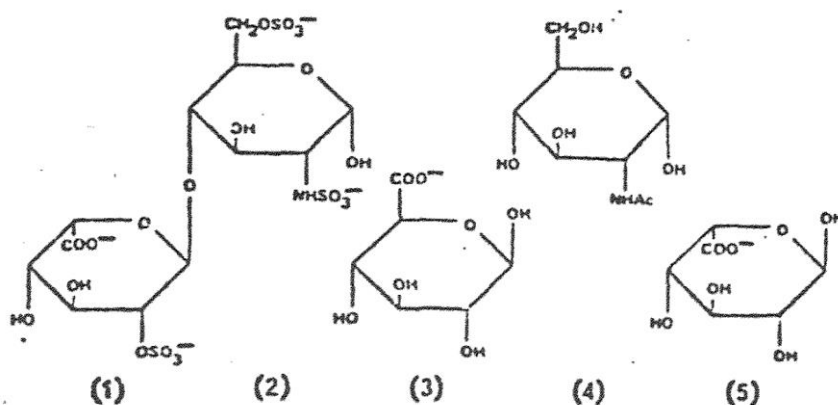


Heparin Sodium Injection, USP

DESCRIPTION

Heparin is a heterogenous group of straight-chain anionic mucopolysaccharides, called glycosaminoglycans having anticoagulant properties. Although others may be present, the main sugars occurring in heparin are: (1) α -L-iduronic acid 2-sulfate, (2) 2-deoxy-2-sulfamino- α -D-glucose 8-sulfate, (3) β -D-glucuronic acid, (4) 2-acetamido-2-deoxy- α -D-glucose, and (5) -L-iduronic acid. These sugars are present in decreasing amounts, usually in the order (2) > (1) > (4) > (3) > (5), and are joined by glycosidic linkages, forming polymers of varying sizes. Heparin is strongly acidic because of its content of covalently linked sulfate and carboxylic acid groups. In heparin sodium, the acidic protons of the sulfate units are partially replaced by sodium ions.

Structure of Heparin Sodium (representative subunits):



Heparin Sodium Injection, USP, is a sterile solution of heparin sodium derived from porcine intestinal mucosa, standardized for anticoagulant activity. It is to be administered by intravenous or deep subcutaneous routes. The potency is determined by a biological assay using a USP reference standard based on units of heparin activity per milligram.

Each mL contains: 1,000, 2,500, 3000, 4,000, 5,000, 6,000, 7,500, 10,000, 20,000, or 40,000 USP Units Heparin Sodium per mL with Benzyl Alcohol 1% as preservative in Water for Injection. Made isotonic with Sodium Chloride when necessary.

Sodium Hydroxide and/or Hydrochloric Acid may have been used to adjust pH.

Refer to vial label for exact formulation of each strength.

CLINICAL PHARMACOLOGY

Heparin inhibits reactions that lead to the clotting of blood and the formation of fibrin clots both *in vitro* and *in vivo*. Heparin acts at multiple sites in the normal coagulation system. Small amounts of heparin in combination with antithrombin III (heparin cofactor) can inhibit thrombosis by inactivating activated Factor X and inhibiting the conversion of prothrombin to thrombin. Once active thrombosis has developed, larger amounts of heparin can inhibit further coagulation by inactivating thrombin and preventing the conversion of fibrinogen to fibrin. Heparin also prevents the formation of a stable fibrin clot by inhibiting the activation of the fibrin stabilizing factor.

Bleeding time is usually unaffected by heparin. Clotting time is prolonged by full therapeutic doses of heparin; in most cases, it is not measurably affected by low doses of heparin.

Peak plasma levels of heparin are achieved 2 to 4 hours following subcutaneous administration, although there are considerable individual variations. Log linear plots of heparin plasma concentrations with time for a wide range of dose levels are linear which suggests the absence of zero order processes. Liver and the reticulo-endothelial system are the site of biotransformation. The biphasic elimination curve, a rapidly declining alpha phase ($t_{1/2} = 10'$) and after the age of 40 a slower beta phase, indicates uptake in organs. The absence of a relationship between anticoagulant half-life and concentration half-life may reflect factors such as protein binding of heparin.

Heparin does not have fibrinolytic activity; therefore, it will not lyse existing clots.

