infection:

6-12 mg/kg daily, depending on the severity of the disease.

Prevention of fungal infections in immunocompromised patients considered at risk as a consequence of neutropenia following cytotoxic chemotherapy or radiotherapy:

3 - 12 mg/kg daily, depending on the extent and duration of the induced neutropenia (see adult dosing).

For children with impaired renal function the daily dose should be reduced in accordance with the guidelines given for adults

Children 4 weeks of age and younger

Neonates excrete fluconazole slowly. In the first two weeks of life the same mg/kg dosing as in older children should be used but administered every 72 hours. During weeks 3 and 4 of life the same dose should be given every 48 hours.

Elderly

Where there is no evidence of renal impairment, normal dosage recommendations should be adopted. For patients with renal impairment (creatinine clearance < 50 mL/min) the dosage schedule should be adjusted as described below.

Renal Impairment

Fluconazole is predominantly excreted in the urine as unchanged drug. No adjustments in single dose therapy are necessary.

In patients with impaired renal function who will receive multiple doses of fluconazole, an initial loading dose of 50 mg to 400 mg should be given. After the loading dose, the daily dose (according to indication) should be based on the following: creatinine clearance >50 mL/min give the recommended dose, creatinine clearance 11-50 mL/min give 50% of the recommended dose and for patients receiving regular dialysis a dose should be given after every dialysis session.

When serum creatinine is the only measure of renal function available, the following formula (based on sex, weight, and age of patient) should be used to estimate the creatinine clearance in mL/minute:

Males: $\frac{\text{weight (kg)} \times (140 - \text{age}) \times 0.0885}{72 \times \text{serum creatinine (mmol/L)}}$

Females: 0.85 of the equivalent male value

Intravenous Administration

Fluconazole-Clarix may be administered by intravenous infusion at a rate not exceeding 200 mg/hour, given as a constant infusion. Fluconazole infusion has been used safely for up to fourteen days of intravenous therapy. Since oral absorption is rapid and almost complete, there is no need to change the daily dosage on transferring from the intravenous to the oral route or vice versa.

The daily dose of Fluconazole-Clarix should be based on the infecting organism and the patient's response to therapy. Treatment should be continued until clinical parameters or laboratory tests indicate that active fungal infection has subsided. An inadequate period of treatment may lead to recurrence of active infection. Patients with AIDS and cryptococcal meningitis or recurrent oropharyngeal candidiasis often require maintenance therapy to prevent relapse.

If Fluconazole-Clarix infusion is administered to patients requiring sodium or fluid restriction, consideration should be given to the salt content of the infusion fluid (15.4 mmol/100 mL) and the total volume of fluid administered.

Fluconazole-Clarix infusion is intended only for intravenous administration using sterile equipment.

Fluconazole-Clarix intravenous infusion is compatible with the following:

- Ringer's solution
- Normal saline
- Dextrose 20%
- Hartmann's solution
- Potassium chloride in dextrose
- Sodium bicarbonate 4.2%
- Aminofusin

Fluconazole-Claris may be infused through an existing line with one of the above listed fluids. Although no specific incompatibilities have been noted, mixing with any other drug prior to infusion is not recommended.

Parenteral drug products should be inspected visually for particulate matter and discoloration prior to administration whenever solution and container permit. Do not use if the solution is cloudy or precipitated or if the seal is not intact.

Contraindications

- Fluconazole Infusion solutions should not be used in patients with known sensitivity to fluconazole, to related azole compounds, or to any of its excipients.
- Concomitant administration with cisapride is contraindicated.

Warnings and Precautions

Anaphylaxis has been reported in rare instances.

Fluconazole has been associated with rare cases of serious hepatic toxicity including fatalities, primarily in patients with serious underlying medical conditions. In cases of fluconazole-associated hepatotoxicity, no obvious relationship to total daily dose, duration of therapy, sex or age of patient has been observed.

Patients who develop abnormal liver function tests during fluconazole therapy should be monitored for the development of more severe hepatic injury. Fluconazole should be discontinued if clinical signs and symptoms consistent with liver disease develop that may be attributable to fluconazole.

Patients have rarely developed exfoliative cutaneous reactions, such as Stevens-Johnson Syndrome and toxic epidermal necrolysis, during treatment with fluconazole. AIDS patients are more prone to the development of serious cutaneous reactions to many drugs. If rash which is attributable to fluconazole develops in a patient treated for a superficial fungal infection, fluconazole should be discontinued. If patients with invasive/systemic fungal infections develop rashes, they should be monitored closely and fluconazole discontinued if bullous lesions or erythema multiforme develop.

