

## Summary of Product Characteristics

### 1 NAME OF THE MEDICINAL PRODUCT

Levofloxacin 5 mg/ml. Solution for Infusion

### 2 QUALITATIVE AND QUANTITATIVE COMPOSITION

Each ml of solution for infusion contains 5 mg of levofloxacin (as levofloxacin hemihydrate).

Each 100 ml of solution for infusion contains 500 mg of levofloxacin (as levofloxacin hemihydrate)

Each 50 ml of solution for infusion contains 250 mg of levofloxacin (as levofloxacin hemihydrate).

Excipients with known effect:

Each ml of solution for infusion contains 0.15 mmol (3.5 mg) sodium (as chloride)

50 ml of solution for infusion contain 7.7 mmol (177.1 mg) sodium (as chloride)

100 ml of solution for infusion contain 15.4 mmol (354.2 mg) sodium (as chloride)

For the full list of excipients, see section 6.1.

### 3 PHARMACEUTICAL FORM

Solution for infusion.

A clear greenish-yellow isotonic solution free from particles.

The pH of the solution for infusion is approximately 4.8

The osmolality of the solution for infusion is approximately 300 mOsm/kg

### 4 CLINICAL PARTICULARS

#### 4.1 Therapeutic Indications

Levofloxacin 5 mg/ml solution for infusion is indicated in adults for the treatment of the following infections (see sections 4.4 and 5.1):

- Community-acquired pneumonia
- Complicated skin and soft tissue infections.

For the above-mentioned infections Levofloxacin 5 mg/ml should be used only when it is considered inappropriate to use antibacterial agents that are commonly recommended for the initial treatment of these infections.

- Pyelonephritis and complicated urinary tract infections (see section 4.4).
- Chronic bacterial prostatitis.
- Inhalation Anthrax: postexposure prophylaxis and curative treatment (see section 4.4).

Consideration should be given to official guidance on the appropriate use of anti-bacterial agents.

#### 4.2 Posology and method of administration

Levofloxacin 5 mg/ml solution for infusion is administered by slow intravenous infusion once or twice daily. The dosage depends on the type and severity of the infection and the susceptibility of the presumed causative pathogen. Treatment with levofloxacin after initial use of the intravenous preparation may be completed with an appropriate oral presentation according to the SmPC for the film-coated tablets and as considered appropriate for the individual patient. Given the bioequivalence of the parenteral and oral forms, the same dosage can be used.

### Posology

The following dose recommendations can be given for Levofloxacin 5 mg/ml solution for infusion:

*Dosage in patients with normal renal function (creatinine clearance > 50 ml/min)*

<b>Indication</b>	<b>Daily dose regimen (according to severity)</b>	<b>Total duration of treatment<sup>1</sup> (according to severity)</b>
Community-acquired pneumonia	500 mg once or twice daily	7 – 14 days
Pyelonephritis	500 mg once daily	7 – 10 days
Complicated urinary tract infections	500 mg once daily	7 – 14 days
Chronic bacterial prostatitis.	500 mg once daily	28 days
Complicated skin and soft tissue infections	500 mg once or twice daily	7 – 14 days
Inhalation anthrax	500 mg once daily	8 weeks

<sup>1</sup>Treatment duration includes intravenous plus oral treatment. The time to switch from intravenous to oral treatment depends on the clinical situation but is normally 2 to 4 days.

### Special populations

*Impaired renal function (creatinine clearance ≤50 ml/min)*

<b>Creatinine clearance</b>	<b>Dose regimen</b>		
	<b>250 mg/24 h</b>	<b>500 mg/24 h</b>	<b>500 mg/12 h</b>
	<i>first dose: 250 mg</i>	<i>first dose: 500 mg</i>	<i>first dose: 500 mg</i>
50 - 20 ml/min	<i>then: 125 mg/24 h</i>	<i>then: 250 mg/24 h</i>	<i>then : 250 mg/12 h</i>
19-10 ml/min	<i>then: 125 mg/48 h</i>	<i>then: 125 mg/24 h</i>	<i>then: 125 mg/12 h</i>
< 10 ml/min (including haemodialysis and CAPD) <sup>1</sup>	<i>then: 125 mg/48 h</i>	<i>then: 125 mg/24 h</i>	<i>then: 125 mg/24 h</i>

<sup>1</sup>No additional doses are required after haemodialysis or continuous ambulatory peritoneal dialysis (CAPD).