INDICATIONS AND USAGE

Heparin sodium is indicated for:

Anticoagulant therapy in prophylaxis and treatment of venous thrombosis and its extension;

(In a low-dose regimen) for prevention of postoperative deep venous thrombosis and pulmonary embolism in patients undergoing major abdomino-thoracic surgery or who for other reasons are at risk of developing thromboembolic disease (see **DOSAGE AND ADMINISTRATION**);

Prophylaxis and treatment of pulmonary embolism;

Atrial fibrillation with embolization;

Diagnosis and treatment of acute and chronic consumption coagulopathies (disseminated intravascular coagulation);

Prevention of clotting in arterial and heart surgery;

Prophylaxis and treatment of peripheral arterial embolism;

As an anticoagulant in blood transfusions, extracorporeal circulation, and dialysis procedures and in blood samples for laboratory purposes.

CONTRAINDICATIONS

Heparin sodium should not be used in patients:

With severe thrombocytopenia;

In whom suitable blood coagulation tests - e.g., the 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);

With an uncontrollable active bleeding state (see **WARNINGS**), except when this is due to disseminated intravascular coagulation.

WARNINGS

Heparin is not intended for intramuscular use.

Hypersensitivity: Patients with documented hypersensitivity to heparin should be given the drug only in clearly life-threatening situations.

Hemorrhage: Hemorrhage can occur at virtually any site in patients receiving heparin. An unexplained fall in hematocrit, fall in blood pressure, or any other unexplained symptom should lead to serious consideration of a hemorrhagic event.

Heparin sodium should be used with extreme caution in disease states in which there is increased danger of hemorrhage. Some of the conditions in which increased danger of hemorrhage exists are:

Cardiovascular - Subacute bacterial endocarditis. Severe hypertension.

Surgical - During and immediately following (a) spinal tap or spinal anesthesia or (b) major surgery, especially involving the brain, spinal cord, or eye.

Hematologic - Conditions associated with increased bleeding tendencies, such as hemophilia, thrombocytopenia, and some vascular purpuras.

Gastrointestinal - Ulcerative lesions and continuous tube drainage of the stomach or small intestine.

Other - Menstruation, liver disease with impaired hemostasis.

Coagulation Testing: When heparin sodium is administered in therapeutic amounts, its dosage should be regulated by frequent blood coagulation tests. If the coagulation test is unduly prolonged or if hemorrhage occurs, heparin sodium should be discontinued promptly (see **OVERDOSAGE**).

Thrombocytopenia: Thrombocytopenia has been reported to occur in patients receiving heparin with a reported incidence of 0 to 30%. Mild thrombocytopenia (count greater than 100,000/mm³) may remain stable or reverse even if heparin is continued. However, thrombocytopenia of any degree should be monitored closely. If the count falls below 100,000/mm³ or if recurrent thrombosis develops (see White Clot Syndrome, **PRECAUTIONS**), the heparin product should be discontinued. If continued heparin therapy is essential, administration of heparin from a different organ source can be reinstituted with caution.

Hyperkalemia: Heparin can suppress adrenal secretion of aldosterone leading to hyperkalemia, particularly in patients with diabetes mellitus, chronic renal failure, pre-existing metabolic acidosis, a raised plasma potassium, or taking potassium sparing drugs. The risk of hyperkalemia appears to increase with duration of therapy but is usually reversible upon discontinuation of heparin.

Measure blood potassium in patients at risk of hyperkalemia before starting heparin therapy and periodically in all patients treated for more than 5 days or earlier as deemed fit by the clinician.

Miscellaneous: This product contains benzyl alcohol as preservative. Benzyl alcohol has been reported to be associated with a fatal "Gaspings Syndrome" in premature infants.

PRECAUTIONS

1. General:

a White Clot Syndrome:

It has been reported that patients on heparin may develop new thrombus formation in association with thrombocytopenia resulting from irreversible aggregation of platelets induced by heparin, the so-called "white clot syndrome." The process may lead to severe thromboembolic complications like skin necrosis, gangrene of the extremities that may lead to amputation, myocardial infarction, pulmonary embolism, stroke, and possibly death. Therefore, heparin administration should be promptly discontinued if a patient develops new thrombosis in association with thrombocytopenia.

b. Heparin Resistance:

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

c. Increased Risk in Older Women:

A higher incidence of bleeding has been reported in women over 60 years of age.

2. Laboratory Tests:

Periodic platelet counts, hematocrits, and tests for occult blood in stool are recommended during the entire course of heparin therapy, regardless of the route of administration (see **DOSAGE AND ADMINISTRATION**).

3. Drug Interactions:

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

Platelet inhibitors: Drugs such as acetylsalicylic acid, dextran, phenylbutazone, ibuprofen, indomethacin, dipyridamole, hydroxychloroquine and others that interfere with platelet-aggregation reactions (the main hemostatic defense of heparinized patients) may induce bleeding and should be used with caution in patients receiving heparin sodium.

