

1. PRODUCT NAME

Heparin Sodium Panpharma, solution for injection 5,000 IU/mL

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

Heparin Sodium Panpharma Injection contains 5,000 IU/mL of heparin sodium as the active ingredient. It is prepared from porcine intestinal mucosa.

Sodium hydroxide or hydrochloric acid are used to adjust the pH between 5.0 and 7.5.

Excipient(s) with known effect:

Benzyl alcohol is used as a preservative at a 1.0 % concentration (10 mg/mL).

For the full list of excipients, see section 6.1.

3. PHARMACEUTICAL FORM

Heparin Sodium Panpharma 5,000 IU/mL is a clear colourless to yellowish solution for injection presented in a glass vial; each vial contains 5 mL of heparin sodium.

4. CLINICAL PARTICULARS

4.1 Therapeutic indications

Heparin is indicated for the prophylaxis and treatment of thromboembolic disorders such as thrombophlebitis, pulmonary embolism and occlusive vascular disease.

It is also used to prevent thromboembolic complications arising from cardiac and vascular surgery, frostbite, dialysis and other perfusion procedures.

Heparin is also used as an anticoagulant in blood transfusions.

4.2 Dose and method of administration

Heparin may be given by intermittent intravenous injection, intravenous infusion or deep subcutaneous injection. It should not be given intramuscularly because of the danger of haematoma formation.

Low dose prophylaxis against postoperative venous thromboembolism: The usual dose is 5,000 units by deep subcutaneous injection 2 hours before surgery and repeated every 8 to 12 hours for 7 days or longer until the patient is fully ambulatory.

Adults

Treatment of established venous thrombosis or pulmonary embolism. Treatment may be given by the following routes:

1. Continuous intravenous infusion: a bolus dose of 5,000 units may be given initially followed by an infusion of 20,000 to 40,000 units over 24 hours.

- Intermittent intravenous injection: an initial dose of 10,000 units followed by 5,000 to 10,000 units every 4 to 6 hours may be given.
- Deep subcutaneous injection: the usual dose is 5,000 units injected intravenously followed by subcutaneous injection of 10,000 units 8 hourly or 15,000 units 12 hourly. A concentrated form of heparin injection should be used (e.g. 25,000 units/mL).

Paediatric population

A suggested dosage is 50 units/kg bodyweight initially by I.V. infusion followed by 100 units/kg bodyweight every 4 hours according to the clotting time.

For single patient use. Use once only and discard any residue.

4.3 Contraindications

Heparin therapy is contraindicated in patients who are hypersensitive to the drug.

It should not be used in the following cases:

- in the presence of actual or potential haemorrhagic states, eg. haemophilia, ascorbic acid deficiency, increased capillary fragility, hiatus hernia, neoplasms, retinopathy, bleeding haemorrhoids or other organic lesions likely to bleed;
- haemorrhagic vascular accident;
- threatened abortion;
- immediate postpartum period;
- subacute bacterial endocarditis or acute infectious endocarditis;
- severe hypertension;
- gastric or duodenal ulcers or other ulcerative conditions which may have a tendency to haemorrhage, eg. ulcerative colitis;
- advanced renal or hepatic disease;
- during and immediately after spinal or major surgery, especially those involving the brain, eye or spinal cord;
- shock;
- severe thrombocytopenia or a history of thrombocytopenia with any kind of heparin or with pentosan polysulfate;
- patients in whom suitable blood coagulation tests, eg whole blood clotting time, partial thromboplastin time, etc, cannot be performed at appropriate intervals (this contraindication refers to full-dose heparin; there is usually no need to monitor coagulation parameters in patients receiving low-dose heparin).
- Hypersensitivity to heparin or to any of the excipients or pork products (e.g. anaphylactoid reactions).

Heparin Injection vials contain benzyl alcohol as a preservative, and should not be administered to premature or low birth-weight neonates. Benzyl alcohol has been associated with deaths in these patients.

4.4 Special warnings and precautions for use

Heparin should not be given by intramuscular injection, due to the risk of haematoma formation.

When neuraxial anaesthesia (epidural/spinal anaesthesia) or spinal puncture is employed, patients anticoagulated or scheduled to be anticoagulated with unfractionated heparin or low molecular weight heparins/heparinoids for prevention of thromboembolic complications are at risk of developing an epidural or spinal haematoma which can result in long term or permanent paralysis.

The risk of these events is increased by the use of indwelling epidural catheters for administration of analgesia or by concomitant use of drugs affecting haemostasis such as non-steroidal anti-inflammatory drugs (NSAIDs), platelet inhibitors, or other anticoagulants. The risk also appears to be increased by traumatic or repeated epidural or spinal puncture.

