MINOCIN®

Minocycline For Injection
100 Mg/Vial Intravenous

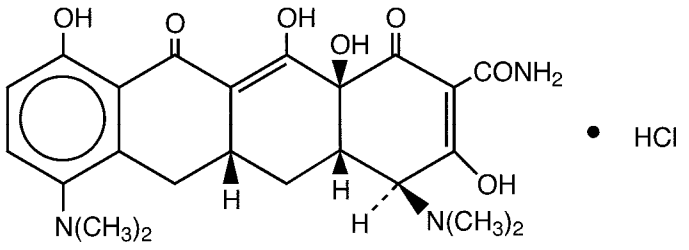
℞ only

To reduce the development of drug-resistant bacteria and maintain the effectiveness of MINOCIN® (minocycline) Injection and other antibacterial drugs, MINOCIN® (minocycline) injection should be used only to treat or prevent infections that are proven or strongly suspected to be caused by bacteria.

DESCRIPTION

MINOCIN, minocycline for injection, a sterile formulation of a semisynthetic derivative of tetracycline, is 4,7-Bis(dimethylamino)-1,4,4a,5,5a,6,11,12a-octahydro-3,10,12,12a-tetrahydroxy-1,11-dioxo-2-naphthacenecarboxamide monohydrochloride.

Its structural formula is:



$C_{23}H_{27}N_3O_7$•HCl M.W. 493.94

Each vial, dried by cryodesiccation, contains minocycline HCl equivalent to 100 mg minocycline. When reconstituted with 5 mL of Sterile Water for Injection USP the pH ranges from 2.0 to 2.8.

CLINICAL PHARMACOLOGY

Following a single dose of Minocin 200 mg administered intravenously to 10 healthy male subjects, serum concentrations of minocycline ranged from 2.52 to 6.63 mcg/mL (average 4.18 mcg/mL) at the end of infusion and 0.82 to 2.64 mcg/mL (average 1.38 mcg/mL) after 12 hours. In a group of 5 healthy male subjects, serum concentrations of minocycline ranged from 1.4 to 1.8 mcg/mL at the end of the dosing interval following administration of Minocin 100 mg every 12 hours for three days. When Minocin 200 mg once daily was administered for three days, serum concentrations of minocycline were approximately 1 mcg/mL at 24 hours. The serum elimination half-life of minocycline following administration of either Minocin 100 mg every 12 hours or 200 mg once daily was not significantly different and ranged from 15 to 23 hours.

The serum elimination half-life of minocycline ranged from 11 to 16 hours in subjects with hepatic impairment (n=7) and 18 to 69 hours in subjects with renal impairment (n=5). In comparison, the serum elimination half-life of minocycline ranged from 11 to 17 hours following a single dose of oral minocycline 200 mg in healthy subjects (n=12).

Microbiology

The tetracyclines are primarily bacteriostatic and are thought to exert their antimicrobial effect by the inhibition of protein synthesis. The tetracyclines, including minocycline, have a similar antimicrobial spectrum of activity against a wide range of Gram-positive and Gram-negative bacteria. Cross-resistance of these bacteria to tetracyclines is common.

Minocycline has been shown to be active against most isolates of the following bacteria, both in vitro and in clinical infections as described in the **INDICATIONS AND USAGE** section:

GRAM-POSITIVE BACTERIA

Because many isolates of the following Gram-positive bacteria have been shown to be resistant to tetracyclines, culture and susceptibility testing are especially recommended.
Bacillus anthracis[1]
Listeria monocytogenes[1]
Staphylococcus aureus
Streptococcus pneumoniae

GRAM-NEGATIVE BACTERIA

Bartonella bacilliformis
Brucella species
Klebsiella (Calymmatobacterium) granulomatis
Campylobacter fetus
Francisella tularensis
Vibrio cholerae
Yersinia pestis

Because many isolates of the following Gram-negative bacteria have been shown to be resistant to tetracyclines, culture and susceptibility testing are especially recommended.
Acinetobacter species
Enterobacter aerogenes
Escherichia coli
Haemophilus influenzae
Klebsiella species
Neisseria meningitidis[1]
Shigella species