Other interactions: Digitalis, tetracyclines, nicotine, or antihistamines may partially counteract the anticoagulant action of heparin sodium.

4. Drug/Laboratory Tests Interactions:

Hyperaminotransferasemia:

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

5. Carcinogenesis, Mutagenesis, Impairment of Fertility:

No long-term studies in animals have been performed to evaluate carcinogenic potential of heparin. Also, no reproduction studies in animals have been performed concerning mutagenesis or impairment of fertility.

6. Pregnancy:

Teratogenic Effects: Animal reproduction studies have not been conducted with heparin sodium. It is also not known whether heparin sodium can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Heparin sodium should be given to a pregnant woman only if clearly needed.

Nonteratogenic Effects: Heparin does not cross the placental barrier.

7. Nursing Mothers:

Heparin is not excreted in human milk.

8. Pediatric Use:

See **DOSAGE AND ADMINISTRATION**.

ADVERSE REACTIONS

1. Hemorrhage.

Hemorrhage is the chief complication that may result from heparin therapy (see **WARNINGS**). An overly prolonged clotting time or minor bleeding during therapy can usually be controlled by withdrawing the drug (see **OVERDOSAGE**). It should be appreciated that gastrointestinal or urinary tract bleeding during anticoagulant therapy may indicate the presence of an underlying occult lesion. Bleeding can occur at any site but certain specific hemorrhagic complications may be difficult to detect:

- a. Adrenal hemorrhage, with resultant acute adrenal insufficiency, has occurred during anticoagulant therapy. Therefore, such treatment should be discontinued in patients who develop signs and symptoms of acute adrenal hemorrhage and insufficiency. Initiation of corrective therapy should not depend on laboratory confirmation of the diagnosis, since any delay in an acute situation may result in the patient's death.
- b. Ovarian (corpus luteum) hemorrhage developed in a number of women of reproductive age receiving short- or long-term anticoagulant therapy. This complication if unrecognized may be fatal.
- c. Retroperitoneal hemorrhage.

2. Local Irritation.

Local irritation, erythema, mild pain, hematoma or ulceration may follow deep subcutaneous (intrafat) injection of heparin sodium. These complications are much more common after intramuscular use, and such use is not recommended.

3. Hypersensitivity.

Generalized hypersensitivity reactions have been reported, with chills, fever, and urticaria as the most usual manifestations, and asthma, rhinitis, lacrimation, headache, nausea and vomiting, and anaphylactoid reactions, including shock, occurring more rarely. Itching and burning, especially on the plantar site of the feet, may occur.

Thrombocytopenia has been reported to occur in patients receiving heparin with a reported incidence of 0 to 30%. While often mild and of no obvious clinical significance, such

thrombocytopenia can be accompanied by severe thromboembolic complications such as skin necrosis, gangrene of the extremities, myocardial infarction, pulmonary embolism, and stroke. (see **WARNINGS, PRECAUTIONS.**)

Certain episodes of painful, ischemic, and cyanosed limbs have in the past been attributed to allergic vasospastic reactions. Whether these are in fact identical to the thrombocytopenia associated complications remains to be determined.

4. Miscellaneous.

Osteoporosis following long-term administration of high-doses of heparin, cutaneous necrosis after systemic administration, suppression of aldosterone synthesis, delayed transient alopecia, priapism, and rebound hyperlipemia on discontinuation of heparin sodium have also been reported.

Significant elevations of aminotransferase (SGOT [S-AST] and SGPT [S-ALT]) levels have occurred in a high percentage of patients (and healthy subjects) who have received heparin.

Postmarketing Experience

The following adverse reaction has been identified during post approval use of heparin sodium. Because this reaction was reported voluntarily from a population of uncertain size, it is not possible to reliably estimate the frequency or establish a causal relationship to drug exposure.

Hyperkalemia

OVERDOSAGE

Symptoms: Bleeding is the chief sign of heparin overdose. Nosebleeds, blood in urine or tarry stools may be noted as the first sign of bleeding. Easy bruising or petechial formations may precede frank bleeding.

Treatment: Neutralization of heparin effect.

When clinical circumstances (bleeding) require reversal of heparinization, protamine sulfate (1% solution) by slow infusion will neutralize heparin sodium. No more than 50 mg should be administered, very slowly, in any 10 minute period. Each mg of protamine sulfate neutralizes approximately 100 USP heparin units. The amount of protamine required decreases over time as heparin is metabolized. Although the metabolism of heparin is complex, it may, for the purpose of choosing a protamine dose, be assumed to have a half-life of about 1/2 hour after intravenous injection.