Some azoles (including fluconazole) have been associated with prolongation of the QT interval on the ECG. During post-marketing surveillance, very rare cases of QT prolongation and torsade de pointes occurred in patients taking fluconazole. These reports included seriously ill patients with multiple confounding factors e.g. structural heart disease, electrolyte abnormalities and concomitant medications that may have been contributory. Fluconazole should be administered with caution to patients with these potentially pro-arrhythmic conditions.

Use during Pregnancy and Lactation

Category D

There are no adequate and well controlled studies in pregnant women. There have been reports of multiple congenital abnormalities in infants whose mothers were being treated for 3 or more months with high dose (400-800 mg/day) fluconazole therapy for coccidioidomycosis. The relationship between fluconazole use and these events is unclear. Adverse foetal effects have been seen in animals only at high dose levels associated with maternal toxicity. These findings are not considered relevant to fluconazole used at therapeutic doses. Use in pregnancy should be avoided except in patients with severe or potentially life-threatening fungal infections in whom fluconazole may be used if the anticipated benefit outweighs the possible risk to the foetus.

Fluconazole is found in human breast milk at concentrations similar to plasma, hence its use in nursing mothers is not recommended.

Effects on ability to drive and use machines

Fluconazole is unlikely to have any effect on the patient's ability to drive or use machinery.

Adverse Effects

Adults

The safety profile of fluconazole appears similar in adults and children. The profile established for adults, given different dosage regimens and for different indications, is given below.

Multiple daily dosing for treatment of oral and for oral and oropharyngeal candidiasis; cryptococcal meningitis; or systemic candidiasis.

Fluconazole is generally well tolerated. Sixteen percent of over 4000 patients treated in clinical trials lasting seven days or more experienced adverse events. Treatment was discontinued in 1.5% of patients due to adverse clinical events and in 1.3% due to laboratory abnormalities.

Clinical adverse events were reported more frequently in HIV infected patients (21%) than in non-HIV infected patients (13%). However, the patterns in HIV infected and non-HIV infected patients were similar. The proportion of patients discontinuing therapy due to clinical adverse events was similar in the two groups (1.5%).

In some patients, (especially those with serious underlying diseases e.g. AIDS and cancer) changes in renal and haematological function test results and hepatic abnormalities have been observed during treatment with fluconazole and comparative agents. The clinical significance and relationship to treatment is uncertain.

Hepatobiliary disorders:

In combined clinical trials and marketing experience, the spectrum of hepatic reactions has ranged from mild transient elevations in transaminases to clinical hepatitis, cholestasis and fulminant hepatic failure, including fatalities. Elevations in plasma levels of hepatic enzymes have been observed, both in otherwise healthy patients and in patients with underlying disease. There have been rare cases of serious hepatic reactions during treatment with Fluconazole. Instances of fatal hepatic reactions were noted to occur primarily in patients with serious underlying medical conditions (predominantly AIDS or malignancy) and often while taking multiple concomitant medications. Transient hepatic reactions, including hepatitis and jaundice, have occurred among patients with no other identifiable risk factors. In each of these cases, liver function returned to baseline on discontinuation of Fluconazole.

In trials evaluating the efficacy of Fluconazole for the suppression of relapse of cryptococcal meningitis, a statistically significant increase was observed in median AST (SGOT) levels from a baseline value of 30 IU/L to 41 IU/L in one trial and 34 IU/L to 66 IU/L in the other. The overall rate of serum transaminase elevations of more than 8 times the upper limit of normal, was approximately 1% in fluconazole-treated patients in the pre-marketing clinical trials (which included patients with severe underlying disease, predominantly AIDS or malignancies, most of whom were receiving multiple concomitant medications, including many known to be hepatotoxic). The incidence of abnormally elevated serum transaminases was greater in patients taking Fluconazole concomitantly with one or more of the following - rifampicin, phenytoin, isoniazid, valproic acid, or oral sulphonylurea hypoglycaemic agents. Other adverse reactions observed included:

Common ($\geq 1\%$ and $< 10\%$)