“OTHER” MICROORGANISMS
Actinomyces species[1]
Borrelia recurrentis
Chlamydia psittaci
Chlamydia trachomatis
Clostridium species[1]
Entamoeba species
Fusobacterium nucleatum subspecies *fusiforme*[1]
Mycobacterium marinum
Mycoplasma pneumoniae
Propionibacterium acnes
Rickettsiae
Treponema pallidum subspecies *pallidum*[1]
Treponema pallidum subspecies *pertenue*[1]
Ureaplasma urealyticum

[1]When penicillin is contraindicated, tetracyclines are alternative drugs in the treatment of infections caused by the cited bacteria.

Susceptibility Tests

When available, the clinical microbiology laboratory should provide the results of in vitro susceptibility test results for antimicrobial drugs used in resident hospitals to the physician as periodic reports that describe the susceptibility profile of nosocomial and community-acquired pathogens. These reports should aid the physician in selecting an antibacterial drug for treatment.*

Broth microdilution and agar dilution susceptibility testing should be performed with **tetracycline except when testing** *Neisseria meningitidis* **(see below)** since it predicts susceptibility to minocycline. However, certain bacteria (e.g. *Acinetobacter* species) may be more susceptible to minocycline and doxycycline than to tetracycline.

Dilution techniques:
Quantitative methods are used to determine antimicrobial minimal inhibitory concentrations (MICs). These MICs provide estimates of the susceptibility of bacteria to antimicrobial compounds. The MICs should be determined using a standardized procedure. Standardized procedures are based on a dilution method[1,,3] (broth or agar) or equivalent with standardized inoculum concentrations and standardized concentrations of tetracycline powder (Note: minocycline powder should be used for testing *Neisseria meningiditis*). The MIC values should be interpreted according to the following criteria:

For Enterobacteriaceae, *Acinetobacter* species, *Staphylococcus aureus,* and *Vibrio cholerae*

MIC (µg/mL)	Interpretation
≤4.0	Susceptible (S)
8.0	Intermediate (I)
≥16.0	Resistant (R)

For *Haemophilus influenzae* and *Streptococcus pneumoniae*

MIC (µg/mL)	Interpretation
≤2.0	Susceptible (S)
4.0	Intermediate (I)
≥8.0	Resistant (R)

For *Neisseria meningiditis* (use minocycline powder for testing)

MIC (mcg/mL)	Interpretation
≤2.0	Susceptible (S)

For *Bacillus anthracis*

MIC (mcg/mL)	Interpretation
≤1.0	Susceptible (S)

For *Francisella tularensis*

MIC (mcg/mL)	Interpretation
≤4.0	Susceptible (S)

A report of “Susceptible” indicates that the pathogen is likely to be inhibited if the antimicrobial compound in the blood reaches the concentrations usually achievable. A report of “Intermediate” indicates that the result should be considered equivocal, and, if the microorganism is not fully susceptible to alternative, clinically feasible drugs, the test should be repeated. This category implies possible clinical applicability in body sites where the drug is physiologically concentrated or in situations where high dosage of drug can be used. This category also provides a buffer zone which prevents small uncontrolled technical factors from causing major discrepancies in interpretation. A report of “Resistant” indicates that the pathogen is not likely to be inhibited if the antimicrobial compound in the blood reaches the concentrations usually achievable; other therapy should be selected.

Standardized susceptibility test procedures require the use of laboratory control bacteria to control the technical aspects of the laboratory procedures. Standard **tetracycline** powder should provide the following MIC values:

Microorganism	MIC Range (µg/mL)
Escherichia coli ATCC 25922	0.5-2.0
Haemophilus influenzae ATCC 49247	4-32
Staphylococcus aureus ATCC 29213	0.06-0.5
Streptococcus pneumoniae ATCC 49619	0.12-0.5

Diffusion techniques:

Quantitative methods that require measurement of zone diameters also provide reproducible estimates of the susceptibility of bacteria to antimicrobial compounds. One such standardized procedure[2,,3] requires the use of standardized inoculum concentrations. This procedure uses paper disks impregnated with 30 mcg tetracycline (class disk) or 30 mcg minocycline to test the susceptibility of bacteria to minocycline.

