

## HIGHLIGHTS OF PRESCRIBING INFORMATION

These highlights do not include all the information needed to use NEXTERONE safely and effectively. See full prescribing information for NEXTERONE.

**NEXTERONE (amiodarone HCl) Premixed Injection for intravenous use**  
**Initial U.S. Approval: 1985**

### RECENT MAJOR CHANGES

Dosage and Administration (2) March 2015  
Warnings and Precautions (5) March 2015

### INDICATIONS AND USAGE

NEXTERONE is an antiarrhythmic agent indicated for initiation of treatment and prophylaxis of frequently recurring ventricular fibrillation (VF) and hemodynamically unstable ventricular tachycardia (VT) in patients refractory to other therapy. (1)

### DOSAGE AND ADMINISTRATION

- The recommended starting dose is about 1000 mg over the first 24 hours of therapy, delivered by the following infusion regimen (2):
  - Initial Load: 150 mg in 100 mL infused over 10 minutes
  - Followed by: 1 mg/min for 6 hours
  - Followed by: 0.5 mg/min thereafter
- For breakthrough episodes of VF or hemodynamically unstable VT, repeat the Initial Load (2)

### DOSAGE FORMS AND STRENGTHS

Injection, 1.5 mg/mL (150 mg/100 mL) Premixed in Dextrose (3)  
Injection, 1.8 mg/mL (360 mg/200 mL) Premixed in Dextrose (3)

### CONTRAINDICATIONS

NEXTERONE is contraindicated in patients with (4):

- Known hypersensitivity to any of the components of NEXTERONE, including iodine
- Cardiogenic shock

- Marked sinus bradycardia
- Second- or third-degree atrio-ventricular (AV) block unless a functioning pacemaker is available.

### WARNINGS AND PRECAUTIONS

- Hypotension: Slow the infusion; as needed, add vasopressor drugs, positive inotropic agents, and volume expansion. (5.1)
- Bradycardia and AV block: Slow the infusion or discontinue. (5.2)

### ADVERSE REACTIONS

- The most common adverse reactions (1-2%) leading to discontinuation of intravenous amiodarone therapy are hypotension, asystole/cardiac arrest/pulseless electrical activity, VT, and cardiogenic shock. (6)
- Other important adverse reactions are torsade de pointes, congestive heart failure, and liver function test abnormalities. (6)

To report SUSPECTED ADVERSE REACTIONS, contact Baxter Healthcare at 1-866-888-2472 or FDA at 1-800-FDA-1088 or [www.fda.gov/medwatch](http://www.fda.gov/medwatch).

### DRUG INTERACTIONS

- Amiodarone is a substrate for CYP3A and CYP2C8, so inhibitors and inducers affect amiodarone exposure (7)
- Amiodarone inhibits p-glycoprotein and CYP1A2, CYP2C9, CYP2D6, and CYP3A, increasing exposure to other drugs (7)

### USE IN SPECIFIC POPULATIONS

- Pregnancy: Use NEXTERONE during pregnancy only if the potential benefit to the mother justifies the risk to the fetus (8.1).
- Nursing mothers: Advise mothers to discontinue breast feeding (8.3).
- Pediatric use: Safety and efficacy have not been established (8.4).

See 17 for PATIENT COUNSELING INFORMATION

Revised: March 2015

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## FULL PRESCRIBING INFORMATION

### 1 INDICATIONS AND USAGE

NEXTERONE is indicated for initiation of treatment and prophylaxis of frequently recurring ventricular fibrillation (VF) and hemodynamically unstable ventricular tachycardia (VT) in patients refractory to other therapy. NEXTERONE also can be used to treat patients with VT/VF for whom oral amiodarone is indicated, but who are unable to take oral medication. During or after treatment with NEXTERONE, patients may be transferred to oral amiodarone therapy [see *Dosage and Administration (2)*].

Use NEXTERONE for acute treatment until the patient's ventricular arrhythmias are stabilized. Most patients will require this therapy for 48 to 96 hours, but NEXTERONE may be safely administered for longer periods if necessary.

### 2 DOSAGE AND ADMINISTRATION

Amiodarone shows considerable interindividual variation in response. Although a starting dose adequate to suppress life-threatening arrhythmias is needed, close monitoring with adjustment of dose is essential. The recommended starting dose of NEXTERONE is about 1000 mg over the first 24 hours of therapy, delivered by the following infusion regimen:

**Table 1: NEXTERONE PREMIXED INJECTION DOSE RECOMMENDATIONS: FIRST 24 HOURS**

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<b>Loading infusions</b>	<b>First Rapid:</b> <b>150 mg over the FIRST 10 minutes (15 mg/min).</b>
	Directly infuse NEXTERONE Premixed Injection (150 mg/100 mL; 1.5mg/mL) at a rate of 10mL/min.
	<b>Followed by Slow:</b> <b>360 mg over the NEXT 6 hours (1 mg/min).</b>
	Directly infuse NEXTERONE Premixed Injection (360 mg/200 mL; 1.8 mg/mL) at a rate of 0.556 mL/min.
<b>Maintenance infusion</b>	<b>540 mg over the REMAINING 18 hours (0.5 mg/min).</b> Decrease the rate of the slow loading infusion to 0.5 mg/min. Directly infuse NEXTERONE Premixed Injection (360 mg/200 mL; 1.8 mg/mL) at a rate of 0.278 mL/min.

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After the first 24 hours, continue the maintenance infusion rate of 0.5 mg/min (720 mg per 24 hours) by directly infusing NEXTERONE Premixed Injection (360 mg/200 mL; 1.8 mg/mL) at a rate of 0.278 mL/min. The rate of the maintenance infusion may be increased to achieve effective arrhythmia suppression.

In the event of breakthrough episodes of VF or hemodynamically unstable VT, use 150 mg supplemental infusions of NEXTERONE (infused over 10 minutes to minimize the potential for hypotension).

The first 24-hour dose may be individualized for each patient; however, in controlled clinical trials, mean daily doses above 2100 mg were associated with an increased risk of hypotension. Do not exceed an initial infusion rate of 30 mg/min.

Based on the experience from clinical studies of intravenous amiodarone, a maintenance infusion of up to 0.5 mg/min can be continued for 2 to 3 weeks regardless of the patient's

age, renal function, or left ventricular function. There has been limited experience in patients receiving intravenous amiodarone for longer than 3 weeks.

Administer NEXTERONE, whenever possible, through a central venous catheter dedicated to that purpose. Use an in-line filter during administration.

Intravenous amiodarone loading infusions at much higher concentrations and rates of infusion much faster than recommended have resulted in hepatocellular necrosis and acute renal failure, leading to death [see *Warnings and Precautions (5.3)*].

Intravenous amiodarone concentrations greater than 3 mg/mL have been associated with a high incidence of peripheral vein phlebitis; however, concentrations of 2.5 mg/mL or less appear to be less irritating. Therefore, for infusions longer than 1 hour, do not exceed NEXTERONE concentrations of 2 mg/mL, unless a central venous catheter is used [see *Adverse Reactions (6.2)*].