Patients should be frequently monitored for signs and symptoms of neurological impairment. If neurological compromise is noted, urgent treatment is necessary.

The physician should consider the potential benefit versus risk before neuraxial intervention in patients anticoagulated or to be anticoagulated for thromboprophylaxis.

As heparin is derived from animal tissue, it should be used with caution in patients with a history of allergy or asthma. Before a therapeutic dose is given to such a patient, a trial dose of 1,000 units may be advisable.

Heparin should be used with extreme caution in patients with continuous tube drainage of the stomach or small intestine.

Any action which may cause vascular injury, with the exception of necessary intravenous or subcutaneous injections, should be avoided where possible.

Outpatients should be warned of the haemorrhagic risks in case of possible trauma.

Heparin should be administered with caution to patients with hepatic or renal disease, hypertension, a history of ulcers, other organic lesions liable to bleed, hemostasis disorder, endocarditis, vascular diseases of the chorio-retina or during surgery of the eyes and central nervous system. Dosage reduction may be necessary in patients with advanced renal or hepatic disease.

Increased resistance to heparin is frequently encountered with fever, thrombosis, thrombophlebitis, infections with thrombosing tendencies, myocardial infarction, cancer and in post-surgical patients.

Heparin therapy increases the risk of localised haemorrhage during and following oral surgical (dental) procedures. Temporary heparin dosage reduction or withdrawal may therefore be advisable prior to oral surgery.

Heparin therapy should be monitored carefully. Adequate monitoring of therapy reduces the risk of overdosage and consequent risk of haemorrhage and is an important guide to the development of serious adverse reactions such as delayed onset thrombocytopenia.

Thrombocytopenia

Thrombocytopenia is known to occur in patients treated with heparin and may appear from 4-21 days after the start of treatment, although it may occur sooner if there is a history of heparin induced thrombocytopenia. There have been reports of mild transient thrombocytopenia (type I) with platelet counts greater than $100,000/\text{mm}^3$. In general, there are no complications and treatment can be continued. In rare cases, severe immune-mediated thrombocytopenia (type II) has been reported to occur a few days after the start of treatment.

Heparin-induced thrombocytopenia (HIT) may progress to the development of venous and arterial thromboses, a condition known as heparin induced thrombocytopenia and thrombosis (HITT) the so-called "White Clot Syndrome". These serious thromboembolic events include deep vein thrombosis, pulmonary embolism, cerebral vein thrombosis, limb ischemia, stroke, myocardial infarction, renal arterial thrombosis, skin necrosis, gangrene of the extremities that may lead to amputation, and possibly death. Monitor thrombocytopenia of any degree closely.

It is therefore recommended that the platelet count be checked at the start of treatment with heparin and then monitored regularly until the end of treatment. Treatment should be discontinued and an alternative therapy should be initiated if the platelet count falls below $100,000/\text{mm}^3$, associated with positive or unknown in vitro platelet antibody test results in the presence of heparin or if recurrent thrombosis develop.

Delayed onset of HIT and HITT

Heparin-induced Thrombocytopenia and Heparin-induced Thrombocytopenia and Thrombosis can occur up to several weeks after the discontinuation of heparin therapy. Patients presenting with thrombocytopenia or thrombosis after discontinuation of heparin should be evaluated for HIT and HITT.

Skin Necrosis

With subcutaneous administration of heparin, some cases of skin necrosis have been described, sometimes preceded by painful erythematous lesions. In these cases, immediate suspension of the treatment is advised.

Use in geriatrics

Dosage should be reduced in elderly people. Patients aged 65 years or over, especially women, may be more susceptible to haemorrhage during heparin therapy. Patients should be carefully monitored.

Hyperkalemia

Heparin can suppress adrenal secretion of aldosterone leading to hyperkalemia, in patients at risk of increased potassium levels such as patients with diabetes mellitus, renal insufficiency or taking drugs that may increase plasma potassium levels such as ACE inhibitors. The risk of hyperkalemia appears to increase with the duration of treatment, but is normally reversible.

Heparin Resistance

Resistance to heparin is encountered in patients with antithrombin III deficiency. Adjustment of heparin doses based on anti-Factor Xa levels may be warranted.

Paediatric population

Heparin Sodium Panpharma vials contain benzyl alcohol as a preservative and should not be administered to premature or low-weight neonates (see section 4.3).

Effects on laboratory tests

Significant elevations of AST and ALT levels have occurred in a high percentage of patients (and healthy subjects) who have received heparin. Since AST determinations are important in the differential diagnosis of myocardial infarction, liver disease and pulmonary embolism, rises that might be caused by drugs (like heparin) should be interpreted with caution.