Reports from the laboratory providing results of the standard single-disk susceptibility test with a 30 mcg **tetracycline or 30 mcg minocycline** disk should be interpreted according to the following criteria:

For Enterobacteriaceae and *Acinetobacter* species with tetracycline disk

Zone Diameter (mm)	Interpretation
≥15	Susceptible (S)
12-14	Intermediate (I)
≤11	Resistant (R)

For Enterobacteriaceae and *Acinetobacter* species with minocycline disk

Zone Diameter (mm)	Interpretation
≥16	Susceptible (S)
13-15	Intermediate (I)
≤12	Resistant (R)

For *Haemophilus influenzae* with tetracycline disk

Zone Diameter (mm)	Interpretation
≥29	Susceptible (S)
26-28	Intermediate (I)
≤25	Resistant (R)

For *Streptococcus pneumoniae* with tetracycline disk

Zone Diameter (mm)	Interpretation
≥23	Susceptible (S)
19-22	Intermediate (I)
≤18	Resistant (R)

For *Staphylococcus aureus* and *Vibrio cholerae* with tetracycline disk

Zone Diameter (mm)	Interpretation
≥19	Susceptible (S)
15-18	Intermediate (I)
≤14	Resistant (R

For *Neisseria meningitidis* with minocycline disk

Zone Diameter (mm)	Interpretation
≥26	Susceptible (S)

As with standardized dilution techniques, diffusion methods require the use of laboratory control bacteria that are used to control the technical aspects of the laboratory procedures. For the diffusion technique, the 30 mcg tetracycline disk or 30 mcg minocycline disk should provide the following zone diameters in these laboratory test quality control strains:

Microorganism	Zone Diameter Range (mm)	
	Tetracycline	Minocycline
Escherichia coli ATCC 25922	18-25	19-25
Haemophilus influenzae ATCC 49247	14-22	-------
Staphylococcus aureus ATCC 259233	24-30	
Streptococcus pneumoniae ATCC 49619	27-31	--------

INDICATIONS AND USAGE

MINOCIN® Intravenous is indicated in the treatment of the following infections due to susceptible isolates of the designated bacteria:

Rocky Mountain spotted fever, typhus fever and the typhus group, Q fever, rickettsialpox and tick fevers caused by rickettsiae.
Respiratory tract infections caused by *Mycoplasma pneumoniae*.
Lymphogranuloma venereum caused by *Chlamydia trachomatis*.
Psittacosis (Ornithosis) due to *Chlamydia psittaci*.
Trachoma caused by *Chlamydia trachomatis*, although the infectious agent is not always eliminated, as judged by immunofluorescence.
Inclusion conjunctivitis caused by *Chlamydia trachomatis*.
Nongonococcal urethritis, endocervical, or rectal infections in adults caused by *Ureaplasma urealyticum* or *Chlamydia trachomatis.*
Relapsing fever due to *Borrelia recurrentis*.
Plague due to *Yersinia pestis*.
Tularemia due to *Francisella tularensis*.
Cholera caused by *Vibrio cholerae*.
Campylobacter fetus infections caused by *Campylobacter fetus*.
Brucellosis due to *Brucella* species (in conjunction with streptomycin).
Bartonellosis due to *Bartonella bacilliformis*.
Granuloma inguinale caused by Klebsiella (*Calymmatobacterium) granulomatis*.

Minocycline is indicated for the treatment of infections caused by the following Gram-negative bacteria when bacteriologic testing indicates appropriate susceptibility to the drug:

Escherichia coli.
Enterobacter aerogenes.
Shigella species.
Acinetobacter species.
Respiratory tract infections caused by *Haemophilus influenzae*.
Respiratory tract and urinary tract infections caused by *Klebsiella* species.