NEXTERONE Premixed Injection is available in GALAXY containers as a single-use, ready-to-use, iso-osmotic solution in dextrose for intravenous administration. No further dilution is required. NEXTERONE Premixed Injection should not be combined with any product in the same intravenous line or premixed container. Do not add supplemental medication. Protect from light until ready to use.

NEXTERONE does not need to be protected from light during administration.

Since the premixed container is for single-use only, any unused portion should be discarded.

**NOTE:** Inspect parenteral drug products for particulate matter and discoloration prior to administration, whenever solution and container permit, solution should be clear. Visually inspect the container. If the administration port protector is damaged, detached or not present, discard the container as the solution path sterility may be compromised. Check for minute leaks prior to use by squeezing the bag firmly. If leaks are detected, discard solution as sterility may be impaired.

**CAUTION:** Do not use plastic containers in series connections. Such use could result in air embolism due to residual air being drawn from the primary container before the administration of the fluid from the secondary container is complete.

Preparation of NEXTERONE Premixed Injection for administration:

1. Suspend container from eyelet support.
2. Remove protector from outlet port at bottom of container.
3. Attach administration set. Refer to complete directions accompanying set.

#### **Admixture Incompatibility**

Amiodarone in D<sub>5</sub>W Injection forms precipitates with the drugs shown in Table 2. If co-administration of the following drugs is necessary, use separate intravenous administration lines.

**Table 2: Y-SITE INJECTION INCOMPATIBILITY**

Drug	Vehicle	Amiodarone Concentration
Aminophylline	D <sub>5</sub> W; NS	4 mg/mL
Amoxicillin Sodium-Clavulanic Acid	unknown	12.5 mg/mL
Ampicillin Sodium-Sulbactam Sodium	NS	6 mg/mL
Argatroban	D <sub>5</sub> W	1.8 mg/mL
Bivalirudin	D <sub>5</sub> W	4 mg/mL
Cefamandole Nafate	D <sub>5</sub> W	4 mg/mL

Cefazolin Sodium	D <sub>5</sub> W	4 mg/mL
Ceftazidime	D <sub>5</sub> W	6 mg/mL
Digoxin	D <sub>5</sub> W	6 mg/mL
Furosemide (10 mg/mL)	D <sub>5</sub> W	6 mg/mL
Mezlocillin Sodium	D <sub>5</sub> W	4 mg/mL
Heparin Sodium	D <sub>5</sub> W	--
Imipenem-Cilastin Sodium	D <sub>5</sub> W	6 mg/mL
Magnesium Sulfate (500 mg/mL)	D <sub>5</sub> W	6 mg/mL
Micafungin	NS	4 mg/mL
Piperacillin Sodium –Tazobactam Sodium	D <sub>5</sub> W	6 mg/mL
Potassium Phosphates	D <sub>5</sub> W	6 mg/mL
Sodium Bicarbonate	D <sub>5</sub> W	3 mg/mL
Sodium Nitroprusside	D <sub>5</sub> W	1.5, 6 and 15 mg/mL
Sodium Phosphates	D <sub>5</sub> W	6 mg/mL

D<sub>5</sub>W = Dextrose 5% in Sterile Water, NS = Normal Saline

#### **Intravenous to Oral Transition**

Patients whose arrhythmias have been suppressed by NEXTERONE may be switched to oral amiodarone. The optimal dose for changing from intravenous to oral administration of amiodarone will depend on the dose of NEXTERONE already administered, as well as the bioavailability of oral amiodarone. When changing to oral amiodarone therapy, clinical monitoring is recommended, particularly for elderly patients. See package insert for oral amiodarone.

Since grapefruit juice is known to inhibit CYP3A-mediated metabolism of oral amiodarone in the intestinal mucosa, resulting in increased plasma levels of amiodarone, do not drink grapefruit juice during treatment with oral amiodarone [*see Drug Interactions (7)*].

Table 3 provides suggested doses of oral amiodarone to be initiated after varying durations of NEXTERONE administration. These recommendations are made on the basis of a similar total body amount of amiodarone delivered by the intravenous and oral routes, based on 50% bioavailability of oral amiodarone.

**Table 3: RECOMMENDATIONS FOR ORAL DOSAGE AFTER INTRAVENOUS INFUSION**

Duration of NEXTERONE Infusion <sup>#</sup>	Initial Daily Dose of Oral Amiodarone
< 1 week	800-1600 mg
1-3 weeks	600-800 mg
> 3 weeks*	400 mg

<sup>#</sup> Assuming a 720 mg/day infusion (0.5 mg/min).

\* NEXTERONE is not intended for maintenance treatment.

### **3 DOSAGE FORMS AND STRENGTHS**

Injection, 1.5 mg/mL (150 mg/100 mL) Premixed in Dextrose

Injection, 1.8 mg/mL (360 mg/200 mL) Premixed in Dextrose

#### **4 CONTRAINDICATIONS**

NEXTERONE is contraindicated in patients with:

- Known hypersensitivity to any of the components of NEXTERONE Premixed Injection, including iodine. Hypersensitivity reactions may involve rash, angioedema, cutaneous/mucosal hemorrhage (bleeding), fever, arthralgias (joint pains), eosinophilia (abnormal blood counts), urticaria (hives), thrombotic thrombocytopenic purpura, or severe periarteritis (inflammation around blood vessels).
- Cardiogenic shock.
- Marked sinus bradycardia.
- Second- or third-degree atrio-ventricular (AV) block unless a functioning pacemaker is available.

#### **5 WARNINGS AND PRECAUTIONS**

NEXTERONE should be administered only by physicians who are experienced in the treatment of life-threatening arrhythmias, who are thoroughly familiar with the risks and benefits of amiodarone therapy, and who have access to facilities adequate for monitoring the effectiveness and side effects of treatment.

Because of the long half-life of amiodarone and its metabolite desethylamiodarone, the potential for adverse reactions or interactions, as well as observed adverse effects, can persist following amiodarone withdrawal.

##### **5.1 Hypotension**

Hypotension is the most common adverse reaction seen with intravenous amiodarone. In clinical trials, treatment-emergent, drug-related hypotension was reported as an adverse effect in 288 (16%) of 1836 patients treated with intravenous amiodarone. Clinically significant hypotension during infusions was seen most often in the first several hours of treatment and was not dose related, but appeared to be related to the rate of infusion. Hypotension necessitating alterations in intravenous amiodarone therapy was reported in 3% of patients, with permanent discontinuation required in less than 2% of patients.

Treat hypotension initially by slowing the infusion; additional standard therapy may be needed, including the following: vasopressor drugs, positive inotropic agents, and volume expansion. Monitor the initial rate of infusion closely and do not exceed the recommended rate [*see Dosage and Administration (2)*].