4.5 Interaction with other medicines and other forms of interaction**Drugs increasing the effects of heparin**

Heparin may prolong the one-stage prothrombin time. Therefore, when heparin is given with oral anticoagulants such as warfarin, a period of at least 5 hours after the last intravenous dose, or 24 hours after the last subcutaneous dose of heparin, should elapse before blood is drawn for a valid prothrombin time to be obtained.

Drugs which affect platelet function, e.g. aspirin, other salicylates and other non-steroidal anti-inflammatory agents, dextran, platelet aggregation inhibitors, glycoprotein IIb/IIIa antagonists, thienopyridines, dipyridamole and systemic corticosteroids, may increase the risk of haemorrhage and should be used with caution in patients receiving heparin. Where concomitant use cannot be avoided, careful clinical and biological monitoring should be undertaken.

Concomitant use of thrombolytic agents such as alteplase, or streptokinase may also increase the risk of haemorrhage.

Heavy alcohol drinkers are at greater risk of major heparin-associated bleeding than moderate or non-drinkers.

Drugs antagonising the effects of heparin

Intravenous nitroglycerin administered to heparinised patients may result in a decrease of the partial thromboplastin time with subsequent rebound effect upon discontinuation of nitroglycerin. Careful monitoring of partial thromboplastin time and adjustment of heparin dosage are recommended during coadministration of heparin and intravenous nitroglycerin.

The concomitant use of heparin with andexanet alfa may reduce the effectiveness of heparin. Andexanet alfa, a recombinant modified human coagulation factor Xa used for reversal of anticoagulation with apixaban or rivaroxaban, has been shown to bind to heparin-bound antithrombin III (ATIII) and may reduce the anticoagulant effect of heparin.

Antihistamines, digitalis glycosides, tetracyclines, nicotine, ascorbic acid and quinine may reduce the anticoagulant effect of heparin.

Glyceryl trinitrate has been reported to reduce the activity of heparin when both drugs are administered simultaneously intravenously. This effect may be due to the presence of propylene glycol as a solvent in many glyceryl trinitrate parenteral preparations. No interaction has been reported when the glyceryl trinitrate was administered immediately after the heparin. Adjustment of heparin dosage during and following administration of intravenous glyceryl trinitrate may be required.

Experimental evidence suggests that heparin may antagonise the actions of ACTH, corticosteroids and insulin.

Effect of heparin on other drugs

Other drugs which may potentiate the effect of heparin include hydroxychloroquine, probenecid, vitamin K antagonists, cytostatic agents, cephamandole, valproic acid and propylthiouracil. High doses of penicillins, some contrast media, asparaginase and epoprostenol may also affect the coagulation process and increase the risk of haemorrhage.

Heparin is incompatible with certain substances in aqueous solution. Reference to specialised literature should be made to verify in which solution the incompatibility was noted. The following incompatibilities have been reported: hydrocortisone, hyaluronidase, some antihistamines, narcotic analgesics, phenothiazines and antibiotics.

Heparin can increase the effect of oral antidiabetic agents such as sulfonylureas, as well as benzodiazepines (chlordiazepoxide, diazepam, oxazepam) and propranolol.

4.6 Fertility, pregnancy and lactation

Fertility

No data available.

Pregnancy

Category C. The use of heparin in pregnancy has the usual risks for the mother, in particular osteoporosis and thrombocytopenia.

Although heparin does not cross the placenta, it should be administered with caution during pregnancy especially during the last trimester and withdrawn one or two days before the delivery date, due to the risk of fetal-maternal hemorrhage.

Although heparin does not cause malformations, an increased incidence of human foetal loss and prematurity associated with haemorrhage has been reported.

Long-term usage of therapeutic doses of heparin during pregnancy may increase the risk of osteoporosis and vertebral fractures.

Lactation

Heparin is not distributed into milk and heparin therapy is therefore not contraindicated in women who are breast-feeding. However, administration to breast-feeding women has rarely been reported to cause rapid (within 2 to 4 weeks) development of severe osteoporosis and vertebral collapse.

4.7 Effects on ability to drive and use machines

The effect of the heparin on the ability to drive or use machines has not been systematically evaluated. Patients should refrain from driving or using machines until they know that the medicinal product does not negatively affect these abilities.

4.8 Undesirable effects

Haemorrhage is the major risk of heparin therapy and may range from minor local ecchymoses to major haemorrhagic complications. An overly prolonged clotting time or minor bleeding can usually be controlled by discontinuing the heparin (see section 4.9). The occurrence of significant gastrointestinal or urinary tract bleeding during heparin therapy may indicate the presence of an underlying occult lesion.