MINOCIN® Intravenous is indicated for the treatment of infections caused by the following Gram-positive bacteria when bacteriologic testing indicates appropriate susceptibility to the drug:

Upper respiratory tract infections caused by *Streptococcus pneumoniae.*
Skin and skin structure infections caused by *Staphylococcus aureus* (Note: Minocycline is not the drug of choice in the treatment of any type of staphylococcal infection.)

When penicillin is contraindicated, minocycline is an alternative drug in the treatment of the following infections:

Meningitis due to *Neisseria meningitidis*.
Syphilis caused by *Treponema pallidum* subspecies *pallidum*.
Yaws caused by *Treponema pallidum* subspecies *pertenue*.
Listeriosis due to *Listeria monocytogenes*.
Anthrax due to *Bacillus anthracis*.
Vincent's infection caused by *Fusobacterium fusiforme.*
Actinomycosis caused by *Actinomyces israelii*.
Infections caused by *Clostridium* species.

In *acute intestinal amebiasis*, minocycline may be a useful adjunct to amebicides.

In severe *acne*, minocycline may be useful adjunctive therapy.

To reduce the development of drug-resistant bacteria and maintain the effectiveness of MINOCIN® (minocycline) Injection and other antibacterial drugs, MINOCIN® (minocycline) Injection should be used only to treat or prevent infections that are proven or strongly suspected to be caused by susceptible bacteria. When culture and susceptibility information are available, they should be considered in selecting or modifying antibacterial therapy. In the absence of such data, local epidemiology and susceptibility patterns may contribute to the empiric selection of therapy.

CONTRAINDICATIONS

This drug is contraindicated in persons who have shown hypersensitivity to any of the tetracyclines or to any of the components of the product formulation.

WARNINGS

MINOCIN, LIKE OTHER TETRACYCLINE-CLASS ANTIBIOTICS, CAN CAUSE FETAL HARM WHEN ADMINISTERED TO A PREGNANT WOMAN. IF ANY TETRACYCLINE IS USED DURING PREGNANCY, OR IF THE PATIENT BECOMES PREGNANT WHILE TAKING THESE DRUGS, THE PATIENT SHOULD BE APPRISED OF THE POTENTIAL HAZARD TO THE FETUS. THE USE OF DRUGS OF THE TETRACYCLINE CLASS DURING TOOTH DEVELOPMENT (LAST HALF OF PREGNANCY, INFANCY, AND CHILDHOOD TO THE AGE OF 8 YEARS) MAY CAUSE PERMANENT DISCOLORATION OF THE TEETH (YELLOW-GRAY-BROWN).

This adverse reaction is more common during long-term use of the drugs but has been observed following repeated short-term courses. Enamel hypoplasia has also been reported. **TETRACYCLINE DRUGS, THEREFORE, SHOULD NOT BE USED DURING TOOTH DEVELOPMENT UNLESS OTHER DRUGS ARE NOT LIKELY TO BE EFFECTIVE OR ARE CONTRAINDICATED.**

All tetracyclines form a stable calcium complex in any bone-forming tissue. A decrease in the fibula growth rate has been observed in premature human infants given oral tetracycline in doses of 25 mg/kg every six hours. This reaction was shown to be reversible when the drug was discontinued.

Results of animal studies indicate that tetracyclines cross the placenta, are found in fetal tissues, and can have toxic effects on the developing fetus (often related to retardation of skeletal development). Evidence of embryotoxicity has been noted in animals treated early in pregnancy.

Drug Rash with Eosinophilia and Systemic Symptoms (DRESS) including fatal cases have been reported with minocycline use. If this syndrome is recognized, the drug should be discontinued immediately.

The anti-anabolic action of the tetracyclines may cause an increase in BUN. While this is not a problem in those with normal renal function, in patients with significantly impaired function, higher serum levels of tetracycline may lead to azotemia, hyperphosphatemia, and acidosis. Under such conditions, monitoring of creatinine and BUN is recommended, and the total daily dosage should not exceed 200 mg in 24 hours (See **DOSAGE AND ADMINISTRATION)** If renal impairment exists, even usual oral or parenteral doses may lead to systemic accumulation of the drug and possible liver toxicity.