In some cases, hypotension may be refractory and result in a fatal outcome [*see Adverse Reactions (6.2)*].

##### **5.2 Bradycardia and Atrio-ventricular Block**

In 90 (4.9%) of 1836 patients in clinical trials, drug-related bradycardia that was not dose-related occurred while they were receiving intravenous amiodarone for life-threatening VT/VF. Treat bradycardia by slowing the infusion rate or discontinuing NEXTERONE. In some patients, inserting a pacemaker is required. Despite such measures, bradycardia was progressive and terminal in 1 patient during the controlled trials. Treat patients with a known predisposition to bradycardia or AV block with NEXTERONE in a setting where a temporary pacemaker is available.

##### **5.3 Hepatic Injury**

Elevations of blood hepatic enzyme values [alanine aminotransferase (ALT), aspartate aminotransferase (AST), and gamma-glutamyl transferase (GGT)] are commonly seen in patients with immediately life-threatening VT/VF. Interpreting elevated AST activity can be difficult because the values may be elevated in patients who have had recent myocardial infarction, congestive heart failure, or multiple electrical defibrillations. Approximately 54% of patients receiving intravenous amiodarone in clinical studies had baseline liver enzyme elevations, and 13% had clinically significant elevations. In 81% of patients with both baseline and on-therapy data available, the liver enzyme elevations either improved during therapy or remained at baseline levels. Baseline abnormalities in hepatic enzymes are not a contraindication to treatment. Elevated bilirubin levels have been reported in patients administered intravenous amiodarone.

Acute, centrilobular confluent hepatocellular necrosis leading to hepatic coma, acute renal failure, and death has been associated with the administration of intravenous amiodarone (*see Dosage and Administration (2)*).

In patients with life-threatening arrhythmias, the potential risk of hepatic injury should be weighed against the potential benefit of NEXTERONE therapy. Carefully monitor patients receiving NEXTERONE for evidence of progressive hepatic injury. In such cases, consider reducing the rate of administration or withdrawing NEXTERONE.

#### **5.4 Proarrhythmia**

Like all antiarrhythmic agents, NEXTERONE may cause a worsening of existing arrhythmias or precipitate a new arrhythmia, sometimes leading to fatal outcomes [*see Adverse Reactions (6.2)*]. Proarrhythmia, primarily torsade de pointes (TdP), has been associated with prolongation, by intravenous amiodarone, of the QTc interval to 500 ms or greater. Although QTc prolongation occurred frequently in patients receiving intravenous amiodarone, TdP or new-onset VF occurred infrequently (less than 2%). Monitor patients for QTc prolongation during infusion with NEXTERONE. Reserve the combination of amiodarone with other antiarrhythmic therapies that prolong the QTc to patients with life-threatening ventricular arrhythmias who are incompletely responsive to a single agent.

Correct hypokalemia, hypomagnesemia or hypocalcemia whenever possible before initiating treatment with NEXTERONE, as these disorders can exaggerate the degree of QTc prolongation and increase the potential for TdP. Give special attention to electrolyte and acid-base balance in patients experiencing severe or prolonged diarrhea or in patients receiving concomitant diuretics and laxatives.

Amiodarone causes thyroid dysfunction in some patients, which may lead to potentially fatal breakthrough or exacerbated arrhythmias.

#### **5.5 Pulmonary Injury**

##### *Early-onset Pulmonary Toxicity*

There have been postmarketing reports of acute-onset (days to weeks) pulmonary injury in patients treated with intravenous amiodarone. Findings have included pulmonary infiltrates and masses on X-ray, bronchospasm, wheezing, fever, dyspnea, cough, hemoptysis, and hypoxia. Some cases have progressed to respiratory failure or death.

##### *ARDS*

Two percent (2%) of patients were reported to have adult respiratory distress syndrome (ARDS) during clinical studies involving 48 hours of therapy.

##### *Pulmonary Fibrosis*

There have been reports of early development of pulmonary fibrosis (within 1 to 3 months) following initiation of amiodarone treatment. Only 1 of more than 1000 patients treated with intravenous amiodarone in clinical studies developed pulmonary fibrosis. In that patient, the condition was diagnosed 3 months after treatment with intravenous amiodarone, during which time the patient received oral amiodarone. Pulmonary toxicity is a well-recognized complication of long-term amiodarone use (*see package insert for oral amiodarone*).

#### **5.6 Loss of Vision**

Cases of optic neuropathy and optic neuritis, usually resulting in visual impairment, have been reported in patients treated with oral amiodarone or intravenous amiodarone. In some cases, visual impairment has progressed to permanent blindness. Optic neuropathy and neuritis may occur at any time following initiation of therapy. A causal relationship to the drug has not been clearly established. Perform an ophthalmic examination if symptoms of visual impairment appear, such as changes in visual acuity and decreases in peripheral vision. Re-evaluate the necessity of amiodarone therapy if optic neuropathy or neuritis is suspected. Perform regular ophthalmic examination, including funduscopy and slit-lamp examination, during administration of NEXTERONE.

#### **5.7 Thyroid Abnormalities**

Amiodarone inhibits peripheral conversion of thyroxine (T4) to triiodothyronine (T3) and may cause increased T4 levels, decreased T3 levels, and increased levels of inactive reverse T3 (rT3) in clinically euthyroid patients. Amiodarone is also a potential source of large amounts of inorganic iodine and can cause either hypothyroidism or hyperthyroidism. Evaluate thyroid function prior to treatment and periodically thereafter, particularly in elderly patients, and in any patient with a history of thyroid nodules, goiter, or other thyroid dysfunction. Because of the slow elimination of amiodarone and its metabolites, high plasma iodide levels, altered thyroid function, and abnormal thyroid-function tests may persist for several weeks or even months following NEXTERONE withdrawal.

There have been postmarketing reports of thyroid nodules/thyroid cancer in patients treated with amiodarone. In some instances hyperthyroidism was also present.

#### *Hyperthyroidism and Thyrotoxicosis*

Amiodarone causes hyperthyroidism in about 2% of patients. Thyrotoxicosis and arrhythmia with fatal outcome has been reported in the presence of pre-existing hyperthyroidism even following a single intravenous amiodarone dose. Consider the possibility of hyperthyroidism if any new signs of arrhythmia appear.

Hyperthyroidism may result from iodine load (type 1 amiodarone-induced thyrotoxicosis [type 1 AIT]; in particular in patients with underlying autonomous thyroid nodules or latent Grave's disease). Hyperthyroidism may also result from direct amiodarone-induced destructive thyroiditis that occurs in individuals with no underlying thyroid disease (type 2 AIT), resulting in the release of preformed thyroid hormone into the bloodstream from damaged thyroid follicular epithelium. Mixed forms of hyperthyroidism as a result of both pathogenic mechanisms (excessive thyroid hormone production and thyroid destruction) can also occur. The risk of hyperthyroidism may be higher among patients with prior inadequate dietary iodine intake.