Bleeding can occur at any site, but some specific haemorrhagic complications can be difficult to detect:

- Adrenal haemorrhage with resultant acute adrenal insufficiency has occurred during anticoagulant therapy. Anticoagulant treatment should be discontinued in patients who develop signs and symptoms of acute adrenal haemorrhage and insufficiency. Plasma cortisol levels should be measured immediately. Corticosteroid therapy should be initiated promptly, before laboratory confirmation of the diagnosis, as any delay in treatment may result in the patient's death.
- Ovarian (corpus luteum) haemorrhage may be fatal if unrecognised.
- Retroperitoneal haemorrhage.

Thrombocytopenia has been reported to occur in up to 30% of patients receiving heparin. Although the thrombocytopenia is often mild and of no obvious clinical significance, it may be accompanied by severe thromboembolic complications such as skin necrosis, gangrene of the extremities, myocardial infarction, pulmonary embolism and stroke (see section 4.4). Certain episodes of painful, ischaemic and cyanosed limbs have in the past been attributed to allergic vasospastic reactions; however these reactions may instead be complications of thrombocytopenia.

Delayed onset thrombocytopenia is also a possible complication of heparin therapy. If this occurs, the drug should be withdrawn immediately.

Skin necrosis has infrequently been reported at injection sites. It is thought to be a localised manifestation of heparin-induced platelet aggregation and thrombosis, and should be taken as a warning sign in patients who develop it. Heparin should be discontinued immediately.

Local irritation, erythema, mild pain, haematoma or ulceration may follow deep subcutaneous injection. The emergence of firm nodules may be noted in some cases; however, these nodules usually disappear after a few days.

Allergic reactions to heparin occur rarely. Hypersensitivity may be manifested by pruritus, urticaria, chills, fever, asthma-like symptoms, rhinitis, lacrimation, headache, nausea, vomiting and anaphylactoid reactions, including angioedema and shock. The most common manifestations are urticaria, chills and fever. Itching and burning, especially on the plantar side of the feet, may occur.

Osteoporosis complicated by spontaneous bone fracture has been reported with prolonged use of large doses of heparin.

Alopecia and priapism have occurred rarely in patients treated with heparin.

Spinal hematoma, epidural hematoma.

Suppression of aldosterone synthesis with hyperkalaemia and/or metabolic acidosis have been noted in patients at risk (e.g. diabetes, renal failure).

Suppression of renal functions has occurred following long-term, high dose administration of heparin.

Significant elevations of AST and ALT levels have occurred in a high percentage of subjects who have received heparin (see section 4.4).

Hypereosinophilia, which is reversible on discontinuation of heparin treatment, has occurred.

Rebound hyperlipidaemia has been reported following discontinuation of heparin therapy has also been reported.

Reporting of suspected adverse reactions

Reporting suspected adverse reactions after authorisation of the medicine is important. It allows continued monitoring of the benefit/risk balance of the medicine. Healthcare professionals are asked to report any suspected adverse reactions <https://pophealth.my.site.com/carmreportnz/s/>.

4.9 Overdose

Symptoms

The main complication associated with heparin overdose is over-anticoagulation and hemorrhage. Examples of types of bleeding observed in patients receiving heparin sodium following subcutaneous administration include melanemia, haematoma, hematuria, ecchymoses, epistaxis, haematemesis, intracranial hemorrhages, pulmonary hemorrhage and other hemorrhage.

Treatment

Slight haemorrhage due to overdosage can usually be treated by withdrawing the drug. Severe bleeding may be reduced by the administration of protamine sulphate. Protamine sulphate should be administered intravenously. To avoid circulatory side effects, the injection should be

given slowly at a rate of 5 mL over a period of about 10 minutes. Not more than 50 mg should be given at any one time. The dose of protamine sulphate required is governed by the amount of heparin that has to be neutralised; approximately 1 mg of protamine sulphate neutralises 100 units of heparin (mucous) that has been injected in the previous 15 minutes. Since heparin is being continuously excreted, the dose should be reduced as more time elapses after the heparin injection. Ideally, the dose of protamine sulphate required should be accurately determined by titration methods as the antagonist itself, in gross excess, acts as an anticoagulant.

For risk assessment and advice on the management of overdose please contact the National Poisons Centre on 0800 POISON (0800 764766).

5. PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

ATC code: B01AB01, antithrombotic agent (Anticoagulant).