Photosensitivity manifested by an exaggerated sunburn reaction has been observed in some individuals taking tetracyclines. This has been reported with minocycline.

Central nervous system side effects including light-headedness, dizziness or vertigo have been reported. Patients who experience these symptoms should be cautioned about driving vehicles or using hazardous machinery while on minocycline therapy. These symptoms may disappear during therapy and usually disappear rapidly when the drug is discontinued.

Clostridium difficile associated diarrhea (CDAD) has been reported with use of nearly all antibacterial agents, including MINOCIN®, and may range in severity from mild diarrhea to fatal colitis. Treatment with antibacterial agents alters the normal flora of the colon leading to overgrowth of *C. difficile*.

C. difficile produces toxins A and B which contribute to the development of CDAD. Hypertoxin producing strains of *C. difficile* cause increased morbidity and mortality, as these infections can be refractory to antimicrobial therapy and may require colectomy. CDAD must be considered in all patients who present with diarrhea following antibiotic use. Careful medical history is necessary since CDAD has been reported to occur over two months after the administration of antibacterial agents.

If CDAD is suspected or confirmed, ongoing antibiotic use not directed against *C. difficile* may need to be discontinued. Appropriate fluid and electrolyte management, protein supplementation, antibiotic treatment of *C. difficile*, and surgical evaluation should be instituted as clinically indicated.

PRECAUTIONS

General

As with other antibiotic preparations, use of this drug may result in overgrowth of nonsusceptible organisms, including fungi. If superinfection occurs, the antibiotic should be discontinued and appropriate therapy instituted.

Pseudotumor cerebri (benign intracranial hypertension) in adults has been associated with the use of tetracyclines. The usual clinical manifestations are headache and blurred vision. Bulging fontanels have been associated with the use of tetracyclines in infants. While both of these conditions and related symptoms usually resolve soon after discontinuation of the tetracycline, the possibility for permanent sequelae exists.

Hepatotoxicity has been reported with minocycline; therefore, minocycline should be used with caution in patients with hepatic dysfunction and in conjunction with other hepatotoxic drugs.

Incision and drainage or other surgical procedures should be performed in conjunction with antibiotic therapy when indicated.

Prescribing MINOCIN® Injection in the absence of a proven or strongly suspected bacterial infection or a prophylactic indication is unlikely to provide benefit to the patient and increases the risk of the development of drug-resistant bacteria.

Information for Patients

Patients should be counseled that antibacterial drugs including MINOCIN® (minocycline) Injection should only be used to treat bacterial infections. They do not treat viral infections (eg, the common cold). When MINOCIN® (minocycline) Injection is prescribed to treat a bacterial infection, patients should be told that although it is common to feel better early in the course of therapy, the medication should be taken exactly as directed. Skipping doses or not completing the full course of therapy may (1) decrease the effectiveness of the immediate treatment and (2) increase the likelihood that bacteria will develop resistance and will not be treatable by MINOCIN® (minocycline) Injection or other antibacterial drugs in the future.

Diarrhea is a common problem caused by antibiotics which usually ends when the antibiotic is discontinued. Sometimes after starting treatment with antibiotics, patients can develop watery and bloody stools (with or without stomach cramps and fever) even as late as two or more months after having taken the last dose of the antibiotic. If this occurs, patients should contact their physician as soon as possible.

Laboratory Tests

Periodic laboratory evaluation of organ systems, including hematopoietic, renal and hepatic studies should be performed.

All patients with gonorrhea should have a serologic test for syphilis at the time of diagnosis. Patients treated with minocycline should have a follow-up serologic test for syphilis after 3 months.

Drug Interactions

Because tetracyclines have been shown to depress plasma prothrombin activity, patients who are on anticoagulant therapy may require downward adjustment of their anticoagulant dosage.

Since bacteriostatic drugs may interfere with the bactericidal action of penicillin, it is advisable to avoid giving tetracyclines in conjunction with penicillin.