Identify hyperthyroidism by relevant clinical signs and symptoms, subnormal serum levels of thyroid stimulating hormone (TSH), abnormally elevated serum free T4, and elevated or normal serum T3. Since arrhythmia breakthroughs may accompany amiodarone-induced hyperthyroidism, aggressive medical treatment is indicated, including, if possible, dose reduction or withdrawal of amiodarone. Amiodarone hyperthyroidism may be followed by a transient period of hypothyroidism.

The institution of antithyroid drugs,  $\beta$ -adrenergic blockers or temporary corticosteroid therapy may be necessary. The action of antithyroid drugs may be especially delayed in amiodarone-induced thyrotoxicosis because of substantial quantities of preformed thyroid hormones stored in the gland. Radioactive iodine therapy is not recommended because of the low radioiodine uptake associated with amiodarone-induced hyperthyroidism.

When aggressive treatment of amiodarone-induced thyrotoxicosis has failed or amiodarone cannot be discontinued because it is the only drug effective against the resistant arrhythmia, surgical management may be an option. Experience with thyroidectomy as a treatment for amiodarone-induced thyrotoxicosis is limited, and this form of therapy could induce thyroid storm. Therefore, surgical and anesthetic management require careful planning.

#### *Hypothyroidism*

Hypothyroidism has been reported in 2 to 10% of patients receiving amiodarone and may be primary or subsequent to resolution of preceding amiodarone-induced hyperthyroidism. This condition may be identified by clinical symptoms and elevated serum TSH levels. Cases of severe hypothyroidism and myxedema coma, sometimes fatal, have been reported in association with amiodarone therapy. In some clinically hypothyroid amiodarone-treated patients, free thyroxine index values may be normal. Manage hypothyroidism by reducing the dose of or discontinuing NEXTERONE and considering the need for thyroid hormone supplement.

## **5.8 Neonatal Injury**

Amiodarone can cause fetal harm when administered to a pregnant woman. Fetal exposure may increase the potential for adverse experiences including cardiac, thyroid, neurodevelopmental, neurological and growth effects in neonate. Inform the patient of the potential hazard to the fetus if NEXTERONE is administered during pregnancy or if the patient becomes pregnant while taking NEXTERONE [See Pregnancy (8.1)].

### **5.9 Exaggerated Effects of Perisurgical Therapy**

Perform close perioperative monitoring in patients undergoing general anesthesia who are on amiodarone therapy as they may be more sensitive to the myocardial depressant and conduction defects of halogenated inhalational anesthetics.

### **5.10 Interference with Corneal Refractive Laser Surgery**

Advise patients that most manufacturers of corneal refractive laser surgery devices contraindicate corneal refractive laser surgery in patients taking amiodarone.

### **5.11 Hypersensitivity Reactions**

Anaphylactic/anaphylactoid reactions have been reported with intravenous amiodarone including shock (sometimes fatal), cardiac arrest, and the following manifestations: hypotension, tachycardia, hypoxia, cyanosis, rash, flushing, hyperhidrosis and cold sweat. Since NEXTERONE contains dextrose, patients with allergy to corn or corn products are at risk for allergic reaction.

## **6 ADVERSE REACTIONS**

The following adverse reactions are described in Warnings and Precautions: hypotension, rhythm disturbances, hepatic injury, pulmonary injury, thyroid injury, hypersensitivity.

### **6.1 Clinical Trials Experience**

Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in practice.

In a total of 1836 patients in controlled and uncontrolled clinical trials, 14% of patients received intravenous amiodarone for at least one week, 5% received it for at least 2 weeks, 2% received it for at least 3 weeks, and 1% received it for more than 3 weeks, without an increased incidence of severe adverse reactions. The mean duration of therapy in these studies was 5.6 days; median exposure was 3.7 days.

The most important adverse reactions were hypotension, asystole/cardiac arrest/pulseless electrical activity (PEA), cardiogenic shock, congestive heart failure, bradycardia, liver function test abnormalities, VT, and AV block. Overall, treatment was discontinued for about 9% of the patients because of adverse reactions. The most common adverse reactions leading to discontinuation of intravenous amiodarone therapy were hypotension (1.6%), asystole/cardiac arrest/PEA (1.2%), VT (1.1%), and cardiogenic shock (1%).

Table 4 lists the most common (incidence  $\geq 2\%$ ) adverse reactions during intravenous amiodarone therapy considered at least possibly drug-related. These data were collected in clinical trials involving 1836 patients with life-threatening VT/VF. Data from all assigned treatment groups are pooled because none of the adverse reactions appeared to be dose-related.

**Table 4: ADVERSE REACTIONS IN PATIENTS RECEIVING INTRAVENOUS AMIODARONE IN CONTROLLED AND OPEN-LABEL STUDIES ( $\geq 2\%$  INCIDENCE)**

Study Event	Controlled Studies (n = 814)	Open-Label Studies (n = 1022)	Total (n = 1836)
<b>Body as a whole</b>			
Fever	24 (2.9%)	13 (1.2%)	37 (2.0%)
<b>Cardiovascular System</b>			
Bradycardia	49 (6.0%)	41 (4.0%)	90 (4.9%)
Congestive heart failure	18 (2.2%)	21 (2.0%)	39 (2.1%)
Heart arrest	29 (3.5%)	26 (2.5%)	55 (2.9%)
Hypotension	165 (20.2%)	123 (12.0%)	288 (15.6%)
Ventricular tachycardia	15 (1.8%)	30 (2.9%)	45 (2.4%)
<b>Digestive System</b>			
Liver function tests abnormal	35 (4.2%)	29 (2.8%)	64 (3.4%)
Nausea	29 (3.5%)	43 (4.2%)	72 (3.9%)

Other adverse reactions reported in less than 2% of patients receiving intravenous amiodarone in controlled and uncontrolled studies included the following: abnormal kidney function, atrial fibrillation, diarrhea, increased ALT, increased AST, lung edema, nodal arrhythmia, prolonged QT interval, atrioventricular block, respiratory disorder, shock, sinus bradycardia, Stevens-Johnson syndrome, thrombocytopenia, VF, and vomiting.

## 6.2 Post-Marketing Experience

The following adverse reactions have been reported in the post-marketing experience during or in close temporal relationship to intravenous amiodarone administration. Because these reactions are reported voluntarily from a population of uncertain size, it is not always possible to reliably estimate their frequency or establish a causal relationship to drug exposure.

*Blood and Lymphatic System Disorders:* pancytopenia, neutropenia, hemolytic anemia, aplastic anemia, thrombocytopenia, and granulocytosis.

*Cardiac Disorders:* sinus node dysfunction (sinus arrest, sinoatrial block), intraventricular conduction disorders including bundle branch block and infra-HIS block, bradycardia (sometimes fatal), ventricular extrasystoles, and antegrade conduction via an accessory pathway.

