

SUMMARY OF PRODUCT CHARACTERISTICS

1 NAME OF THE MEDICINAL PRODUCT

Clarithromycin 250 mg Film-coated Tablets

2 QUALITATIVE AND QUANTITATIVE COMPOSITION

Each film-coated tablet contains 250 mg clarithromycin

For a full list of excipients, see section 6.1.

3 PHARMACEUTICAL FORM

Film-coated tablet.

Bright yellow coloured, oval shaped, biconvex, film coated tablets, engraved with 'C2' on

one face and other face plain, approximately 16 mm long and 8.2 mm wide.

4.1 Therapeutic indications

Consideration should be given to official guidance on the appropriate use of antibacterial agents.

Clarithromycin film-coated tablets are indicated in adults and children 12 years and older.,

Clarithromycin is indicated for treatment of infections caused by susceptible organisms. Indications include:

Lower respiratory tract infections for example, acute and chronic bronchitis, and pneumonia (see section 4.4 and 5.1 regarding Sensitivity Testing).

Upper respiratory tract infections for example, sinusitis and pharyngitis.

Clarithromycin is appropriate for initial therapy in community acquired respiratory infections and has been shown to be active *in vitro* against common and atypical respiratory pathogens as listed in the microbiology section.

Clarithromycin is also indicated in skin and soft tissue infections of mild to moderate severity (e.g. folliculitis, cellulitis, erysipelas) (see section 4.4 and 5.1 regarding Sensitivity Testing).

Clarithromycin in the presence of acid suppression effected by omeprazole or lansoprazole is also indicated for the eradication of *H. pylori* in patients with duodenal ulcers. See Dosage and Administration section.

Clarithromycin is usually active against the following organisms in vitro:

Gram-positive Bacteria: *Staphylococcus aureus* (methicillin susceptible); *Streptococcus pyogenes* (Group A beta-haemolytic streptococci); alpha-haemolytic streptococci (viridans group); *Streptococcus (Diplococcus) pneumoniae*; *Streptococcus agalactiae*; *Listeria monocytogenes*.

Gram-negative Bacteria: *Haemophilus influenzae*; *Haemophilus parainfluenzae*; *Moraxella (Branhamella) catarrhalis*; *Neisseria gonorrhoeae*; *Legionella pneumophila*; *Bordetella pertussis*; *Helicobacter pylori*; *Campylobacter jejuni*.

- Mycoplasma: *Mycoplasma pneumoniae*; *Ureaplasma urealyticum*.
- Other Organisms: *Chlamydia trachomatis*; *Mycobacterium avium*; *Mycobacterium leprae*.
- Anaerobes: Macrolide-susceptible *Bacteroides fragilis*; *Clostridium perfringens*; Peptococcus species; Peptostreptococcus species; *Propionibacterium acnes*.
- Clarithromycin has bactericidal activity against several bacterial strains. The organisms include *Haemophilus influenzae*; *Streptococcus pneumoniae*; *Streptococcus pyogenes*; *Streptococcus agalactiae*; *Moraxella (Branhamella) catarrhalis*; *Neisseria gonorrhoeae*; *H. pylori* and *Campylobacter* spp.
- The activity of clarithromycin against *H. pylori* is greater at neutral pH than at acid pH.

4.2 Posology and method of administration

Patients with respiratory tract/skin and soft tissue infections.

Adults: The usual dose is 250 mg twice daily although this may be increased to 500mg twice daily in severe infections. The usual duration of treatment is 6 to 14 days.

Children older than 12 years: As for adults.

Children younger than 12 years:

Use of Clarithromycin 500mg Tablets are not recommended for children younger than 12 years. Clinical trials have been conducted using clarithromycin paediatric suspension in children 6 months to 12 years of age. Therefore, children under 12 years of age should use clarithromycin paediatric suspension (granules for oral suspension).

Clarithromycin may be given without regard to meals as food does not affect the extent of bioavailability.

Eradication of *H. pylori* in patients with duodenal ulcers (Adults)

The usual duration of treatment is 6 to 14 days.

Triple Therapy

Clarithromycin (500mg) twice daily and lansoprazole 30mg twice daily should be given with amoxycillin 1000mg twice daily.

Triple Therapy

Clarithromycin (500mg) twice daily and lansoprazole 30mg twice daily should be given with metronidazole 400mg twice daily.

Triple Therapy

Clarithromycin (500mg) twice daily and omeprazole 40mg daily should be given with amoxycillin 1000mg twice daily or metronidazole 400mg twice daily.

Triple Therapy

Clarithromycin (500mg) twice daily and omeprazole 20mg daily should be given with amoxycillin 1000mg twice daily.

Elderly: As for adults.

Renal impairment:

In patients with renal impairment with creatinine clearance less than 30 mL/min, the dosage of clarithromycin should be reduced by one-half, i.e. 250 mg once daily, or 250 mg twice daily in more severe infections. Treatment should not be continued beyond 14 days in these patients.

4.3 Contraindications

Hypersensitivity to macrolide antibiotic drugs or to any of the excipients listed in section 6.1.

Concomitant administration of clarithromycin and ergot alkaloids (e.g., ergotamine or dihydroergotamine) is contraindicated, as this may result in ergot toxicity (see section 4.5).

Concomitant administration of clarithromycin and oral midazolam is contraindicated (see section 4.5).

Concomitant administration of clarithromycin and any of the following drugs is contraindicated: astemizole, cisapride, pimozide and terfenadine as this may result in QT prolongation and cardiac arrhythmias, including ventricular tachycardia, ventricular fibrillation, and torsades de pointes (see section 4.5).

Clarithromycin should not be given to patients with history of QT prolongation (congenital or documented acquired QT prolongation) or ventricular cardiac arrhythmia, including torsades de pointes (see sections 4.4 and 4.5).

Concomitant administration with ticagrelor or ranolazine is contraindicated.

Clarithromycin should not be used concomitantly with HMG-CoA reductase inhibitors (statins) that are extensively metabolized by CYP3A4, (lovastatin or simvastatin), due to the increased risk of myopathy, including rhabdomyolysis. (See section 4.5).