The concurrent use of tetracyclines and methoxyflurane has been reported to result in fatal renal toxicity.

Concurrent use of tetracyclines with oral contraceptives may render oral contraceptives less effective.

Administration of isotretinoin should be avoided shortly before, during, and shortly after minocycline therapy. Each drug alone has been associated with pseudotumor cerebri (See **PRECAUTIONS).**

Increased risk of ergotism when ergot alkaloids or their derivatives are given with tetracyclines.

Drug/Laboratory Test Interactions

False elevations of urinary catecholamine levels may occur due to interference with the fluorescence test.

Carcinogenesis, Mutagenesis, Impairment of Fertility

Dietary administration of minocycline in long-term tumorigenicity studies in rats resulted in evidence of thyroid tumor production. Minocycline has also been found to produce thyroid hyperplasia in rats and dogs. In addition, there has been evidence of oncogenic activity in rats in studies with a related antibiotic, oxytetracycline (ie, adrenal and pituitary tumors). Likewise, although mutagenicity studies of minocycline have not been conducted, positive results in *in vitro* mammalian cell assays (ie, mouse lymphoma and Chinese hamster lung cells) have been reported for related antibiotics (tetracycline hydrochloride and oxytetracycline). Segment I (fertility and general reproduction) studies have provided evidence that minocycline impairs fertility in male rats.

Pregnancy

Teratogenic Effects: Pregnancy Category D (See **WARNINGS)**

All pregnancies have a background risk of birth defects, loss, or other adverse outcome regardless of drug exposure. There are no adequate and well-controlled studies on the use of minocycline in pregnant women. Minocycline, like other tetracycline-class antibiotics, crosses the placenta and may cause fetal harm when administered to a pregnant woman. Rare spontaneous reports of congenital anomalies including limb reduction have been reported in post-marketing experience. Only limited information is available regarding these reports; therefore, no conclusion on causal association can be established. If minocycline is used during pregnancy or if the patient becomes pregnant while taking this drug, the patient should be apprised of the potential hazard to the fetus.

Nonteratogenic Effects (See **WARNINGS**)

Labor and Delivery

The effect of tetracyclines on labor and delivery is unknown.

Nursing Mothers

Tetracyclines are excreted in human milk. Because of the potential for serious adverse reactions in nursing infants from tetracyclines, a decision should be made whether to discontinue nursing or discontinue the drug, taking into account the importance of the drug to the mother. (See **WARNINGS**.)

Pediatric Use

Minocycline is not recommended for use in children below 8 years of age unless the expected benefits of therapy outweigh the risks (See **WARNINGS**).

Geriatric Use

Clinical studies of intravenous minocycline did not include sufficient numbers of subjects aged 65 and over to determine whether they respond differently from younger subjects. In general, dose selection for an elderly patient should be cautious, usually starting at the low end of the dosing range, reflecting the greater frequency of decreased hepatic, renal, or cardiac function, and of concomitant disease or other drug therapy (See **WARNINGS**, **DOSAGE AND ADMINISTRATION**).

MINOCIN® IV (sterile minocycline hydrochloride, USP) does not contain sodium.

ADVERSE REACTIONS

The following adverse reactions have been observed in patients receiving tetracyclines.

Body as a whole: Fever, and discoloration of secretions.

Gastrointestinal: Anorexia, nausea, vomiting, diarrhea, dyspepsia, stomatitis, glossitis, dysphagia, enamel hypoplasia, enterocolitis, pseudomembranous colitis, pancreatitis, inflammatory lesions (with monilial overgrowth) in the oral and anogenital regions. These reactions have been caused by both the oral and parenteral administration of tetracyclines.

Genitourinary: Vulvovaginitis.

Hepatic toxicity: Hyperbilirubinemia, hepatic cholestasis, increases in liver enzymes, fatal hepatic failure, and jaundice. Hepatitis, including autoimmune hepatitis, and liver failure have been reported (See **PRECAUTIONS**).