*Endocrine Disorders:* syndrome of inappropriate antidiuretic hormone secretion (SIADH)

*Eye Disorders:* visual field defect and blurred vision.

*Gastrointestinal Disorders:* pancreatitis.

*General Disorders and Administration Site Conditions:* infusion site reactions, including thrombosis, phlebitis, thrombophlebitis, cellulitis, pain, induration, edema, inflammation, urticaria, pruritus, erythema, pigment changes, hypoesthesia, skin sloughing, extravasation possibly leading to venous/infusion site necrosis, intravascular amiodarone deposition/mass (developed in the superior vena cava around a central venous catheter after long-term [28 days] amiodarone therapy administered through a central line), and granuloma.

*Hepatobiliary Disorders:* cholestasis, cirrhosis, jaundice, alkaline phosphatase and blood lactate dehydrogenase increase.

*Musculoskeletal and Connective Tissue Disorders:* myopathy, muscle weakness, rhabdomyolysis, muscle spasms, and back pain.

*Neoplasms benign, malignant and unspecified (incl cysts and polyps) Disorders:* thyroid nodules/thyroid cancer.

*Nervous System Disorders:* intracranial pressure increased, pseudotumor cerebri, tremor, dizziness and hypoesthesia.

*Psychiatric Disorders:* confusional state, hallucination, disorientation, and delirium.

*Renal and Urinary Disorders:* acute renal failure (sometimes fatal), renal impairment, renal insufficiency, and blood creatinine increased.

*Reproductive Disorders and Breast Disorders:* Epididymitis

*Respiratory, Thoracic and Mediastinal Disorders:* interstitial pneumonitis, bronchiolitis obliterans organizing pneumonia (possibly fatal), pulmonary alveolar hemorrhage, pulmonary phospholipidosis, pleural effusion, bronchospasm, dyspnea, cough, hemoptysis, wheezing, and hypoxia.

*Skin and Subcutaneous Tissue Disorders:* toxic epidermal necrolysis (sometimes fatal), Stevens-Johnson syndrome, exfoliative dermatitis, erythema multiforme, skin cancer, pruritus, angioedema, and urticaria.

*Vascular Disorders:* vasculitis and flushing.

## **7 DRUG INTERACTIONS**

### **7.1 Pharmacodynamic Interactions**

*Drugs prolonging the QT interval:* Co-administration of drugs prolonging the QT interval (such as class I and III antiarrhythmics, lithium, certain phenothiazines, tricyclic antidepressants, certain fluoroquinolone and macrolide antibiotics, azole antifungals, halogenated inhalation anesthetic agents) increases the risk of Torsade de Pointes. In general, avoid concomitant use of drugs that prolong the QT interval [see *Warnings and Precautions (5.4)*].

*Drugs that slow heart rate:* Concomitant use of drugs with depressant effects on the sinus and AV node (e.g., digoxin, beta blockers, verapamil, diltiazem, clonidine) can potentiate the electrophysiologic and hemodynamic effects of amiodarone, resulting in bradycardia, sinus arrest, and AV block. Monitor heart rate in patients on amiodarone and concomitant drugs that slow heart rate.

### **7.2 Pharmacokinetic Interactions**

#### **Effect of other drugs on amiodarone**

Amiodarone is metabolized to the active metabolite desethylamiodarone (DEA) by the cytochrome P450 (CYP450) enzyme group, specifically CYP3A and CYP2C8.

Amiodarone has the potential for interactions with drugs or substances that may be substrates, inhibitors or inducers of CYP450 enzymes (e.g., inhibitors such as *protease inhibitors, grapefruit juice, certain fluoroquinolone and macrolide antibiotics, azole antifungals* and inducers such as *St. John's Wort*) or P-glycoprotein. In view of the long and variable half-life of amiodarone, potential for drug interactions exists not only with concomitant medication but also with drugs administered after discontinuation of amiodarone [see *Clinical Pharmacology (12.3)*].

Patients should avoid *grapefruit juice* beverages while taking amiodarone because exposure to amiodarone is significantly increased [see *Clinical Pharmacology (12.3)*].

#### **Effect of amiodarone on other drugs**

Amiodarone and DEA are inhibitors of P-glycoprotein and certain CYP450 enzymes, including CYP1A2, CYP2C9, CYP2D6 and CYP3A [see *Clinical Pharmacology (12.3)*].

Antiarrhythmics: The metabolism of *quinidine, procainamide, flecainide* can be inhibited by amiodarone. In general, initiate any added antiarrhythmic drug at a lower than usual dose and monitor the patient carefully. During transfer to oral amiodarone, reduce the

dose levels of previously administered agents by 30 to 50% several days after the addition of oral amiodarone. Review the continued need for the other antiarrhythmic agent after the effects of amiodarone have been established, and attempt discontinuation [see *Clinical Pharmacology* (12.3)].

*Digoxin*: In patients receiving *digoxin* therapy, administration of oral amiodarone results in an increase in serum digoxin concentration. Reduce dose of digoxin by half or discontinue digoxin. If digitalis treatment is continued, monitor serum levels closely and observe patients for clinical evidence of toxicity [see *Clinical Pharmacology* (12.3)].

HMG-CoA Reductase Inhibitors: Limit the dose of *simvastatin* in patients on amiodarone to 20 mg daily. Limit the daily dose of *lovastatin* to 40 mg. Lower starting and maintenance doses of other CYP3A4 substrates (e.g., atorvastatin) may be required as amiodarone may increase the plasma concentration of these drugs.

Anticoagulants: Potentiation of *warfarin*-type (CYP2C9 and CYP3A substrate) anticoagulant response is almost always seen in patients receiving amiodarone and can result in serious or fatal bleeding. Since the concomitant administration of warfarin with amiodarone increases the INR by 100% after 3 to 4 days, reduce the dose of the anticoagulant by one-third to one-half, and monitor INR closely.

*Cyclosporine* (CYP3A substrate) administered in combination with oral amiodarone has been reported to produce persistently elevated plasma concentrations of cyclosporine resulting in elevated creatinine, despite reduction in dose of cyclosporine. Monitor cyclosporine drug levels and renal function in patients taking both drugs.

Increased steady-state levels of *phenytoin* during concomitant therapy with amiodarone have been reported. Monitor phenytoin levels in patients taking both drugs.

## **8 USE IN SPECIFIC POPULATIONS**

### **8.1 Pregnancy**

Pregnancy Category D [see *Warnings and Precautions* (5.8)].

#### Teratogenic Effects

Amiodarone and desethylamiodarone cross the placenta.

Reported risks include:

- neonatal bradycardia, QT prolongation, and periodic ventricular extrasystoles
- neonatal hypothyroidism (with or without goiter) detected antenatally or in the newborn and reported even after a few days of exposure
- neonatal hyperthyroxinemia
- neurodevelopmental abnormalities independent of thyroid function, including speech delay and difficulties with written language and arithmetic, delayed motor development, and ataxia.
- jerk nystagmus with synchronous head titubation
- fetal growth retardation
- premature birth

Amiodarone has caused a variety of adverse effects in animals.