Administration of protamine sulfate can cause severe hypotensive and anaphylactoid reactions. Because fatal reactions often resembling anaphylaxis have been reported, the drug should be given only when resuscitation techniques and treatment of anaphylactoid shock are readily available.

For additional information the labeling of Protamine Sulfate Injection, USP products should be consulted.

DOSAGE AND ADMINISTRATION

Parenteral drug products should be inspected visually for particulate matter and discoloration prior to administration, whenever solution and container permit. Slight discoloration does not alter potency.

When heparin is added to an infusion solution for continuous intravenous administration, the container should be inverted at least six times to insure adequate mixing and prevent pooling of the heparin in the solution.

Heparin sodium is not effective by oral administration and should be given by intermittent intravenous injection, intravenous infusion, or deep subcutaneous (intrafat, i.e., above the iliac crest or abdominal fat layer) injection. The intramuscular route of administration should be avoided because of the frequent occurrence of hematoma at the injection site.

The dosage of heparin sodium should be adjusted according to the patient's coagulation test results. When heparin is given by continuous intravenous infusion, the coagulation time should be determined approximately every 4 hours in the early stages of treatment. When the drug is administered intermittently by intravenous injection, coagulation tests should be performed before each injection during the early stages of treatment and at appropriate intervals thereafter. Dosage is considered adequate when the activated partial thromboplastin time (APTT) is 1.5 to 2 times normal or when the whole blood clotting time is elevated approximately 2.5 to 3 times the control value. After deep subcutaneous (intrafat) injections, tests for adequacy of dosage are best performed on samples drawn 4 to 6 hours after the injections.

Periodic platelet counts, hematocrits, and tests for occult blood in stool are recommended during the entire course of heparin therapy, regardless of the route of administration.

Converting to Oral Anticoagulant:

When an oral anticoagulant of the coumarin or similar type is to be begun in patients already receiving heparin sodium, baseline and subsequent tests of prothrombin activity must be determined at a time when heparin activity is too low to affect the prothrombin time. This is about 5 hours after the last I.V. bolus and 24 hours after the last subcutaneous dose. If continuous I.V. heparin infusion is used, prothrombin time can usually be measured at any time.

In converting from heparin to an oral anticoagulant, the dose of the oral anticoagulant should be the usual initial amount and thereafter prothrombin time should be determined at the usual intervals. To ensure continuous anticoagulation, it is advisable to continue full heparin therapy for several days after the prothrombin time has reached the therapeutic range. Heparin therapy may then be discontinued without tapering.

Therapeutic Anticoagulant Effect with Full-Dose Heparin

Although dosage must be adjusted for the individual patient according to the results of suitable laboratory tests, the following dosage schedules may be used as guidelines:

METHOD OF ADMINISTRATION	FREQUENCY	RECOMMENDED DOSE*
Deep Subcutaneous (Intrafat) Injection	Initial Dose	5,000 units by I.V. injection, followed by 10,000 to 20,000 units of a concentrated solution, subcutaneously
A different site should be used for each injection to prevent the development of massive hematoma	Every 8 hours or Every 12 hours	8,000 to 10,000 units of a concentrated solution. 15,000 to 20,000 units of a concentrated solution.
Intermittent Intravenous Injection	Initial dose Every 4 to 6 hours	10,000 units, either undiluted or in 50 to 100 mL of 0.9% Sodium Chloride Injection, USP 5,000 to 10,000 units, either undiluted or in 50 to 100 mL of 0.9% Sodium Chloride Injection, USP
Continuous Intravenous Infusion	Initial dose Continuous	5,000 units by I.V. injection 20,000 to 40,000 units/24 hours in 1,000 mL of 0.9% Sodium Chloride Injection, USP (or in any compatible solution) for infusion

* Based on 150-lb. (68 kg) patient.

Pediatric Use

Follow recommendations of appropriate pediatric reference texts. In general, the following dosage schedule may be used as a guideline:

Initial Dose: 50 units/kg (I.V., drip)
Maintenance Dose: 100 units/kg (I.V., drip) every four hours, or
20,000 units/M²/24 hours continuously

Surgery of the Heart and Blood Vessels

Patients undergoing total body perfusion for open-heart surgery should receive an initial dose of not less than 150 units of heparin sodium per kilogram of body weight. Frequently, a dose of 300 units per kilogram is used for procedures estimated to last less than 60 minutes or 400 units per kilogram for those estimated to last longer than 60 minutes.