Skin: Alopecia, erythema nodosum, hyperpigmentation of nails, pruritus, toxic epidermal necrolysis, and vasculitis, maculopapular and erythematous rashes. Exfoliative dermatitis has been reported. Fixed drug eruptions have been reported. Lesions occurring on the glans penis have caused balanitis. Erythema multiforme and Stevens-Johnson syndrome have been reported. Photosensitivity is discussed above (See **WARNINGS**). Pigmentation of the skin and mucous membranes has been reported.

Local Reactions: Injection site erythema and injection site pain.

Respiratory: Cough, dyspnea, bronchospasm, exacerbation of asthma, and pneumonitis.

Renal toxicity: Interstitial nephritis. Elevations in BUN have been reported and are apparently dose related (See **WARNINGS**). Acute renal failure has been reported.

Musculoskeletal: Arthralgia, arthritis, bone discoloration, myalgia, joint stiffness, and joint swelling.

Hypersensitivity reactions: Urticaria, angioneurotic edema, polyarthralgia, anaphylaxis/anaphylactoid reaction (including shock and fatalities), anaphylactoid purpura, myocarditis, pericarditis, exacerbation of systemic lupus erythematosus, and pulmonary infiltrates with eosinophilia have been reported. A lupus-like syndrome and serum sickness-like reactions also have been reported.

Blood: Agranulocytosis, hemolytic anemia, thrombocytopenia, leukopenia, neutropenia, pancytopenia, and eosinophilia have been reported.

Central Nervous System: Convulsions, dizziness, hypesthesia, paresthesia, sedation, and vertigo. Pseudotumor cerebri (benign intracranial hypertension) in adults and bulging fontanels in infants (See **PRECAUTIONS-General).** Headache has also been reported.

Other: Thyroid cancer has been reported in the post-marketing setting in association with minocycline products. When minocycline therapy is given over prolonged periods, monitoring for signs of thyroid cancer should be considered. When given over prolonged periods, tetracyclines have been reported to produce brown-black microscopic discoloration of the thyroid gland. Cases of abnormal thyroid function have been reported.

Tooth discoloration in pediatric patients less than 8 years of age (see **WARNINGS**) and in adults has been reported.

Oral cavity discoloration (including tongue, lip, and gum) have been reported.

Tinnitus and decreased hearing have been reported in patients on MINOCIN® (minocycline for injection).

The following syndromes have been reported. In some cases involving these syndromes, death has been reported. As with other serious adverse reactions, if any of these syndromes are recognized, the drug should be discontinued immediately:

Hypersensitivity syndrome consisting of cutaneous reaction (such as rash or exfoliative dermatitis), eosinophilia, and one or more of the following: hepatitis, pneumonitis, nephritis, myocarditis, and pericarditis. Fever and lymphadenopathy may be present.

Lupus-like syndrome consisting of positive antinuclear antibody; arthralgia, arthritis, joint stiffness, or joint swelling; and one or more of the following: fever, myalgia, hepatitis, rash, and vasculitis.

Serum sickness-like syndrome consisting of fever; urticaria or rash; and arthralgia, arthritis, joint stiffness, or joint swelling. Eosinophilia may be present.

OVERDOSAGE

The adverse events more commonly seen in overdose are dizziness, nausea, and vomiting.

No specific antidote for minocycline is known.

In case of overdosage, discontinue medication, treat symptomatically, and institute supportive measures. Minocycline is not removed in significant quantities by hemodialysis or peritoneal dialysis.

DOSAGE AND ADMINISTRATION

THE USUAL DOSAGE AND FREQUENCY OF ADMINISTRATION OF MINOCYCLINE DIFFERS FROM THAT OF THE OTHER TETRACYCLINES. EXCEEDING THE RECOMMENDED DOSAGE MAY RESULT IN AN INCREASED INCIDENCE OF SIDE EFFECTS.

Note: Rapid administration is to be avoided. Parenteral therapy is indicated only when oral therapy is not adequate or tolerated. Oral therapy should be instituted as soon as possible. If intravenous therapy is given over prolonged periods of time, thrombophlebitis may result.