Amiodarone was given intravenously to rabbits at dosages of 5, 10, or 25 mg/kg per day (about 0.1, 0.3, and 0.7 times human intravenous maintenance dose of 0.5mg/min on a body surface area basis), during gestation days 8 to 16 (organogenesis). The incidence of maternal deaths increased with increasing dose and occurred in all treated groups and controls. Mean fetal weights were significantly decreased in the low and middle dose groups and embryotoxicity (as manifested by fewer full-term fetuses and increased resorptions) occurred at dosages of 10 mg/kg and above. There were no significant differences in the number of minor fetal abnormalities and no major fetal abnormalities were observed.

Amiodarone was administered by continuous intravenous infusion to rats at dosages of 25, 50, or 100 mg/kg per day (about 0.3, 0.7 and 1.3 times the human intravenous maintenance dose of 0.5 mg/min on a body surface area basis) during gestation days 8 to 16 (organogenesis). Maternal toxicity (manifest as reduced weight gain and food consumption) and embryotoxicity (manifest as increased resorptions, decreased live litter size and fetal body weights, and delayed sternal and metacarpal ossification) were observed in the 100 mg/kg group. The delayed ossification was reversible and related to decreased fetal weight. Fetal thyroid tissues appeared normal in all groups.

#### Nonteratogenic Effects

Very high concentrations of amiodarone and desethylamiodarone may be found in testes. An elevated follicle-stimulating hormone and luteinizing hormone levels, suggestive of testicular dysfunction, have been reported in men on long-term amiodarone treatment.

While planning pregnancy after discontinuation of amiodarone treatment, consider the long half-life of amiodarone and its metabolite DEA.

### **8.2 Labor and Delivery**

It is not known whether the use of amiodarone during labor or delivery has any immediate or delayed adverse effects. Preclinical studies in rodents have not shown any effect on the duration of gestation or on parturition.

### **8.3 Nursing Mothers**

Amiodarone and one of its major metabolites, desethylamiodarone (DEA), are excreted in human milk, suggesting that breast-feeding could expose the nursing infant to a significant dose of the drug. Nursing offspring of lactating rats administered amiodarone have demonstrated reduced viability and transient reduced body weight gains. The risk of exposing the infant to amiodarone and DEA must be weighed against the potential benefit of arrhythmia suppression in the mother. Advise the mother to discontinue nursing.

### **8.4 Pediatric Use**

The safety and effectiveness of amiodarone in pediatric patients have not been established; therefore, the use of amiodarone in pediatric patients is not recommended. In a pediatric trial of 61 patients, aged 30 days to 15 years, hypotension (36%), bradycardia (20%), and AV block (15%) were common dose-related adverse reactions and were severe or life-threatening in some cases. Injection site reactions were seen in 5 (25%) of the 20 patients receiving intravenous amiodarone through a peripheral vein irrespective of dose regimen.

### **8.5 Geriatric Use**

Clinical studies of amiodarone did not include sufficient numbers of subjects aged 65 and over to determine whether they respond differently from younger subjects. Other reported clinical experience has not identified differences in responses between the elderly and younger patients. Carefully consider dose selection in an elderly patient. In general, start at the low end of the dosing range in the elderly to reflect the greater frequency of decreased hepatic, renal, or cardiac function, and concomitant disease or other drug therapy.

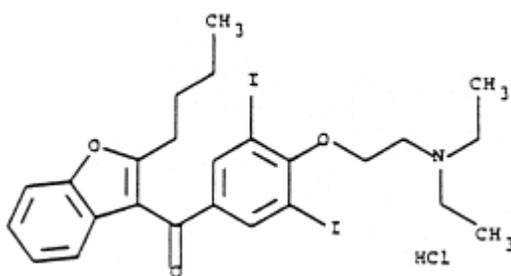
## **10 OVERDOSAGE**

There have been cases, some fatal, of amiodarone overdose. Effects of an inadvertent overdose of intravenous amiodarone include hypotension, cardiogenic shock, bradycardia, AV block, and hepatotoxicity. Treat hypotension and cardiogenic shock by slowing the infusion rate or with standard therapy: vasopressor drugs, positive inotropic agents, and volume expansion. Bradycardia and AV block may require temporary pacing. Monitor hepatic enzyme concentrations closely. Neither amiodarone nor DEA is dialyzable.

## **11 DESCRIPTION**

NEXTERONE contains amiodarone HCl ( $C_{25}H_{29}I_2NO_3 \cdot HCl$ ), a class III antiarrhythmic drug. Amiodarone HCl is (2-butyl-3-benzo-furanyl)[4-[2-(diethylamino)ethoxy]-3,5-diodophenyl]methanone hydrochloride.

Amiodarone HCl has the following structural formula:



Amiodarone HCl is a white to slightly yellow crystalline powder, and is very slightly soluble in water. It has a molecular weight of 681.78 and contains 37.3% iodine by weight. NEXTERONE Premixed Injection is a sterile clear, colorless to slightly yellow solution visually free from particulates. NEXTERONE Premixed Injection is available as a ready-to-use, nonpyrogenic, iso-osmotic solution for intravenous administration in 100mL GALAXY containers with 150 mg of amiodarone HCl, USP (1.5mg/mL) in dextrose; and 200mL GALAXY containers with 360 mg of amiodarone HCl, USP (1.8 mg/mL) in dextrose.

**NEXTERONE Premixed Injection (150 mg/100 mL, 1.5 mg/mL):**

Each mL contains 1.5 mg of amiodarone HCl, USP; 15 mg Betadex Sulfobutyl Ether Sodium, NF; 0.362 mg citric acid anhydrous, 0.183 mg sodium citrate dihydrate and 42.1 mg dextrose anhydrous in water for injection. Sodium hydroxide or hydrochloric acid may have been added to adjust pH.

**NEXTERONE Premixed Injection (360 mg/200 mL, 1.8 mg/mL):**

Each mL contains 1.8 mg of amiodarone HCl, USP; 18 mg Betadex Sulfobutyl Ether Sodium, NF; 0.362 mg citric acid anhydrous, 0.183 mg sodium citrate dihydrate and 41.4 mg dextrose anhydrous in water for injection. Sodium hydroxide or hydrochloric acid may have been added to adjust pH.

NEXTERONE does not contain polysorbate 80 or benzyl alcohol.

The GALAXY container is fabricated from a specially designed multilayered plastic (PL 2501). Solutions are in contact with the polyethylene layer of the container and can leach out certain chemical components of the plastic in very small amounts within the expiration period. The suitability and safety of the plastic have been confirmed in tests in animals according to the USP biological tests for plastic containers, as well as by tissue culture toxicity studies.