Gastrointestinal – nausea, vomiting, abdominal pain, diarrhoea

Nervous system – headache

Skin and subcutaneous tissue – rash

Rare ($\geq 0.01\%$ and $< 0.1\%$)

Blood and lymphatic system – leucopenia including neutropenia and agranulocytosis and thrombocytopenia

Immunological system – anaphylaxis

Metabolism and nutrition – hypercholesterolaemia, hypertriglyceridaemia, hypokalaemia

Nervous system – seizures

Skin and subcutaneous tissue – angioedema, exfoliative skin disorders including Steven Johnson syndrome and toxic epidermal necrolysis, alopecia

Patients treated with 150mg weekly in dermal therapeutic studies

Common ($\geq 1\%$ and $< 10\%$)

Gastrointestinal – abdominal pain, dyspepsia

Nervous system – headache

Skin and subcutaneous tissue – acne

Uncommon ($\geq 0.1\%$ and $< 1\%$)

Laboratory results – elevation of transaminase greater than 2-3 times the normal upper limit

Nervous system – paraesthesia, somnolence

Psychiatric – insomnia

Skin and subcutaneous tissues – pruritus, urticaria

Children

In clinical studies involving children ranging in age from birth to 17 years who received doses ranging between 1-12 mg/kg/day for up to 129 days, approximately 10% experienced adverse events which were considered treatment related. The incidence of these events do not suggest any marked difference between the paediatric and adult populations. The following events were considered treatment related:

Common ($\geq 1\%$ and $< 10\%$)

Gastrointestinal – vomiting, diarrhoea, abdominal pain

Uncommon ($\geq 0.1\%$ and $< 1\%$)

Cardiac – cardiomyopathy

Ear and labyrinth – deafness

Gastrointestinal – nausea, dyspepsia, ileus, stomatitis, loose stools

Hepatobiliary – hepatocellular damage, jaundice

Infections and infestations – infection

Metabolism and nutrition – anorexia

Nervous system – headache, taste perversion

Respiratory, thoracic and mediastinal – hypoxia, respiratory disorder

Skin and subcutaneous tissue – rash (erythematous and macro-papular), pruritus, purpura

Vascular – hypertension

Post-marketing experience

The following adverse events have occurred post-marketing:

Cardiac – Torsade de pointes

Gastrointestinal – dyspepsia, vomiting

Hepatobiliary – hepatocellular necrosis

Immune system – anaphylaxis including face oedema, angioedema and pruritus

ECG – QT prolongation

Metabolism and nutrition - hypercholesterolaemia, hypertriglyceridaemia, hypokalaemia

Nervous system – dizziness

Interactions

Fluconazole is an inhibitor of the cytochrome P450 system, particularly the CYP 2C and to a lesser extent the CYP 3A isoforms. While in vitro studies demonstrate that the extent of inhibition of CYP 3A isoforms is lower with fluconazole than with ketoconazole and itraconazole, co-administration of fluconazole with other drugs metabolised primarily by the P450 isoforms, may result in altered plasma concentrations of the drugs that could alter the therapeutic effects and/or adverse event profile.

Clinically or potentially significant drug interactions are:

Azithromycin:

An open-label, randomised, three-way crossover study in 18 healthy subjects assessed the effect of a single 1200 mg oral dose of azithromycin on the pharmacokinetics of a single 800

mg oral dose of fluconazole as well as the effects of fluconazole on the pharmacokinetics of azithromycin. There was no significant pharmacokinetic interaction between fluconazole and azithromycin.

Benzodiazepines (short acting):

Studies in human subjects have reported changes in midazolam pharmacokinetics and clinical effects, that are dependent on dosage and route of administration. Single doses of fluconazole 150 mg resulted in modest increases in midazolam concentrations and psychomotor effects following oral administration of 10 mg that may not be clinically significant. At doses used to treat systemic mycoses, fluconazole resulted in substantial increases in midazolam concentrations and psychomotor effects following oral administration of midazolam 7.5 mg, but only modest increases that are not likely to be clinically significant following intravenous infusion of midazolam 0.05 mg/kg.

This effect on midazolam appears to be more pronounced following oral administration of fluconazole than with fluconazole administered intravenously. There have been reports of sleepiness and disturbed consciousness in patients taking fluconazole for systemic mycoses and triazolam, however, in most of these cases the patients had serious underlying illnesses and/or concomitant therapies that could have contributed to the reported events, and a relationship to a fluconazole-triazolam interaction is uncertain. If concomitant benzodiazepine therapy is necessary in patients being treated with fluconazole, consideration should be given to decreasing the benzodiazepine dosage, and the patient should be appropriately monitored.