As with other strong CYP3A4 inhibitors, Clarithromycin should not be used in patients taking colchicine (see section 4.4 and 4.5).

Clarithromycin should not be given to patients with hypokalaemia (risk of prolongation of QT-time).

Clarithromycin should not be used in patients who suffer from severe hepatic failure in combination with renal impairment.

4.4 Special warnings and precautions for use

Use of any antimicrobial therapy, such as clarithromycin, to treat *H. pylori* infection may select for drug-resistant organisms.

The physician should not prescribe clarithromycin to pregnant women without carefully weighing the benefits against risk; particularly during the first three months of pregnancy (see section 4.6).

Clarithromycin is principally metabolised by the liver. Therefore, caution should be exercised in administering this antibiotic to patients with impaired hepatic function.

Caution should also be exercised when administering clarithromycin to patients with moderate to severe renal impairment (See section 4.2).

Cases of fatal hepatic failure (see section 4.8) have been reported. Some patients may have had pre-existing hepatic disease or may have been taking other hepatotoxic medicinal products. Patients should be advised to stop treatment and contact their doctor if signs and symptoms of hepatic disease develop, such as anorexia, jaundice, dark urine, pruritus, or tender abdomen.

Pseudomembranous colitis has been reported with nearly all antibacterial agents, including macrolides, and may range in severity from mild to life-threatening. *Clostridium difficile*-associated diarrhoea (CDAD) has been reported with use of nearly all antibacterial agents including clarithromycin, and may range in severity from mild diarrhoea to fatal colitis. Treatment with antibacterial agents alters the normal flora of the colon, which may lead to overgrowth of *C. difficile*. CDAD must be considered in all patients who present with diarrhoea following antibiotic use. Careful medical history is necessary since CDAD has been reported to occur over two months after the administration of antibacterial agents. Therefore, discontinuation of clarithromycin therapy should be considered regardless of the indication. Microbial testing should be performed and adequate treatment initiated. Drugs inhibiting peristalsis should be avoided.

There have been post-marketing reports of colchicine toxicity with concomitant use of clarithromycin and colchicine, especially in the elderly, some of which occurred in patients with renal insufficiency. Deaths have been reported in some such patients (see section 4.5). Concomitant administration of clarithromycin and colchicine is contraindicated (see section 4.3).

Caution is advised regarding concomitant administration of clarithromycin and triazolobenzodiazepines, such as triazolam and intravenous or oromucosal midazolam (see section 4.5).

Cardiovascular Events

Prolonged cardiac repolarisation and QT interval, imparting a risk of developing cardiac arrhythmia and torsades de pointes, have been seen in treatment with macrolides including clarithromycin (see section 4.8). Therefore as the following situations may lead to an

increased risk for ventricular arrhythmias (including torsades de pointes), clarithromycin should be used with caution in the following patients:

- Patients with coronary artery disease, severe cardiac insufficiency, conduction disturbances or clinically relevant bradycardia.
- Patients with electrolyte disturbances such as hypomagnesaemia. Clarithromycin must not be given to patients with hypokalaemia (see section 4.3).
- Patients concomitantly taking other medicinal products associated with QT prolongation (see section 4.5).
- Concomitant administration of clarithromycin with astemizole, cisapride, pimozone and terfenadine is contraindicated (see section 4.3).
- Clarithromycin must not be used in patients with congenital or documented acquired QT prolongation or history of ventricular arrhythmia (see section 4.3).

Epidemiological studies investigating the risk of adverse cardiovascular outcomes with macrolides have shown variable results. Some observational studies have identified a rare short-term risk of arrhythmia, myocardial infarction and cardiovascular mortality associated with macrolides including clarithromycin. Consideration of these findings should be balanced with treatment benefits when prescribing clarithromycin.

Pneumonia: In view of the emerging resistance of *Streptococcus pneumoniae* to macrolides, it is important that sensitivity testing be performed when prescribing clarithromycin for community-acquired pneumonia. In hospital acquired pneumonia, clarithromycin should be used in combination with additional appropriate antibiotics.

Skin and soft tissue infections of mild to moderate severity: These infections are most often caused by *Staphylococcus aureus* and *Streptococcus pyogenes*, both of which may be resistant to macrolides. Therefore, it is important that sensitivity testing be performed. In cases where beta-lactam antibiotics cannot be used (e.g. allergy), other antibiotics, such as clindamycin, may be the drug of first choice. Currently, macrolides are only considered to play a role in some skin and soft tissue infections, such as those caused by *Corynebacterium minutissimum*, acne vulgaris, and erysipelas and in situations where penicillin treatment cannot be used.

In the event of severe acute hypersensitivity reactions, such as anaphylaxis, severe cutaneous adverse reactions (SCAR) (e.g. Acute generalised exanthematous pustulosis (AGEP), Stevens - Johnson syndrome, toxic epidermal necrolysis and drug rash with eosinophilia and systemic symptoms (DRESS)), clarithromycin therapy should be discontinued immediately and appropriate treatment should be urgently initiated.

Clarithromycin should be used with caution when administered concurrently with medications that induce the cytochrome CYP3A4 enzyme (see section 4.5).

HMG-CoA Reductase Inhibitors (statins): Concomitant use of clarithromycin with lovastatin or simvastatin is contraindicated (see section 4.3). Caution should be exercised when prescribing clarithromycin with other statins. Rhabdomyolysis has been reported in patients taking clarithromycin and statins. Patients should be monitored for signs and symptoms of myopathy.

In situations where the concomitant use of clarithromycin with statins cannot be avoided, it is recommended to prescribe the lowest registered dose of the statin. Use of a statin that is not dependent on CYP3A metabolism (e.g. fluvastatin) can be considered (see section 4.5).

Oral hypoglycaemic agents/Insulin: The concomitant use of clarithromycin and oral hypoglycaemic agents (such as sulphonylauriad) and/or insulin can result in significant hypoglycaemia. Careful monitoring of glucose is recommended (see section 4.5).

Oral anticoagulants: There is a risk of serious haemorrhage and significant elevations in International Normalized Ratio (INR) and prothrombin time when clarithromycin is co-administered with warfarin (see section 4.5). INR and prothrombin times should be frequently monitored while patients are receiving clarithromycin and oral anticoagulants concurrently.