Low-Dose Prophylaxis of Postoperative Thromboembolism

A number of well-controlled clinical trials have demonstrated that low-dose heparin prophylaxis, given just prior to and after surgery, will reduce the incidence of postoperative deep vein

thrombosis in the legs (as measured by the I-125 fibrinogen technique and venography) and of clinical pulmonary embolism. The most widely used dosage has been 5,000 units 2 hours before surgery and 5,000 units every 8 to 12 hours thereafter for 7 days or until the patient is fully ambulatory, whichever is longer. The heparin is given by deep subcutaneous (intrafat, i.e., above the iliac crest or abdominal fat layer, arm or thigh) injection with a fine (25 to 26 - gauge) needle to minimize tissue trauma. A concentrated solution of heparin sodium is recommended. Such prophylaxis should be reserved for patients over the age of 40 who are undergoing major surgery. Patients with bleeding disorders and those having brain or spinal cord surgery, spinal anesthesia, eye surgery, or potentially sanguineous operations should be excluded, as should patients receiving oral anticoagulants or platelet-active drugs (see **WARNINGS**). The value of such prophylaxis in hip surgery has not been established. The possibility of increased bleeding during surgery or postoperatively should be borne in mind. If such bleeding occurs, discontinuance of heparin and neutralization with protamine sulfate are advisable. If clinical evidence of thromboembolism develops despite low-dose prophylaxis, full therapeutic doses of anticoagulants should be given unless contraindicated. Prior to initiating heparinization the physician should rule out bleeding disorders by appropriate history and laboratory tests, and appropriate coagulation tests should be repeated just prior to surgery. Coagulation tests values should be normal or only slightly elevated at these times.

Extracorporeal Dialysis

Follow equipment manufacturers' operating directions carefully.

Blood Transfusion

Addition of 400 to 600 USP units per 100 mL of whole blood is usually employed to prevent coagulation. Usually, 7,500 USP units of heparin sodium are added to 100 mL of 0.9% Sodium Chloride Injection, USP (or 75,000 USP units per 1,000 mL of 0.9% Sodium Chloride Injection, USP) and mixed; from this sterile solution, 6 to 8 mL are added per 100 mL of whole blood.

Laboratory Samples

Addition of 70 to 150 units of heparin sodium per 10 to 20 mL sample of whole blood is usually employed to prevent coagulation of the sample. Leukocyte counts should be performed on heparinized blood within 2 hours after addition of the heparin. Heparinized blood should not be used for isoagglutinin, complement, or erythrocyte fragility tests or platelet counts.

Clearing Intermittent Infusion (Heparin lock) Sets

To prevent clot formation in a heparin lock set following its proper insertion, dilute heparin solution (Heparin lock Flush Solution, USP) is injected via the injection hub in a quantity sufficient to fill the entire set to the needle tip. This solution should be replaced each time the heparin lock is used. Aspirate before administering any solution via the lock in order to confirm potency and location of needle or catheter tip. If the drug to be administered is incompatible with heparin, the entire heparin lock set should be flushed with sterile water or normal saline before and after the medication is administered; following the second flush, the dilute heparin solution

may be reinstalled into the set. The set manufacturer's instructions should be consulted for specifics concerning the heparin lock set in use at a given time.

NOTE: Since repeated injections of small doses of heparin can alter tests for activated partial thromboplastin time (APTT), a baseline value for APTT should be obtained prior to insertion of a heparin lock set.

HOW SUPPLIED

Heparin Sodium Injection, USP is available as follows:

Potency per 1 mL	Indiv. Vial Content	Package Size
1,000 Units	30 mL	Indiv Box
	10 mL	Indiv Box
	1 mL	Box of 25
2,500 Units	1 mL	Box of 25
3,000 Units	1 mL	Box of 25
4,000 Units	1 mL	Box of 25
5,000 Units	10 mL	Indiv Box
	1 mL	Box of 25
6,000 Units	1 mL	Box of 25
7,500 Units	1 mL	Box of 25
10,000 Units	10 mL	Indiv Box
	5 mL	Indiv Box
	4 mL	Indiv Box
	1 mL	Box of 25
20,000 Units	10 mL	Indiv Box
	5 mL	Indiv Box
	4 mL	Indiv Box
	2 mL	Box of 25
	1 mL	Box of 25
40,000 Units	10 mL	Indiv Box
	5 mL	Indiv Box
	4 mL	Indiv Box
	2 mL	Box of 25
	1 mL	Box of 25

Store at 15°-39°C (59°-86°F).

CAUTION: Federal law prohibits dispensing without prescription.

Distributor:
Dr. Reddy's Laboratories Inc.,
Princeton, NJ 08540

Made in India

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