Cisapride:

There have been reports of cardiac events including torsade de pointes in patients to whom fluconazole and cisapride were co-administered. In most of these cases, the patients appear to have been predisposed to arrhythmias or had serious underlying illness. A controlled study found that concomitant fluconazole 200 mg once daily and cisapride 20 mg four times a day yielded a significant increase in cisapride plasma levels and prolongation of QTc interval. Co-administration of cisapride is contraindicated in patients receiving fluconazole.

Cyclosporin:

A kinetic study in renal transplant patients found fluconazole 200 mg daily to slowly increase cyclosporin concentrations. However, in another multiple dose study with 100 mg daily, fluconazole did not affect cyclosporin levels in patients with bone marrow transplants. Cyclosporin plasma concentration monitoring in patients (with or without impaired renal function) receiving fluconazole is recommended.

Gastrointestinal Drugs:

In fasted, normal volunteers, absorption of orally administered fluconazole does not appear to be affected by agents that increase gastric pH. Single dose administration of fluconazole (100 mg) with cimetidine (400 mg) resulted in a 13% reduction in AUC and 21% reduction in C_{max} of fluconazole. Administration of an antacid containing aluminium and magnesium hydroxides immediately prior to a single dose of fluconazole (100 mg) had no effect on the absorption or elimination of fluconazole.

Hydrochlorothiazide:

Concomitant oral administration of 100 mg fluconazole and 50 mg hydrochlorothiazide for 10 days in normal volunteers resulted in an increase of 41% in C_{max} and an increase of 43% in AUC of fluconazole, compared to fluconazole given alone. Overall the plasma concentrations of fluconazole were approximately 3.26 - 6.52 $\mu\text{mol/L}$ higher with concomitant diuretic. These changes are attributable to a mean net reduction of approximately 20% in renal clearance of fluconazole.

Oral Contraceptives:

Three kinetic studies with a combined oral contraceptive have been performed using multiple doses of fluconazole. There were no relevant effects on either hormone level in the 50 mg fluconazole study, while at 200 mg daily, the AUCs of ethinyl estradiol and levonorgestrel were increased 40% and 24%, respectively. In a 300 mg, once weekly fluconazole study, the

AUCs of ethinyl estradiol and norethindrone were increased by 24% and 13%, respectively. Therefore, multiple dose use of fluconazole at these doses is unlikely to have an effect on the efficacy of the combined oral contraceptive.

Oral Hypoglycaemic Agents:

The effects of fluconazole on the pharmacokinetics of the sulphonylurea oral hypoglycaemic agents tolbutamide, glipizide and glibenclamide were examined in three placebo-controlled crossover studies in normal volunteers. All subjects received the sulphonylurea alone and following treatment with 100 mg of fluconazole as a single daily oral dose for 7 days. Fluconazole administration resulted in significant increases in C_{max} and AUC of the sulphonylurea. Several subjects in these three studies experienced symptoms consistent with hypoglycaemia. In the glibenclamide study, several volunteers required oral glucose treatment. When fluconazole and sulphonylureas are co-administered, blood glucose concentrations should be monitored carefully and the dose of the sulphonylurea adjusted accordingly.

Phenytoin:

Concomitant administration of oral fluconazole (200 mg) with phenytoin at steady state resulted in an average increase of 75% of phenytoin AUC values in normal volunteers. Careful monitoring of phenytoin concentrations in patients receiving fluconazole and phenytoin is recommended.

Rifabutin:

There have been reports that an interaction exists when fluconazole is administered concomitantly with rifabutin, leading to increased serum levels of rifabutin. There have been reports of uveitis in patients to whom fluconazole and rifabutin were co-administered. Patients receiving rifabutin and fluconazole concomitantly should be carefully monitored.

Rifampicin:

Administration of a single oral 200 mg dose of fluconazole after chronic rifampicin administration resulted in a 25% decrease in AUC and a 20% shorter half-life of fluconazole in normal volunteers. Depending on clinical circumstances, an increased dose of fluconazole should be considered when it is administered with rifampicin.