Long-term use may, as with other antibiotics, result in colonisation with increased numbers of non-susceptible bacteria and fungi. If superinfections occur, appropriate therapy should be instituted.

Attention should also be paid to the possibility of cross resistance between clarithromycin and other macrolide drugs, as well as lincomycin and clindamycin.

Patients with rare hereditary problems of fructose intolerance, glucose-galactose malabsorption or sucrase-isomaltase insufficiency should not take Clarithromycin tablets.

4.5 Interaction with other medicinal products and other forms of interaction

The use of the following drugs is strictly contraindicated due to the potential for severe drug interaction effects:

Cisapride, pimozide, astemizole and terfenadine:

Elevated cisapride levels have been reported in patients receiving clarithromycin and cisapride concomitantly. This may result in QT prolongation and cardiac arrhythmias including ventricular tachycardia, ventricular fibrillation and torsades de pointes. Similar effects have been observed in patients taking clarithromycin and pimozide concomitantly (see section 4.3).

Macrolides have been reported to alter the metabolism of terfenadine resulting in increased levels of terfenadine which has occasionally been associated with cardiac arrhythmias, such as QT prolongation, ventricular tachycardia, ventricular fibrillation and torsades de pointes (see section 4.3). In one study in 14 healthy volunteers, the concomitant administration of clarithromycin and terfenadine resulted in 2- to 3-fold increase in the serum level of the acid metabolite of terfenadine and in prolongation of the QT interval which did not lead to any clinically detectable effect. Similar effects have been observed with concomitant administration of astemizole and other macrolides.

Ergot alkaloids

Post-marketing reports indicate that co-administration of clarithromycin with ergotamine or dihydroergotamine has been associated with acute ergot toxicity characterized by vasospasm, and ischaemia of the extremities and other tissues including the central nervous system. Concomitant administration of clarithromycin and ergot alkaloids is contraindicated (see section 4.3).

Oral Midazolam

When midazolam was co-administered with clarithromycin tablets (500 mg twice daily), midazolam AUC was increased 7-fold after oral administration of midazolam. Concomitant administration of oral midazolam and clarithromycin is contraindicated (see section 4.3).

HMG-CoA Reductase Inhibitors (statins)

Concomitant use of clarithromycin with lovastatin or simvastatin is contraindicated (see 4.3) as these statins are extensively metabolized by CYP3A4 and concomitant treatment with clarithromycin increases their plasma concentration, which increases the risk of myopathy, including rhabdomyolysis. Reports of rhabdomyolysis have been received for patients taking clarithromycin concomitantly with these statins. If treatment with clarithromycin cannot be avoided, therapy with lovastatin or simvastatin must be suspended during the course of treatment.

Caution should be exercised when prescribing clarithromycin with statins. In situations where the concomitant use of clarithromycin with statins cannot be avoided, it is recommended to prescribe the lowest registered dose of the statin. Use of a statin that is not dependent on CYP3A metabolism (e.g. fluvastatin) can be considered. Patients should be monitored for signs and symptoms of myopathy.

Effects of Other Medicinal Products on Clarithromycin

Drugs that are inducers of CYP3A (e.g. rifampicin, phenytoin, carbamazepine, phenobarbital, St John's wort) may induce the metabolism of clarithromycin. This may result in sub-therapeutic levels of clarithromycin leading to reduced efficacy. Furthermore, it might be necessary to monitor the plasma levels of the CYP3A inducer, which could be increased owing to the inhibition of CYP3A by clarithromycin (see also the relevant product information for the CYP3A4 inducer administered). Concomitant administration of rifabutin and clarithromycin resulted in an increase in rifabutin, and decrease in clarithromycin serum levels together with an increased risk of uveitis.

The following drugs are known or suspected to affect circulating concentrations of clarithromycin; clarithromycin dosage adjustment or consideration of alternative treatments may be required.

Efavirenz, nevirapine, rifampicin, rifabutin and rifapentine

Strong inducers of the cytochrome P450 metabolism system such as efavirenz, nevirapine, rifampicin, rifabutin, and rifapentine may accelerate the metabolism of clarithromycin and thus lower the plasma levels of clarithromycin, while increasing those of 14-OH-clarithromycin, a metabolite that is also microbiologically active. Since the microbiological activities of clarithromycin and 14-OH-clarithromycin are different for different bacteria, the intended therapeutic effect could be impaired during concomitant administration of clarithromycin and enzyme inducers.

Etravirine

Clarithromycin exposure was decreased by etravirine; however, concentrations of the active metabolite, 14-OH-clarithromycin, were increased. Because 14-OH-clarithromycin has reduced activity against *Mycobacterium avium* complex (MAC), overall activity against this pathogen may be altered; therefore alternatives to clarithromycin should be considered for the treatment of MAC.

Fluconazole

Concomitant administration of fluconazole 200 mg daily and clarithromycin 500 mg twice daily to 21 healthy volunteers led to increases in the mean steady-state minimum clarithromycin concentration (C_{min}) and area under the curve (AUC) of 33% and 18% respectively. Steady state concentrations of the active metabolite 14-OH-clarithromycin were not significantly affected by concomitant administration of fluconazole. No clarithromycin dose adjustment is necessary.

Ritonavir

A pharmacokinetic study demonstrated that the concomitant administration of ritonavir 200 mg every eight hours and clarithromycin 500 mg every 12 hours resulted in a marked inhibition of the metabolism of clarithromycin. The clarithromycin C_{max} increased by 31%, C_{min} increased 182% and AUC increased by 77% with concomitant administration of ritonavir. An essentially complete inhibition of the formation of 14-OH-clarithromycin was noted. Because of the large therapeutic window for clarithromycin, no dosage reduction should be necessary in patients with normal renal function. However, for patients with renal impairment, the following dosage adjustments should be considered: For patients with CL_{CR} 30 to 60 mL/min the dose of clarithromycin should be reduced by 50%. For patients with CL_{CR} <30 mL/min the dose of clarithromycin should be decreased by 75%. Doses of clarithromycin greater than 1 g/day should not be co-administered with ritonavir.