Mechanism of action

Heparin is a naturally occurring mucopolysaccharide which inhibits the clotting of blood in vitro and in vivo. It enhances the rate at which antithrombin III neutralises thrombin and activated factor X (X_a). Antithrombin III also neutralises other activated coagulation factors, e.g. factors IX, XI, XII and plasmin. With low-dose heparin therapy, anticoagulation appears to result from neutralisation of X_a which prevents the conversion of prothrombin to thrombin. With full dose heparin therapy, anticoagulation appears to result primarily from neutralisation of thrombin which prevents the conversion of fibrinogen to fibrin. Full-dose heparin therapy also prevents the formation of a stable fibrin clot by inhibiting activation of fibrin stabilising factor.

5.2 Pharmacokinetic properties

Heparin is not absorbed from the gastrointestinal tract and must be administered parenterally. Its onset of action is immediate following I.V. administration. There may be considerable variation among patients in the extent of absorption following deep subcutaneous injection of heparin; however, the onset of activity usually occurs within 20-60 minutes.

Heparin is extensively bound to plasma proteins. It does not cross the placenta and is not distributed into milk.

The metabolic fate of heparin is not fully understood. No biotransformation in plasma or liver, nor any renal excretory mechanism has been identified as primarily responsible for elimination of the drug. It has been suggested that transfer and storage in the reticuloendothelial system may play a role, or that heparin may be partially metabolised in the liver. After administration of large doses intravenously, a small fraction of unchanged drug is excreted in the urine.

5.3 Preclinical safety data

Genotoxicity

No data available.

Carcinogenicity

No data available.

Reproductive and developmental toxicity

No data available.

6. PHARMACEUTICAL PARTICULARS

6.1 List of excipients

- Benzyl alcohol (preservative – at a 1.0 % concentration (10 mg/mL))
- Sodium chloride
- Sodium hydroxide (for pH adjustment)
- Hydrochloric acid (for pH adjustment)
- Water for injections

6.2 Incompatibilities

Incompatibility has been reported between heparin and alteplase, amikacin sulphate, amiodarone, ampicillin sodium, benzylpenicillin sodium, cephalothin sodium, ciprofloxacin lactate, cytarabine, dacarbazine, daunorubicin hydrochloride, diazepam, dobutamine hydrochloride, doxorubicin hydrochloride, droperidol, erythromycin lactobionate, gentamicin sulphate, haloperidol lactate, hyaluronidase, hydrocortisone sodium succinate, kanamycin sulphate, methicillin sodium, netilmicin sulphate, opioid analgesics, oxytetracycline hydrochloride, polymyxin B sulphate, promazine hydrochloride, promethazine hydrochloride, streptomycin sulphate, sulphafurazole diethanolamine, tetracycline hydrochloride, tobramycin sulphate, vancomycin hydrochloride and vinblastine sulphate. Heparin sodium has also been reported to be incompatible with cisatracurium besylate, labetalol hydrochloride and nifedipine hydrochloride. Admixture with glucose can have variable effects. Incompatibility has been reported between heparin and fat emulsion.

6.3 Shelf life

5 years.

Shelf-life after reconstitution

Chemical and physical in-use stability after reconstitution in glucose 5% and in 0.9% sodium chloride solution has been demonstrated for 48 hours at 18-22°C.

Shelf-life after first opening

Chemical and physical in-use stability of the undiluted heparin in its vial after first opening has been demonstrated for 4 weeks at 18-22°C.

6.4 Special precautions for storage

Store below 30°C. Do not freeze.

For storage conditions after reconstitution and first opening of the medicine, see section 6.3.

6.5 Nature and contents of container

Pack of 10 vials each containing 5 ml of solution for injection.

Glass vial of type I or type II, capacity of 5 ml, closed by a chlorobutyl rubber stoppers with aluminium flip-off cap.

6.6 Special precautions for disposal

No specific requirements. Any unused medicine or waste material should be disposed of in accordance with local requirements.

7. MEDICINE SCHEDULE

Prescription medicine

8. SPONSOR

Multichem NZ Limited
Private Bag 93527
Takapuna
Auckland 0740
Telephone: (09) 488 0330

9. DATE OF FIRST APPROVAL

20 August 2020

10. DATE OF REVISION OF THE TEXT

28 July 2025

SUMMARY TABLE OF CHANGES

SECTION	CHANGES
4.5	Section updated: <ul style="list-style-type: none"> • Drug-drug interactions between heparin and andexanet alfa and nitroglycerin. • Information regrouped under new subheadings.
4.8	Changed reporting URL.
4.9	Added risk assessment wording.
All	Minor editorial changes.