## 12 CLINICAL PHARMACOLOGY

### 12.1 Mechanism of Action

Amiodarone is generally considered a class III antiarrhythmic drug, but it possesses electrophysiologic characteristics of all four Vaughan Williams classes. Like class I drugs, amiodarone blocks sodium channels at rapid pacing frequencies, and like class II drugs, amiodarone exerts a noncompetitive antisymphathetic action. One of its main effects, with prolonged administration, is to lengthen the cardiac action potential, a class III effect. The negative chronotropic effect of amiodarone in nodal tissues is similar to the effect of class IV drugs. In addition to blocking sodium channels, amiodarone blocks myocardial potassium channels, which contributes to slowing of conduction and prolongation of refractoriness. The antisymphathetic action and the block of calcium and potassium channels are responsible for the negative dromotropic effects on the sinus node and for the slowing of conduction and prolongation of refractoriness in the atrioventricular (AV) node. Its vasodilatory action can decrease cardiac workload and consequently myocardial oxygen consumption.

Intravenous amiodarone administration prolongs intranodal conduction (Atrial-His, AH) and refractoriness of the atrioventricular node (ERP AVN), but has little or no effect on sinus cycle length (SCL), refractoriness of the right atrium and right ventricle (ERP RA and ERP RV), repolarization (QTc), intraventricular conduction (QRS), and infra-nodal conduction (His-ventricular, HV). A comparison of the electrophysiologic effects of intravenous amiodarone and oral amiodarone is shown in the table below.

**Table 5: EFFECTS OF INTRAVENOUS AND ORAL AMIODARONE ON ELECTROPHYSIOLOGIC PARAMETERS**

Formulation	SCL	QRS	QTc	AH	HV	ERP RA	ERP RV	ERP AVN
Intravenous	↔	↔	↔	↑	↔	↔	↔	↑
Oral	↑	↔	↑	↑	↔	↑	↑	↑

↔ No change

At higher doses (>10 mg/kg) of intravenous amiodarone, prolongation of the ERP RV and modest prolongation of the QRS have been seen. These differences between oral and IV administration suggest that the initial acute effects of intravenous amiodarone may be predominately focused on the AV node, causing an intranodal conduction delay and increased nodal refractoriness due to slow channel blockade (class IV activity) and noncompetitive adrenergic antagonism (class II activity).

## 12.2 Pharmacodynamics

Intravenous amiodarone has been reported to produce negative inotropic and vasodilatory effects in animals and humans. In clinical studies of patients with refractory VF or hemodynamically unstable VT, treatment-emergent, drug-related hypotension occurred in 288 of 1836 patients (16%) treated with intravenous amiodarone. No correlations were seen between the baseline ejection fraction and the occurrence of clinically significant hypotension during infusion of intravenous amiodarone.

No data are available on the activity of DEA in humans, but in animals, it has significant electrophysiologic and antiarrhythmic effects generally similar to amiodarone itself. DEA's precise role and contribution to the antiarrhythmic activity of oral amiodarone are not certain. The development of maximal ventricular class III effects after oral amiodarone administration in humans correlates more closely with DEA accumulation over time than with amiodarone accumulation. On the other hand, after intravenous amiodarone administration, there is evidence of activity well before significant concentrations of DEA are attained [see *Clinical Trials (14)*].

## 12.3 Pharmacokinetics

### **Disposition:**

Amiodarone exhibits complex disposition characteristics after intravenous administration. Peak serum concentrations after single 5 mg/kg 15-minute intravenous infusions in healthy subjects range between 5 and 41 mg/L. Peak concentrations after 10-minute infusions of 150 mg intravenous amiodarone in patients with ventricular fibrillation (VF) or hemodynamically unstable ventricular tachycardia (VT) range between 7 and 26 mg/L. Due to rapid distribution, serum concentrations decline to 10% of peak values within 30 to 45 minutes after the end of the infusion. In clinical trials, after 48 hours of continued infusions (125, 500 or 1000 mg/day) plus supplemental (150 mg) infusions (for recurrent arrhythmias), amiodarone mean serum concentrations between 0.7 to 1.4 mg/L were observed (n=260).

### **Metabolism:**

N-desethylamiodarone (DEA) is the major active metabolite of amiodarone in humans. DEA serum concentrations above 0.05 mg/L are not usually seen until after several days of continuous infusion but with prolonged therapy reach approximately the same concentration as amiodarone. Amiodarone is metabolized to DEA by the cytochrome P450 (CYP450) enzyme group, specifically cytochrome P4503A (CYP3A) and CYP2C8. The CYP3A isoenzyme is present in both the liver and intestines. The highly variable systemic availability of oral amiodarone may be attributed potentially to large interindividual variability in CYP3A activity.

***Distribution/Elimination:***

From in vitro studies, the protein binding of amiodarone is >96%. Amiodarone and DEA cross the placenta and both appear in breast milk. Neither amiodarone nor DEA is dialyzable.

Amiodarone is eliminated primarily by hepatic metabolism and biliary excretion and there is negligible excretion of amiodarone or DEA in urine. In studies in healthy subjects following single intravenous administration (5 mg/kg of amiodarone over 15 min), the plasma concentration vs. time profile could be characterized by linear sum of four exponential terms with terminal elimination half-lives ( $t_{1/2}$ ) of 9 - 36 days for amiodarone and 9 - 30 days for DEA. The clearance of amiodarone and DEA ranged between 63 - 231 mL/hr/kg and 140 - 400 mL/h/kg, respectively. In clinical studies of 2 to 7 days, clearance of amiodarone after intravenous administration in patients with VT and VF ranged between 220 and 440 mL/hr/kg.

***Special Populations:***

*Effect of Age:* The pharmacokinetics of amiodarone and DEA are affected by age. Normal subjects over 65 years of age show lower clearances (about 100 mL/hr/kg) than younger subjects (about 150 mL/hr/kg) and an increase in  $t_{1/2}$  from about 20 to 47 days.

*Effect of Gender:* Pharmacokinetics of amiodarone and DEA are similar in males and females.

*Renal Impairment:* Renal disease does not influence the pharmacokinetics of amiodarone or DEA.

*Hepatic Impairment:* After a single dose of intravenous amiodarone to cirrhotic patients, significantly lower  $C_{max}$  and average concentration values are seen for DEA, but mean amiodarone levels are unchanged.

*Cardiac Disease:* In patients with severe left ventricular dysfunction, the pharmacokinetics of amiodarone are not significantly altered but the terminal elimination  $t_{1/2}$  of DEA is prolonged.

Although no dosage adjustment for patients with renal, hepatic, or cardiac abnormalities has been defined during chronic treatment with oral amiodarone, close clinical monitoring is prudent for elderly patients and those with severe left ventricular dysfunction.

***Exposure-Response:*** There is no established relationship between drug concentration and therapeutic response for short-term intravenous use.

***Drug Interactions:***Effect of other drugs on amiodarone:

*Cimetidine* inhibits CYP3A and can increase serum amiodarone levels.