Similar dose adjustments should be considered in patients with reduced renal function when ritonavir is used as a pharmacokinetic enhancer with other HIV protease inhibitors including atazanavir and saquinavir (see section below, Bidirectional drug interactions).

Effect of Clarithromycin on Other Medicinal Products

CYP3A-based interactions

Co-administration of clarithromycin, known to inhibit CYP3A, and a drug primarily metabolised by CYP3A may be associated with elevations in drug concentrations that could increase or prolong both therapeutic and adverse effects of the concomitant drug. Clarithromycin should be used with caution in patients receiving treatment with other drugs known to be CYP3A enzyme substrates, especially if the CYP3A substrate has a narrow safety margin (e.g. carbamazepine) and/or the substrate is extensively metabolised by this enzyme.

Dosage adjustments may be considered, and when possible, serum concentrations of drugs primarily metabolised by CYP3A should be monitored closely in patients concurrently receiving clarithromycin.

The following drugs or drug classes are known or suspected to be metabolised by the same CYP3A isozyme: alprazolam, astemizole, carbamazepine, cilostazol, cisapride, ciclosporin, disopyramide, ergot alkaloids, lovastatin, methylprednisolone, midazolam, omeprazole, oral anticoagulants (e.g. warfarin, see 4.4), atypical antipsychotics (e.g. quetiapine), pimozone, quinidine, rifabutin, sildenafil, simvastatin, sirolimus, tacrolimus, terfenadine, triazolam and vinblastine but this list is not exhaustive. Drugs interacting by similar mechanisms through other isozymes within the cytochrome P450 system include phenytoin, theophylline and valproate.

Antiarrhythmics

There have been post-marketed reports of torsades de pointes occurring with the concurrent use of clarithromycin and quinidine or disopyramide. Electrocardiograms should be monitored for QT prolongation during co-administration of clarithromycin with these drugs. Serum levels of quinidine and disopyramide should be monitored during clarithromycin therapy.

There have been post marketing reports of hypoglycemia with the concomitant administration of clarithromycin and disopyramide. Therefore blood glucose levels should be monitored during concomitant administration of clarithromycin and disopyramide.

Oral hypoglycemic agents/Insulin

With certain hypoglycemic drugs such as nateglinide, and repaglinide, inhibition of CYP3A enzyme by clarithromycin may be involved and could cause hypoglycemia when used concomitantly. Careful monitoring of glucose is recommended.

Omeprazole

Clarithromycin (500 mg every 8 hours) was given in combination with omeprazole (40 mg daily) to healthy adult subjects. The steady-state plasma concentrations of omeprazole were increased (C_{max} , AUC_{0-24} , and $t_{1/2}$ increased by 30%, 89%, and 34%, respectively), by the concomitant administration of clarithromycin. The mean 24-hour gastric pH value was 5.2 when omeprazole was administered alone and 5.7 when omeprazole was co-administered with clarithromycin.

Sildenafil, tadalafil and vardenafil

Each of these phosphodiesterase inhibitors is metabolised, at least in part, by CYP3A, and CYP3A may be inhibited by concomitantly administered clarithromycin. Co-administration of clarithromycin with sildenafil, tadalafil or vardenafil would likely result in increased phosphodiesterase inhibitor exposure. Reduction of sildenafil, tadalafil and vardenafil dosages should be considered when these drugs are co-administered with clarithromycin.

Theophylline, carbamazepine

Results of clinical studies indicate that there was a modest but statistically significant ($p \leq 0.05$) increase of circulating theophylline or carbamazepine levels when either of these drugs were administered concomitantly with clarithromycin. Dose reduction may need to be considered.

Tolterodine

The primary route of metabolism for tolterodine is via the 2D6 isoform of cytochrome P450 (CYP2D6). However, in a subset of the population devoid of CYP2D6, the identified pathway of metabolism is via CYP3A. In this population subset, inhibition of CYP3A results in significantly higher serum concentrations of tolterodine. A reduction in tolterodine dosage may be necessary in the presence of CYP3A inhibitors, such as clarithromycin in the CYP2D6 poor metaboliser population.

Triazolobenzodiazepines (e.g., alprazolam, midazolam, triazolam)

When midazolam was co-administered with clarithromycin tablets (500 mg twice daily), midazolam AUC was increased 2.7-fold after intravenous administration of midazolam. If intravenous midazolam is co-administered with clarithromycin, the patient must be closely monitored to allow dose adjustment. Drug delivery of midazolam via oromucosal route, which could bypass pre-systemic elimination of the drug, will likely result in a similar interaction to that observed after intravenous midazolam rather than oral administration. The same precautions should also apply to other benzodiazepines that are metabolised by CYP3A, including triazolam and alprazolam. For benzodiazepines which are not dependent on CYP3A for their elimination (temazepam, nitrazepam, lorazepam), a clinically important interaction with clarithromycin is unlikely.

There have been post-marketing reports of drug interactions and central nervous system (CNS) effects (e.g., somnolence and confusion) with the concomitant use of clarithromycin and triazolam. Monitoring the patient for increased CNS pharmacological effects is suggested.

Other drug interactions

Colchicine

Colchicine is a substrate for both CYP3A and the efflux transporter, P-glycoprotein (Pgp). Clarithromycin and other macrolides are known to inhibit CYP3A and Pgp. When clarithromycin and colchicine are administered together, inhibition of Pgp and/or CYP3A by clarithromycin may lead to increased exposure to colchicine (see section 4.3 and 4.4).

Digoxin

Digoxin is thought to be a substrate for the efflux transporter, P-glycoprotein (Pgp). Clarithromycin is known to inhibit Pgp. When clarithromycin and digoxin are administered together, inhibition of Pgp by clarithromycin may lead to increased exposure to digoxin. Elevated digoxin serum concentrations in patients receiving clarithromycin and digoxin concomitantly have also been reported in post marketing surveillance. Some patients have shown clinical signs consistent with digoxin toxicity, including potentially fatal arrhythmias. Serum digoxin concentrations should be carefully monitored while patients are receiving digoxin and clarithromycin simultaneously.