### Impaired liver function

No adjustment of dose is required since levofloxacin is not metabolised to any relevant extent by the liver and is mainly excreted by the kidneys.

### Elderly population

No adjustment of dose is required in the elderly, other than that imposed by consideration of renal function (see section 4.4. “Tendinitis and tendon rupture” and “QT interval prolongation”).

### Paediatric population

Levofloxacin 5 mg/ml solution for infusion is contraindicated in children and growing adolescents (see section 4.3).

### Method of administration

Levofloxacin 5 mg/ml solution for infusion is only intended for slow intravenous infusion; it is administered once or twice daily. The infusion time must be at least 30 minutes for 250 mg or 60 minutes for 500 mg Levofloxacin solution for infusion (see section 4.4).

For step by step instructions see section 6.6.

For incompatibilities see section 6.2 and compatibility with other infusion solutions see section 6.6.

### 4.3 Contraindications

Levofloxacin solution for infusion must not be used:

- in patients hypersensitive to levofloxacin or any other quinolone and any of the excipients listed in section 6.1,
- in patients with epilepsy,
- in patients with history of tendon disorders related to fluoroquinolone administration,
- in children or growing adolescents,
- during pregnancy (see section 4.6)
- in breast-feeding women (see section 4.6)

### 4.4 Special warnings and precautions for use

Methicillin-resistant *S. aureus* are very likely to possess co-resistance to fluoroquinolones, including levofloxacin. Therefore levofloxacin is not recommended for the treatment of known or suspected MRSA infections unless laboratory results have confirmed susceptibility of the organism to levofloxacin (and commonly recommended antibacterial agents for the treatment of MRSA-infections are considered inappropriate).

Resistance to fluoroquinolones of *E. coli* – the most common pathogen involved in urinary tract infections – varies across the European Union. Prescribers are advised to take into account the local prevalence of resistance of *E. coli* to fluoroquinolones.

Inhalation Anthrax: use in humans is based on *in vitro Bacillus anthracis* susceptibility data and on animal experimental data together with limited human data. Treating physicians should refer to national and/or international consensus documents regarding the treatment of anthrax.

#### *Infusion Time*

The recommended infusion time of at least 30 minutes for 250 mg or 60 minutes for 500 mg Levofloxacin 5mg/ml solution for infusion should be observed. It is known for ofloxacin that during infusion tachycardia and a temporary decrease in blood pressure may develop. In rare cases, as a consequence of a profound drop in blood pressure, circulatory collapse may occur. Should a conspicuous drop in blood pressure occur during infusion of levofloxacin, (L-isomer of ofloxacin) the infusion must be halted immediately.

#### *Sodium content*

This medicinal product contains 7.7 mmol (177.1 mg) sodium per 50 ml and 15.4 mmol (354.2 mg) sodium per 100 ml. To be taken into account in patients on a controlled sodium diet and in cases where fluid restriction is required.

#### *Tendinitis and tendon rupture*

Tendinitis may rarely occur. It most frequently involves the Achilles tendon and may lead to tendon rupture. Tendinitis and tendon rupture, sometimes bilateral, may occur within 48 hours of starting treatment with levofloxacin and have been reported up to several months after discontinuation of treatment. The risk of tendinitis and tendon rupture is increased in patients aged over 60 years, in patients receiving daily doses of 1000 mg and in patients using corticosteroids. The daily dose should be adjusted in elderly patients based on creatinine clearance (see section 4.2). Close monitoring of these patients is therefore necessary if they are prescribed levofloxacin. All patients should consult their physician if they experience symptoms of tendinitis. If tendinitis is suspected, treatment with levofloxacin must be halted immediately, and appropriate treatment (e.g. immobilisation) must be initiated for the affected tendon (see sections 4.3 and 4.8).