Tacrolimus:

There have been reports that an interaction exists when fluconazole is administered concomitantly with tacrolimus, leading to increased serum levels of tacrolimus. There have been reports of nephrotoxicity in patients to whom fluconazole and tacrolimus were coadministered. Patients receiving tacrolimus and fluconazole concomitantly should be carefully monitored.

Theophylline:

In a placebo controlled interaction study, the administration of fluconazole 200 mg for 14 days resulted in an 18% decrease in the mean plasma clearance of theophylline. Patients who are receiving high dose theophylline or who are otherwise at increased risk of theophylline toxicity, should be observed for signs of theophylline toxicity while receiving fluconazole, and therapy modified appropriately if signs of toxicity develop

Warfarin:

A single dose of warfarin (15 mg) given to normal volunteers, following 14 days of orally administered fluconazole (200 mg) resulted in a 12% increase in the prothrombin time response (area under the prothrombin time-time curve). One of 13 subjects experienced a 2-fold increase in his prothrombin time response. In post-marketing experience, as with other azole antifungals, bleeding events (bruising, epistaxis, gastrointestinal bleeding, haematuria and melena) have been reported in association with increases in prothrombin time in patients receiving fluconazole concurrently with warfarin. Careful monitoring of prothrombin time in patients receiving fluconazole and coumarin-type anticoagulants is recommended.

Zidovudine:

Two kinetic studies resulted in increased levels of zidovudine, most likely caused by the decreased conversion of zidovudine to its major metabolite. One study determined zidovudine levels in AIDS or ARC patients before and following fluconazole 200 mg daily for 15 days. There was a significant increase in zidovudine AUC (20%). A second randomised, two-period, two-treatment crossover study examined zidovudine levels in HIV infected patients. On two occasions, 21 days apart, patients received zidovudine 200 mg every eight hours either with or without fluconazole 400 mg daily for seven days. The AUC of zidovudine significantly increased (74%) during co-administration with fluconazole. Patients receiving this combination should be monitored for the development of zidovudine-related adverse reactions.

Carbamazepine

Azole anti-fungals may raise carbamazepine plasma concentrations. Because high plasma concentrations of carbamazepine and/or carbamazepine—10, 11-epoxide may result in adverse effects e.g. dizziness, drowsiness, ataxia, diplopia, the dosage of carbamazepine should be adjusted accordingly and or plasma concentrations monitored when used concomitantly with fluconazole.

Overdosage

There have been case reports of overdosage with fluconazole and in one case, a patient infected with HIV developed hallucinations and exhibited paranoid behaviour after reportedly ingesting 8,200 mg of fluconazole. The patient was admitted to hospital, and his condition resolved within 48 hours.

In the event of overdosage, symptomatic treatment including supportive measures and gastric lavage (if necessary) may be adequate. Symptoms are likely to be an extension of those under Adverse Effects. There is no specific antidote. It is recommended that the patient is monitored for hypokalaemia and elevated liver enzymes and a full blood count be done to monitor for possible thrombocytopenia and agranulocytosis.

Fluconazole is largely excreted in the urine therefore forced volume diuresis would probably increase the elimination rate. A three hour haemodialysis session decreases plasma levels by approximately 50%.

In mice and rats receiving very high doses of fluconazole, clinical effects in both species, included decreased motility and respiration, ptosis, lacrimation, salivation, urinary incontinence, loss of righting reflex and cyanosis. Death was sometimes preceded by clonic convulsions.

Pharmaceutical Precautions

Store below 30 °C.

The product should not be stored in the refrigerator.

Incompatibilities

If compatibility with other infusible solutions or medication has not been established, fluconazole must be administered separately. Visible incompatibility indicators are sedimentation, turbidity and discolouration.

Compatible solutions are physiological saline, Ringer solution and Ringer lactate solution, 20% dextrose solution, 4.2% sodium bicarbonate injection and 5% dextrose solution with 20mmol potassium chloride. When fluconazole infusion solutions are mixed with compatible infusion solutions they should be administered shortly after mixing for microbiological reasons.

Medicines Classification

Prescription Medicine

Package Quantities

50mL: Packs of 6 individually cartoned bottles.
100mL and 200mL: Packs of 1 bottle

Further Information

Product also contains sodium chloride and water for injection. The sodium chloride content (equivalent to 15.4mmol of sodium per 100mL of Fluconazole-Claris infusion solution) should be taken into account for patients on a sodium restricted diet.

Name and Address

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