Zidovudine

Simultaneous oral administration of clarithromycin tablets and zidovudine to HIV-infected adult patients may result in decreased steady-state zidovudine concentrations. Because clarithromycin appears to interfere with the absorption of simultaneously administered oral zidovudine, this interaction can be largely avoided by staggering the doses of clarithromycin and zidovudine to allow for a 4-hour interval between each medication. This interaction does not appear to occur in paediatric HIV-infected patients taking clarithromycin suspension with zidovudine or dideoxyinosine. This interaction is unlikely when clarithromycin is administered via intravenous infusion.

Phenytoin and Valproate

There have been spontaneous or published reports of interactions of CYP3A inhibitors, including clarithromycin with drugs not thought to be metabolised by CYP3A (e.g. phenytoin and valproate). Serum level determinations are recommended for these drugs when administered concomitantly with clarithromycin. Increased serum levels have been reported.

Bi-directional drug interactions

Atazanavir

Both clarithromycin and atazanavir are substrates and inhibitors of CYP3A, and there is evidence of a bi-directional drug interaction. Co-administration of clarithromycin (500 mg twice daily) with atazanavir (400 mg once daily) resulted in a 2-fold increase in exposure to clarithromycin and a 70% decrease in exposure to 14-OH-clarithromycin, with a 28% increase in the AUC of atazanavir. Because of the large therapeutic window for clarithromycin, no dosage reduction should be necessary in patients with normal renal function. For patients with moderate renal function (creatinine clearance 30 to 60 mL/min), the dose of clarithromycin should be decreased by 50%. For patients with creatinine clearance <30 mL/min, the dose of clarithromycin should be decreased by 75% using an appropriate clarithromycin formulation. Doses of clarithromycin greater than 1000 mg per day should not be co-administered with protease inhibitors.

Calcium Channel Blockers

Caution is advised regarding the concomitant administration of clarithromycin and calcium channel blockers metabolized by CYP3A4 (e.g. verapamil, amlodipine, diltiazem) due to the risk of hypotension. Plasma concentrations of clarithromycin as well as calcium channel

blockers may increase due to the interaction. Hypotension, bradyarrhythmias and lactic acidosis have been observed in patients taking clarithromycin and verapamil concomitantly.

Itraconazole

Both clarithromycin and itraconazole are substrates and inhibitors of CYP3A, leading to a bidirectional drug interaction. Clarithromycin may increase the plasma levels of itraconazole, while itraconazole may increase the plasma levels of clarithromycin. Patients taking itraconazole and clarithromycin concomitantly should be monitored closely for signs or symptoms of increased or prolonged pharmacologic effect.

Saquinavir

Both clarithromycin and saquinavir are substrates and inhibitors of CYP3A, and there is evidence of a bi-directional drug interaction. Concomitant administration of clarithromycin (500 mg twice daily) and saquinavir (soft gelatin capsules, 1200 mg three times daily) to 12 healthy volunteers resulted in steady-state AUC and C_{max} values of saquinavir which were 177% and 187% higher than those seen with saquinavir alone. Clarithromycin AUC and C_{max} values were approximately 40% higher than those seen with clarithromycin alone. No dose adjustment is required when the two drugs are co-administered for a limited time at the doses/formulations studied. Observations from drug interaction studies using the soft gelatin capsule formulation may not be representative of the effects seen using the saquinavir hard gelatin capsule. Observations from drug interaction studies performed with saquinavir alone may not be representative of the effects seen with saquinavir/ritonavir therapy. When saquinavir is co-administered with ritonavir, consideration should be given to the potential effects of ritonavir on clarithromycin (see section 4.5: Ritonavir).

Patients taking oral contraceptives should be warned that if diarrhoea, vomiting or breakthrough bleeding occur there is a possibility of contraceptive failure.

4.6 Fertility, pregnancy and lactation

Pregnancy

The safety of clarithromycin for use during pregnancy has not been established. Based on variable results obtained from studies in mice, rats, rabbits and monkeys, the possibility of adverse effects on embryofetal development cannot be excluded. Therefore, use during pregnancy is not advised without carefully weighing the benefits against risk.

Breast-feeding

The safety of clarithromycin for using during breast-feeding of infants has not been established. Clarithromycin is excreted into human breast milk.

4.7 Effects on ability to drive and use machines

There are no data on the effect of clarithromycin on the ability to drive or use machines. The potential for dizziness, vertigo, confusion and disorientation, which may occur with the medication, should be taken into account before patients drive or use machines.

4.8 Undesirable effects

a. Summary of the safety profile

The most frequent and common adverse reactions related to clarithromycin therapy for both adult and paediatric populations are abdominal pain, diarrhoea, nausea, vomiting and taste perversion. These adverse reactions are usually mild in intensity and are consistent with the known safety profile of macrolide antibiotics (see section b of section 4.8).

There was no significant difference in the incidence of these gastrointestinal adverse reactions during clinical trials between the patient population with or without pre-existing mycobacterial infections.

b. Tabulated summary of adverse reactions

The following table displays adverse reactions reported in clinical trials and from post-marketing experience with clarithromycin immediate-release tablets, granules for oral suspension, powder for solution for injection, extended-release tablets and modified-release tablets.

The reactions considered at least possibly related to clarithromycin are displayed by system organ class and frequency using the following convention: very common ($\geq 1/10$), common ($\geq 1/100$ to $< 1/10$), uncommon ($\geq 1/1,000$ to $< 1/100$) and not known (adverse reactions from post-marketing experience; cannot be estimated from the available data). Within each frequency grouping, adverse reactions are presented in order of decreasing seriousness when the seriousness could be assessed.