*Clostridium difficile-associated disease*

Diarrhoea, particularly if severe, persistent and/or bloody, during or after treatment with levofloxacin (including several weeks after treatment), may be symptomatic of *Clostridium difficile*-associated disease (CDAD). CDAD may range in severity from mild to life-threatening, the most severe form of which is pseudomembranous colitis (see section 4.8). It is therefore important to consider this diagnosis in patients who develop serious diarrhoea during or after treatment with levofloxacin. If CDAD is suspected or confirmed, levofloxacin must be stopped immediately and appropriate treatment initiated without delay. Anti-peristaltic medicinal products are contraindicated in this clinical situation.

*Patients predisposed to seizures*

Quinolones may lower the seizure threshold and may trigger seizures. Levofloxacin is contraindicated in patients with a history of epilepsy (see section 4.3) and, as with other quinolones, should be used with extreme caution in patients predisposed to seizures, or with concomitant treatment with active substances that lower the cerebral seizure threshold, such as theophylline (see section 4.5.). In case of convulsive seizures (see section 4.8), treatment with levofloxacin should be discontinued.

*Patients with G-6- phosphate dehydrogenase deficiency*

Patients with latent or actual defects in glucose-6-phosphate dehydrogenase activity may be prone to haemolytic reactions when treated with quinolone antibacterial agents. Therefore, if levofloxacin has to be used in these patients, potential occurrence of haemolysis should be monitored.

*Patients with renal impairment*

Since levofloxacin is excreted mainly by the kidneys, the dose of Levofloxacin 5 mg/ml solution for infusion should be adjusted in patients with renal impairment (see also section 4.2).

*Hypersensitivity reactions*

Levofloxacin can cause serious, potentially fatal hypersensitivity reactions (e.g. angioedema up to anaphylactic shock), occasionally following the initial dose (see section 4.8). Patients should discontinue treatment immediately and contact their doctor or an emergency doctor, who will initiate appropriate emergency measures.

*Severe bullous reactions*

Cases of severe bullous skin reactions such as Stevens-Johnson syndrome or toxic epidermal necrolysis have been reported with levofloxacin (see section 4.8). Patients should be advised to contact their doctor immediately prior to continuing treatment if skin and/or mucosal reactions occur.

*Dysglycaemia*

As with all quinolones, disturbances in blood glucose, including both hypoglycaemia and hyperglycaemia have been reported, usually in diabetic patients receiving concomitant treatment with an oral hypoglycaemic agent (e.g., glibenclamide) or with insulin. Cases of hypoglycaemic coma have been reported. In diabetic patients, careful monitoring of blood glucose is recommended (see section 4.8).

*Prevention of photosensitisation*

Photosensitisation has been reported with levofloxacin (see section 4.8). It is recommended that patients should not expose themselves unnecessarily to strong sunlight or to artificial UV rays (e.g. sunray lamp, solarium), during treatment and for 48 hours following treatment discontinuation in order to prevent photosensitisation.

*Patients treated with Vitamin K antagonists*

Due to possible increase in coagulation tests (PT/INR) and/or bleeding in patients treated with levofloxacin in combination with a vitamin K antagonist (e.g. warfarin), coagulation tests should be monitored when these drugs are given concomitantly (see also section 4.5).

*Psychotic reactions*

Psychotic reactions have been reported in patients receiving quinolones, including levofloxacin. In very rare cases these have progressed to suicidal thoughts and self-endangering behaviour- sometimes after only a single dose of levofloxacin (see section 4.8). In the event that the patient develops these reactions, levofloxacin should be discontinued and appropriate measures instituted. Caution is recommended if levofloxacin is to be used in psychotic patients or in patients with history of psychiatric disease.

*QT interval prolongation*

Caution should be taken when using fluoroquinolones, including levofloxacin, in patients with known risk factors for prolongation of the QT interval such as, for example:

- congenital long QT syndrome
- concomitant use of drugs that are known to prolong the QT interval (e.g. Class IA and III antiarrhythmics, tricyclic antidepressants, macrolides).
- uncorrected electrolyte imbalance (e.g. hypokalemia, hypomagnesemia)
- cardiac disease (e.g. heart failure, myocardial infarction, bradycardia)

Elderly patients and women may be more sensitive to QTc-prolonging medications. Therefore, caution should be taken when using fluoroquinolones, including levofloxacin in these populations. (See section 4.2 Elderly, section 4.5, section 4.8, section 4.9).