For Pediatric Patients above 8 years of Age

Usual pediatric dose: Initial dose of 4 mg/kg, then 2 mg/kg every 12 hours, not to exceed the usual adult dose

Adults

Usual adult dose: Initial dose of 200 mg, then 100 mg every 12 hours and should not exceed 400 mg in 24 hours. The cryodesiccated powder should be reconstituted with 5 mL Sterile Water for Injection USP and immediately further diluted to 500 mL to 1,000 mL with Sodium Chloride Injection USP, Dextrose Injection USP, Dextrose and Sodium Chloride Injection USP, Ringer's Injection USP, or Lactated Ringer's Injection USP, but not with other solutions containing calcium because a precipitate may form especially in neutral and alkaline solutions. When further diluted in 500 mL to 1,000 mL of compatible solutions (except Lactated Ringer's), the pH usually ranges from 2.5 to 4.0. The pH of MINOCIN® IV 100 mg in Lactated Ringer's 500 mL to 1,000 mL usually ranges from 4.5 to 6.0.

Final dilutions (500 mL to 1,000 mL) should be administered immediately but product and diluents are compatible at room temperature for 24 hours without a significant loss of potency. Any unused portions must be discarded after that period.

The pharmacokinetics of minocycline in patients with renal impairment (CL_{CR} <80 mL/min) have not been fully characterized. Current data are insufficient to determine if a dosage adjustment is warranted. The total daily dosage should not exceed 200 mg in 24 hours in patients with renal impairment. However, due to the anti-anabolic effect of tetracyclines, BUN and creatinine should be monitored (See **WARNINGS**).

Parenteral drug products should be inspected visually for particulate matter and discoloration prior to administration, whenever solution and container permit.

Incompatibilities

MINOCIN® IV should not be mixed before or during administration with any solutions containing: adrenocorticotropic hormone (ACTH), aminophylline, amobarbital sodium, amphotericin B, bicarbonate infusion mixtures, calcium gluconate or chloride, carbenicillin, cephalothin sodium, cefazolin sodium, chloramphenicol succinate, colistin sulfate, heparin sodium, hydrocortisone sodium succinate, iodine sodium, methicillin sodium, novobiocin, penicillin, pentobarbital, phenytoin sodium, polymyxin, prochlorperazine, sodium ascorbate, sulfadiazine, sulfisoxazole, thiopental sodium, vitamin K (sodium bisulfate or sodium salt), whole blood.

HOW SUPPLIED

MINOCIN® (minocycline for injection) Intravenous is supplied as 100 mg vials of sterile cryodesiccated powder.

Product No. NDC 14290-545-92

Store at Controlled Room Temperature 20° to 25°C (68° to 77°F).

ANIMAL PHARMACOLOGY AND TOXICOLOGY

Minocycline hydrochloride has been observed to cause a dark discoloration of the thyroid in experimental animals (rats, minipigs, dogs, and monkeys). In the rat, chronic treatment with minocycline hydrochloride has resulted in goiter accompanied by elevated radioactive iodine uptake and evidence of thyroid tumor production. Minocycline hydrochloride has also been found to produce thyroid hyperplasia in rats and dogs.

REFERENCES

1. Clinical and Laboratory Standards (CLSI). Methods for Dilution Susceptibility Tests for Bacteria that Grow Aerobically; Approved Standard – 8th ed. CLSI document M07-A8. CLSI, 940 West Valley Rd., Suite 1400, Wayne, PA 19087-1898, 2009

2. CLSI. Performance Standards for Antimicrobial Disk Susceptibility Tests; Approved Standard-10th ed. CLSI document M02-A10, 2009.

3. CLSI. Performance Standards for Antimicrobial Susceptibility Testing; 19th Informational supplement. CLSI document M100-S19, 2009.

This product's label may have been updated. For current package insert and further product information, please visit www.triaxpharma.com or call our toll-free number: 800 978 5060. Call between 9:00 a.m. and 5:00 p.m. Eastern Time, Monday through Friday.

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Monza (Milan), Italy

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Triax Pharmaceuticals, LLC.
152F504
08/10