System Organ Class	Very common $\geq 1/10$	Common $\geq 1/100$ to $< 1/10$	Uncommon $\geq 1/1,000$ to $< 1/100$	Not Known* (cannot be estimated from the available data)
Infections and Infestations			Cellulitis ¹ , candidiasis, gastroenteritis ² , infection ³ , vaginal infection	Pseudomembranous colitis, erysipelas,
Blood and lymphatic system			Leukopenia, neutropenia ⁴ , thrombocythaemia ³ , eosinophilia ⁴	Agranulocytosis, thrombocytopenia
Immune system disorders			Anaphylactoid reaction ¹ , hypersensitivity	Anaphylactic reaction. angioedema
Metabolism and nutrition disorders			Anorexia, decreased appetite	
Psychiatric disorders		Insomnia	Anxiety, nervousness ³	Psychotic disorder, confusional state ⁵ ,

				depersonalisation , depression, disorientation, hallucinations, abnormal dreams, mania
Nervous system disorders		Dysgeusia, headache,	Loss of consciousness ¹ , dyskinesia ¹ , dizziness, somnolence ⁵ , tremor	Convulsions, ageusia, parosmia, anosmia, paraesthesia
Ear and labyrinth disorders			Vertigo, hearing impaired, tinnitus	Deafness
Cardiac disorders			Cardiac arrest ¹ , atrial fibrillation ¹ , electrocardiogram - QT prolonged, extrasystoles ¹ , palpitations	Torsades de pointes, ventricular tachycardia, ventricular fibrillation
Vascular disorder		Vasodilation ¹		Haemorrhage
Respiratory, thoracic and mediastinal disorder			Asthma ¹ , epistaxis ² , Pulmonary embolism ¹ .	
Gastrointestinal disorder		Diarrhoea, vomiting, dyspepsia, nausea, abdominal pain	Oesophagitis ¹ , gastroesophageal reflux disease ² , gastritis, proctalgia ² , stomatitis, glossitis, abdominal distension ⁴ , constipation, dry mouth, eructation, flatulence,	Pancreatitis acute , tongue discolouration, tooth discolouration
Hepatobiliary disorders		liver function test abnormal	Cholestasis ⁴ , hepatitis ⁴ , alanine aminotransferase increased, aspartate aminotransferase increased, gamma-glutamyltransferase increased ⁴	Hepatic failure, hepatocellular jaundice
Skin and subcutaneous tissue disorders		Rash, hyperhidrosis	Bullous dermatitis ¹ , pruritus, urticaria, rash maculopapular ³	Severe cutaneous adverse reactions (SCAR) (e.g. Acute generalised

				exanthematous pustulosis (AGEP), Stevens-Johnson syndrome, toxic epidermal necrolysis, drug rash with eosinophilia and systemic symptoms (DRESS), acne
Musculoskeletal and conjunctive tissues disorders			Muscular spasms ³ , musculoskeletal stiffness ¹ , myalgia ²	Rhabdomyolysis ^{2, 6} , myopathy
Renal and urinary disorders			Blood creatinine Increased ¹ , blood urea increased ¹	Renal failure, nephritis interstitial
General disorders and administration site conditions	Injection site Phlebitis ¹	Injection site Pain ¹ , Injection site inflammation ¹	Malaise ⁴ , pyrexia ³ , asthenia, chest pain ⁴ , chills ⁴ , fatigue ⁴	
Investigations			Albumin globulin ratio abnormal ¹ , blood alkaline phosphatase increased ⁴ , blood lactate dehydrogenase increased ⁴	International normalised ratio, increased, prothrombin time prolonged, urine colour abnormal

¹ ADRs reported only for the Powder for Solution for Infusion formulation

² ADRs reported only for the Extended-Release Tablets formulation

³ ADRs reported only for the Granules for Oral Suspension formulation

⁴ ADRs reported only for the Immediate-Release Tablets formulation

^{5, 6} See section c)

** 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. Patient exposure is estimated to be greater than 1 billion patient treatment days for clarithromycin.*

c. Description of selected adverse reactions

Injection site phlebitis, injection site pain, and injection site inflammation are specific to the clarithromycin intravenous formulation.

In some of the reports of rhabdomyolysis, clarithromycin was administered concomitantly with statins, fibrates, colchicine or allopurinol (see section 4.3 and 4.4).

There have been post-marketing reports of drug interactions and central nervous system (CNS) effects (e.g. somnolence and confusion) with the concomitant use of clarithromycin and triazolam. Monitoring the patient for increased CNS pharmacological effects is suggested (see section 4.5).

There have been rare reports of clarithromycin ER tablets in the stool, many of which have occurred in patients with anatomic (including ileostomy or colostomy) or functional gastrointestinal disorders with shortened GI transit times. In several reports, tablet residues have occurred in the context of diarrhoea. It is recommended that patients who experience tablet residue in the stool and no improvement in their condition should be switched to a different clarithromycin formulation (e.g. suspension) or another antibiotic.

Special population: Adverse Reactions in Immunocompromised Patients (see section e).

d. Paediatric populations

Clinical trials have been conducted using clarithromycin paediatric suspension in children 6 months to 12 years of age. Therefore, children under 12 years of age should use clarithromycin paediatric suspension.

Frequency, type and severity of adverse reactions in children are expected to be the same as in adults.

e. Other special populations

Immunocompromised patients

In AIDS and other immunocompromised patients treated with the higher doses of clarithromycin over long periods of time for mycobacterial infections, it was often difficult to distinguish adverse events possibly associated with clarithromycin administration from underlying signs of Human Immunodeficiency Virus (HIV) disease or intercurrent illness.

In adult patients, the most frequently reported adverse reactions by patients treated with total daily doses of 1000 mg and 2000mg of clarithromycin were: nausea, vomiting, taste perversion, abdominal pain, diarrhoea, rash, flatulence, headache, constipation, hearing disturbance, Serum Glutamic Oxaloacetic Transaminase (SGOT) and Serum Glutamic Pyruvate Transaminase (SGPT) elevations. Additional low-frequency events included dyspnoea, insomnia and dry mouth. The incidences were comparable for patients treated with 1000mg and 2000mg, but were generally about 3 to 4 times as frequent for those patients who received total daily doses of 4000mg of clarithromycin.

In these immunocompromised patients, evaluations of laboratory values were made by analysing those values outside the seriously abnormal level (i.e. the extreme high or low limit) for the specified test. On the basis of these criteria, about 2% to 3% of those patients who received 1000mg or 2000mg of clarithromycin daily had seriously abnormal elevated levels of SGOT and SGPT, and abnormally low white blood cell and platelet counts. A lower percentage of patients in these two dosage groups also had elevated Blood Urea Nitrogen levels. Slightly higher incidences of abnormal values were noted for patients who received 4000mg daily for all parameters except White Blood Cell.