*Peripheral neuropathy*

Peripheral sensory neuropathy and peripheral sensory motor neuropathy have been reported in patients receiving fluoroquinolones, including levofloxacin, which can be rapid in their onset (see section 4.8). Levofloxacin should be discontinued if the patient experiences symptoms of neuropathy in order to prevent the development of an irreversible condition.

*Hepatobiliary disorders*

Cases of hepatic necrosis up to fatal hepatic failure have been reported with levofloxacin, primarily in patients with severe underlying diseases, e.g. sepsis (see section 4.8). 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.

*Exacerbation of myasthenia gravis*

Fluoroquinolones, including levofloxacin, have neuromuscular blocking activity and may exacerbate muscle weakness in patients with myasthenia gravis. Postmarketing serious adverse reactions, including deaths and the requirement for respiratory support, have been associated with fluoroquinolone use in patients with myasthenia gravis. Levofloxacin is not recommended in patients with a known history of myasthenia gravis.

*Vision disorders*

If vision becomes impaired or any effects on the eyes are experienced, an eye specialist should be consulted immediately (see sections 4.7 and 4.8).

*Superinfection*

The use of levofloxacin, especially if prolonged, may result in overgrowth of non-susceptible organisms. If superinfection occurs during therapy, appropriate measures should be taken.

*Interference with laboratory tests*

In patients treated with levofloxacin, determination of opiates in urine may give false-positive results. It may be necessary to confirm positive opiate screens by more specific methods.

Levofloxacin may inhibit the growth of *Mycobacterium tuberculosis* and, therefore, may give false-negative results in the bacteriological diagnosis of tuberculosis.

**4.5 Interaction with other medicinal products and other forms of interaction**Effect of other medicinal products on Levofloxacin 5mg/ml solution for infusion*Theophylline, fenbufen or similar non-steroidal anti-inflammatory drugs*

No pharmacokinetic interactions of levofloxacin were found with theophylline in a clinical study. However a pronounced lowering of the cerebral seizure threshold may occur when quinolones are given concurrently with theophylline, non-steroidal anti-inflammatory drugs, or other agents which lower the seizure threshold.

Levofloxacin concentrations were about 13% higher in the presence of fenbufen than when administered alone.

*Probenecid and cimetidine*

Probenecid and cimetidine had a statistically significant effect on the elimination of levofloxacin. The renal clearance of levofloxacin was reduced by cimetidine (24%) and probenecid (34%). This is because both drugs are capable of blocking the renal tubular secretion of levofloxacin. However, at the tested doses in the study, the statistically significant kinetic differences are unlikely to be of clinical relevance.

Caution should be exercised when levofloxacin is coadministered with drugs that effect the tubular renal secretion such as probenecid and cimetidine, especially in renally impaired patients.

*Other relevant information*

Clinical pharmacology studies have shown that the pharmacokinetics of levofloxacin were not affected to any clinically relevant extent when levofloxacin was administered together with the following drugs: calcium carbonate, digoxin, glibenclamide, ranitidine.

Effect of Levofloxacin 5 mg/ml solution for infusion on other medicinal products*Ciclosporin*

The half-life of ciclosporin was increased by 33% when coadministered with levofloxacin.

*Vitamin K antagonists*

Increased coagulation tests (PT/INR) and/or bleeding, which may be severe, have been reported in patients treated with levofloxacin in combination with a vitamin K antagonist (e.g. warfarin). Coagulation tests, therefore, should be monitored in patients treated with vitamin K antagonists (see section 4.4.)

*Drugs known to prolong QT interval*

Levofloxacin, like other fluoroquinolones, should be used with caution in patients receiving drugs known to prolong the QT interval (e.g. Class IA and III antiarrhythmics, tricyclic antidepressants, macrolides, antipsychotics) (see section 4.4 QT interval prolongation).

## Other relevant information

In a pharmacokinetic interaction study, levofloxacin did not affect the pharmacokinetics of theophylline (which is a probe substrate for CYP1A2), indicating that levofloxacin is not a CYP1A2 inhibitor.