*Grapefruit juice* given to healthy volunteers increased amiodarone AUC by 50% and  $C_{max}$  by 84%, resulting in increased plasma levels of amiodarone.

*Cholestyramine* reduces enterohepatic circulation of amiodarone thereby increasing its elimination. This results in reduced amiodarone serum levels and half-life.

Effect of amiodarone on other drugs:

Amiodarone taken concomitantly with *quinidine* increases quinidine serum concentration by 33% after two days. Amiodarone taken concomitantly with *procainamide* for less than seven days increases plasma concentrations of procainamide and n-acetyl procainamide by 55% and 33%, respectively.

*Loratadine*, a non-sedating antihistaminic, is metabolized primarily by CYP3A and its metabolism can be inhibited by amiodarone

Metabolism of *lidocaine* can be inhibited by amiodarone. Sinus bradycardia has been reported with oral amiodarone in combination with lidocaine (CYP3A substrate) given

for local anesthesia. Seizure, associated with increased lidocaine concentrations, has been reported with concomitant administration of intravenous amiodarone.

Amiodarone can inhibit the metabolism of *macrolide/ketolide antibiotics* (except for azithromycin) and systemic azole antifungal drugs.

Amiodarone taken concomitantly with *digoxin* increases the serum digoxin concentration by 70% after one day.

*Dextromethorphan* is a substrate for both CYP2D6 and CYP3A. Amiodarone inhibits CYP2D6. Chronic (> 2 weeks) oral amiodarone administration impairs metabolism of dextromethorphan can lead to increased serum concentrations.

*Dabigatran etexilate* when taken concomitantly with oral amiodarone can result in elevated serum concentration of dabigatran.

*Cyclophosphamide* is a prodrug, metabolized by CYP450 including CYP3A to an active metabolite. The metabolism of cyclophosphamide may be inhibited by amiodarone.

*Clopidogrel*, an inactive thienopyridine prodrug, is metabolized in the liver by CYP3A to an active metabolite. A potential interaction between clopidogrel and amiodarone resulting in ineffective inhibition of platelet aggregation has been reported.

## 13 NONCLINICAL TOXICOLOGY

### 13.1 Carcinogenesis, Mutagenesis, Impairment of Fertility

No carcinogenicity studies were conducted with intravenous administration of amiodarone. However, oral amiodarone caused a statistically significant, dose-related increase in the incidence of thyroid tumors (follicular adenoma and carcinoma) in rats. The incidence of thyroid tumors in rats was greater than the incidence in controls even at the lowest dose level tested, i.e., 5 mg/kg/day (much less, on a body surface area basis, than the maximum recommended human maintenance dose of 600 mg/day).

Mutagenicity studies conducted with amiodarone HCl (Ames, micronucleus, and lysogenic induction tests) were negative.

No fertility studies were conducted with intravenous administration of amiodarone. However, in a study in which amiodarone HCl was orally administered to male and female rats, beginning 9 weeks prior to mating, reduced fertility was observed at a dose level of 90 mg/kg/day (approximately 1.4 times the maximum recommended human maintenance dose of 600 mg/day).

## 14 CLINICAL STUDIES

Apart from studies in patients with VT or VF, described below, there are two other studies of amiodarone showing an antiarrhythmic effect before significant levels of DEA could have accumulated. A placebo-controlled study of intravenous amiodarone (300 mg over 2 hours followed by 1200 mg/day) in post-coronary artery bypass graft patients with supraventricular and 2- to 3-consecutive-beat ventricular arrhythmias showed a reduction in arrhythmias from 12 hours on. A baseline-controlled study using a similar IV regimen in patients with recurrent, refractory VT/VF also showed rapid onset of antiarrhythmic activity; amiodarone therapy reduced episodes of VT by 85% compared to baseline.

The acute effectiveness of intravenous amiodarone in suppressing recurrent VF or hemodynamically unstable VT is supported by two randomized, parallel, dose-response studies of approximately 300 patients each. In these studies, patients with at least two episodes of VF or hemodynamically unstable VT in the preceding 24 hours were randomly assigned to receive doses of approximately 125 or 1000 mg over the first 24 hours, an 8-fold difference. In one study, a middle dose of approximately 500 mg was evaluated. The dose regimen consisted of an initial rapid loading infusion, followed by a slower 6-hour loading infusion, and then an 18-hour maintenance infusion. The maintenance infusion was continued up to hour 48. Additional 10-minute infusions of 150 mg intravenous amiodarone were given for "breakthrough" VT/VF more frequently

to the 125 mg dose group, thereby considerably reducing the planned 8-fold differences in total dose to 1.8- and 2.6-fold, respectively, in the two studies.

The prospectively defined primary efficacy end point was the rate of VT/VF episodes per hour. For both studies, the median rate was 0.02 episodes per hour in patients receiving the high dose and 0.07 episodes per hour in patients receiving the low dose, or approximately 0.5 versus 1.7 episodes per day (p=0.07, 2-sided, in both studies). In one study, the time to first episode of VT/VF was significantly prolonged (approximately 10 hours in patients receiving the low dose and 14 hours in patients receiving the high dose). In both studies, significantly fewer supplemental infusions were given to patients in the high-dose group. At the end of double-blind therapy or after 48 hours, all patients were given open access to whatever treatment (including intravenous amiodarone) was deemed necessary. Mortality was not affected in these studies.

## **16 HOW SUPPLIED/STORAGE AND HANDLING**

NEXTERONE (amiodarone HCl) Premixed Injection is supplied as a ready-to-use, sterile, nonpyrogenic, iso-osmotic solution in 100 mL and 200 mL single-dose GALAXY containers (PL 2501 plastic) packaged in individual cartons as follows:

150 mg/100 mL NDC 43066 – 150 – 10 2G3451  
360 mg/200 mL NDC 43066 – 360 – 20 2G3450

Do not add supplementary medication to NEXTERONE Premixed Injection.  
Store at 20° - 25°C (68° - 77°F); excursions permitted to 15° - 30°C (59° - 86°F). See USP Controlled Room Temperature.  
Protect from light and excessive heat. Protect from freezing.  
Use carton to protect contents from light until used.

## **17 PATIENT COUNSELING INFORMATION**

Amiodarone has the potential to cause serious side effects that limit its use to life-threatening and hemodynamically unstable cardiac arrhythmias. Advise female patients to discontinue nursing while being treated with amiodarone, as breast-feeding could expose the nursing infant to a significant dose of the drug. Recommend that patients avoid grapefruit juice, over-the-counter cough medicine (that commonly contain dextromethorphan), and *St. John's Wort*. Inform patients that most manufacturers of corneal refractive laser surgery devices contraindicate corneal refractive laser surgery in patients taking amiodarone. Discuss the symptoms of hypo- and hyper-thyroidism, particularly if patients will be transitioned to oral amiodarone.

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Deerfield, IL 60015

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