Reporting of suspected adverse reactions

Reporting suspected adverse reactions after authorisation of the medicinal product is important. It allows continued monitoring of the benefit/risk balance of the medicinal product. Healthcare professionals are asked to report any suspected adverse reactions via Yellow Card Scheme at: www.mhra.gov.uk/yellowcard or search for MHRA Yellow Card in the Google Play or Apple App Store.

4.9 Overdose

Reports indicate that the ingestion of large amounts of clarithromycin can be expected to produce gastro-intestinal symptoms. One patient who had a history of bipolar disorder ingested 8 grams of clarithromycin and showed altered mental status, paranoid behaviour, hypokalaemia and hypoxaemia.

Adverse reactions accompanying overdosage should be treated by the prompt elimination of unabsorbed drug and supportive measures. As with other macrolides, clarithromycin serum levels are not expected to be appreciably affected by haemodialysis or peritoneal dialysis.

5. PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

ATC classification

Pharmacotherapeutic group: Antibacterial for systemic use, macrolide
ATC code: J01FA09.

Mechanism of action:

Clarithromycin is an antibiotic belonging to the macrolide antibiotic group. It exerts its antibacterial action by selectively binding to the 50s ribosomal subunit of susceptible bacteria preventing translocation of activated amino acids. It inhibits the intracellular protein synthesis of susceptible bacteria.

The 14-hydroxy metabolite of clarithromycin, a product of parent drug metabolism also has antimicrobial activity. The metabolite is less active than the parent compound for most organisms, including mycobacterium spp. An exception is *Haemophilus influenza* where the 14-hydroxy metabolite is twofold more active than the parent compound.

Clarithromycin is usually active against the following organisms in vitro:-

Gram-positive Bacteria: *Staphylococcus aureus* (methicillin susceptible); *Streptococcus pyogenes* (Group A beta-hemolytic streptococci); *alpha-hemolytic streptococci* (viridans group); *Streptococcus* (Diplococcus) *pneumoniae*; *Streptococcus agalactiae*; *Listeria monocytogenes*.

Gram-negative Bacteria: *Haemophilus influenzae*; *Haemophilus parainfluenzae*; *Moraxella* (Branhamella) *catarrhalis*; *Neisseria gonorrhoeae*; *Legionella pneumophila*; *Bordetella pertussis*; *Helicobacter pylori*; *Campylobacter jejuni*.

Mycoplasma: *Mycoplasma pneumoniae*; *Ureaplasma urealyticum*.

Other Organisms: *Chlamydia trachomatis*; *Mycobacterium avium*; *Mycobacterium leprae*, *Mycobacterium kansasii*; *Mycobacterium chelonae*; *Mycobacterium fortuitum*; *Mycobacterium intracellulare*.

Anaerobes: Macrolide-susceptible *Bacteroides fragilis*; *Clostridium perfringens*; *Peptococcus species*; *Peptostreptococcus species*; *Propionibacterium acnes*.

Clarithromycin has bactericidal activity against several bacterial strains. The organisms include *Haemophilus influenzae*, *Streptococcus pneumoniae*, *Streptococcus pyogenes*, *Streptococcus agalactiae*, *Moraxella* (Branhamella) *catarrhalis*, *Neisseria gonorrhoeae*, *H. pylori* and *Campylobacter spp.*

Breakpoints

The following breakpoints have been established by the European Committee for Antimicrobial Susceptibility Testing (EUCAST).

Breakpoints (MIC, mg/ml)		
Microorganism	Susceptibility ($\leq$)	Resistance ($>$)
<i>Streptococcus A, B, C and G</i>	0.25 mg/L	0.5 mg/L
<i>Staphylococcus spp.</i>	1 mg/L	2 mg/L
<i>Streptococcus pneumonia</i>	0.25 mg/L	0.5 mg/L
<i>Viridans group streptococcus</i>	IE	IE
<i>Haemophilus spp.</i>	1 mg/L	32 mg/L
<i>Moraxella catarrhalis</i>	0.25 mg/L	0.5 mg/L ¹
<i>Helicobacter pylori</i>	0.25 mg/L ¹	0.5 mg/L

¹ The breakpoints are based on epidemiological cut-off values (ECOFFs), which distinguish wild-type isolates from those with reduced susceptibility.

"IE" indicates that there is insufficient evidence that the species in question is a good target for therapy with the drug.

Susceptibility

The prevalence of resistance may vary geographically and with time for selected species and local information on resistance is desirable, particularly when treating severe infections. This information gives only an appropriate guidance on the probabilities whether micro-organisms will be susceptible to clarithromycin or not.

Commonly susceptible species
Aerobic, Gram-positive microorganisms
<i>Streptococcus agalactiae</i>

<i>Streptococcus pyogenes</i> (Group A beta-hemolytic streptococci)
<i>Streptococcus viridans</i>
<i>Streptococcus (Diplococcus) pneumoniae</i>
<i>Staphylococcus aureus</i> (methicillin susceptible)
<i>Listeria monocytogenes</i>
Aerobic, Gram-negative microorganisms
<i>Bordetella pertussis</i>
<i>Haemophilus influenzae</i>
<i>Haemophilus parainfluenzae</i>
<i>Helicobacter pylori</i>
<i>Campylobacter jejuni</i>
<i>Moraxella (Branhamella) catarrhalis</i>
<i>Neisseria gonorrhoeae</i>
<i>Legionella</i> spp.
Anaerobic microorganisms
<i>Clostridium perfringens</i>
<i>Bacterioides fragilis</i>
<i>Peptococcus/Peptostreptococcus</i> spp.
<i>Propionibacterium acnes</i>
Other microorganisms
<i>Mycoplasma pneumoniae</i>
<i>Chlamydia trachomatis</i>
<i>Ureaplasma urealyticum</i>
<i>Mycobacterium</i> spp.

Other information

Susceptibility and resistance of *Streptococcus pneumoniae* and *Streptococcus* spp. to clarithromycin can be predicted by testing erythromycin.

The mechanisms of acquired resistance in macrolides are: efflux of drug by an active pump mechanism, inducible or constitutive production of a methylase enzyme that modifies the ribosomal target, hydrolysis of macrolides by esterases, chromosomal mutations that alter a 50 S ribosomal protein. Cross-resistance between clarithromycin and other macrolides and clindamycin and lincomycin may therefore occur. Methicillin-resistant and oxacillin-resistant staphylococci (MRSA) and penicillin-resistant *Streptococcus pneumoniae* are resistant to all currently available Beta-lactam antibiotics and macrolides such as clarithromycin.

Most available clinical experience from controlled randomised clinical trials indicate that clarithromycin 500 mg twice daily in combination with another antibiotic e.g. amoxicillin or metronidazole e.g. omeprazole (given at approved levels) for 7 days achieve > 80% *H. pylori* eradication rate in

patients with gastro-duodenal ulcers. As expected, significantly lower eradication rates were observed in patients with baseline metronidazole-resistant *H. pylori* isolates. Hence, local information on the prevalence of resistance and local therapeutic guidelines should be taken into account in the choice of an appropriate combination regimen for *H. pylori* eradication therapy. Furthermore, in patients with persistent infection, potential development of secondary resistance (in patients with primary susceptible strains) to an antimicrobial agent should be taken into the considerations for a new treatment regimen.

5.2 Pharmacokinetic properties

H. pylori is associated with acid peptic disease including duodenal ulcer and gastric ulcer in which about 95% and 80% of patients respectively are infected with the agent. *H. pylori* is also implicated as a major contribution factor in the development of gastric and ulcer recurrence in such patients.

Clarithromycin has been used in small numbers of patients in other treatment regimens. Possible kinetic interactions have not been fully investigated. These regimens include:

Clarithromycin plus tinidazole and omeprazole; clarithromycin plus tetracycline, bismuth subsalicylate and ranitidine; clarithromycin plus ranitidine alone.

Clinical studies using various different *H. pylori* eradication regimens have shown that eradication of *H. pylori* prevents ulcer recurrence.

Clarithromycin is rapidly and well absorbed from the gastro-intestinal tract After oral administration of Clarithromycin tablets. The microbiologically active metabolite 14-hydroxyclearithromycin is formed by first pass metabolism. Clarithromycin may be given without regard to meals as food does not affect the extent of bioavailability of Clarithromycin tablets. Food does slightly delay the onset of absorption of clarithromycin and formation of the 14-hydroxymetabolite

The pharmacokinetics of clarithromycin are non linear; however, steady-state is attained within 2 days of dosing. At 250 mg b.i.d. 15-20% of unchanged drug is excreted in the urine. With 500 mg b.i.d. daily dosing urinary excretion is greater (approximately 36%). The 14-hydroxyclearithromycin is the major urinary metabolite and accounts for 10-15% of the dose. Most of the remainder of the dose is eliminated in the faeces, primarily via the bile. 5-10% of the parent drug is recovered from the faeces.

When clarithromycin 500 mg is given three times daily, the clarithromycin plasma concentrations are increased with respect to the 500 mg twice daily dosage

Clarithromycin provides tissue concentrations that are several times higher than the circulating drug levels. Increased levels have been found in both tonsillar and lung tissue. Clarithromycin is 80% bound to plasma proteins at therapeutic levels.

Clarithromycin also penetrates the gastric mucus. Levels of clarithromycin in gastric mucus and gastric tissue are higher when clarithromycin is coadministered with omeprazole than when clarithromycin is administered alone.

5.3 Preclinical safety data

In acute mouse and rat studies, the median lethal dose was greater than the highest feasible dose for administration (5g/kg).

In repeated dose studies, toxicity was related to dose, duration of treatment and species. Dogs were more sensitive than primates or rats. The major clinical signs at toxic doses included emesis, weakness, reduced food consumption and weight gain, salivation, dehydration and hyperactivity. In all species the liver was the primary target organ at toxic doses. Hepatotoxicity was detectable by early elevations of liver function tests. Discontinuation of the drug generally resulted in a return to or toward normal results. Other tissues less commonly affected included the stomach, thymus and other lymphoid tissues and the kidneys. At near therapeutic doses, conjunctival injection and lacrimation occurred only in dogs. At a massive dose of 400mg/kg/day, some dogs and monkeys developed corneal opacities and/or oedema.

Fertility and reproduction studies in rats have shown no adverse effects. Teratogenicity studies in rats (Wistar (p.o.) and Sprague-Dawley (p.o. and i.v.)), New Zealand White rabbits and cynomolgous monkeys failed to demonstrate any teratogenicity from clarithromycin. However, a further similar study in Sprague-Dawley rats indicated a low (6%) incidence of cardiovascular abnormalities which appeared to be due to spontaneous expression of genetic changes.

Two mouse studies revealed a variable incidence (3-30%) of cleft palate and embryonic loss was seen in monkeys but only at dose levels which were clearly toxic to the mothers.

6 PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Tablet Core:

Cellulose Microcrystalline

Croscarmellose sodium

Povidone (PVPK-30)

Low substituted hydroxypropylcellulose

Silica Colloidal anhydrous

Magnesium Stearate

Film-coat:

Hypromellose (E464)

Propylene glycol (E1520)

Titanium dioxide (E171)

Hydroxypropyl Cellulose (E463)

Sorbitan Monoleate

Quinoline Yellow Aluminium Lake (E104)

Sorbic acid (E200)

Vanillin

6.2 Incompatibilities

Not applicable.

6.3 Shelf life

36 Months

HDPE pack: Use within 180 days of first opening

6.4 Special precautions for storage

Does not require any special storage conditions.

6.5 Nature and contents of container

Clarithromycin Tablets 250 mg are packed in;

- PVC/PVdC-Aluminium Blisters
- High Density polyethylene container with Polypropylene Cap

Blister Packs of 6's/7's/8's/10's/12's/14's/16's/20's

Container: Pack of 100's/500's

Not all pack sizes may be marketed.

6.6 Special precautions for disposal

Any unused medicinal product or waste material should be disposed of in accordance with local requirements.

7 MARKETING AUTHORISATION HOLDER

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UK

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