**4.6 Fertility, pregnancy and lactation**Pregnancy

There are limited amount of data from the use of levofloxacin in pregnant women. Animal studies do not indicate direct or indirect harmful effects with respect to reproductive toxicity (see section 5.3). However in the absence of human data and due to the fact that experimental data suggest a risk of damage by fluoroquinolones to the weight-bearing cartilage of the growing organism, levofloxacin must not be used in pregnant women (see sections 4.3 and 5.3).

Breast-feeding

Levofloxacin is contraindicated in breast-feeding women. There is insufficient information on the excretion of levofloxacin in human milk; however other fluoroquinolones are excreted in breast milk. In the absence of human data and due to the fact that experimental data suggest a risk of damage by fluoroquinolones to the weight-bearing cartilage of the growing organism, levofloxacin must not be used in breast-feeding women (see sections 4.3 and 5.3).

Fertility

Levofloxacin caused no impairment of fertility or reproductive performance in rats.

**4.7 Effects on ability to drive and use machines**

Levofloxacin has a minor or moderate influence on the ability to drive and use machines.

Some undesirable effects of levofloxacin, such as dizziness/vertigo, drowsiness and visual disturbances (see section

4.8), may impair the patient's ability to concentrate and react and therefore may constitute a risk in situations where these abilities are of special importance (e.g. driving a car or operating machinery).

#### 4.8 Undesirable effects

The information given below is based on data from clinical studies in more than 8300 patients and on extensive post marketing experience.

Frequencies in this table are defined using the following convention: very common ( $\geq 1/10$ ), common ( $\geq 1/100$  to  $< 1/10$ ), uncommon ( $\geq 1/1000$  to  $< 1/100$ ), rare ( $\geq 1/10000$  to  $< 1/1000$ ), very rare ( $< 1/10000$ ), not known (cannot be estimated from the available data).

Within each frequency grouping, undesirable effects are presented in order of decreasing seriousness.

System organ class	Common ( $\geq 1/100$ to $< 1/10$ )	Uncommon ( $\geq 1/1,000$ to $< 1/100$ )	Rare ( $\geq 1/10,000$ to $< 1/1,000$ )	Not known (cannot be estimated from the available data)
Infections and infestations		Fungal infection including Candida infection, Pathogen resistance		
Blood and lymphatic system disorders		Leukopenia, Eosinophilia	Thrombocytopenia, Neutropenia	Pancytopenia, Agranulocytosis, Haemolytic anaemia
Immune system disorders			Angioedema Hypersensitivity (see section 4.4)	Anaphylactic shock <sup>a</sup> Anaphylactoid shock <sup>a</sup> (see section 4.4)
Metabolism and nutrition disorders		Anorexia	Hypoglycaemia, particularly in diabetic patients (see section 4.4)	Hyperglycaemia Hypoglycaemic coma (see section 4.4)
Psychiatric disorders	Insomnia	Anxiety Confusional state Nervousness	Psychotic reactions (with e.g. hallucination paranoia) Depression Agitation Abnormal dreams Nightmares	Psychotic disorders with self-endangering behaviour including suicidal ideation or suicide attempt (see section 4.4),
Nervous system disorders	Headache Dizziness,	Somnolence Tremor Dysgeusia	Convulsion (see sections 4.3. and 4.4) Paraesthesia	Peripheral sensory neuropathy (see section 4.4) Peripheral sensory motor neuropathy (see section 4.4) Parsomia including ansomia Dyskinesia

				Extrapyramidal disorder Ageusia Syncope Benign intracranial hypertension
Eye disorders			Visual disturbances such as blurred vision (see section 4.4)	Transient vision loss (see section 4.4)
Ear and Labyrinth disorders		Vertigo	Tinnitus	Hearing loss Hearing impaired
Cardiac disorders			Tachycardia Palpitation	Ventricular tachycardia which may result in cardiac arrest. Ventricular arrhythmia and torsade de pointes (reported predominantly in patients with risk factors of QT prolongation), electrocardiogram QT prolonged (see sections 4.4 and 4.9)
Vascular disorders	<i>Applies to i.v. form only:</i> Phlebitis		Hypotension	
Respiratory, thoracic and mediastinal disorders		Dyspnoea		Bronchospasm Pneumonitis allergic
Gastro-intestinal disorders	Diarrhoea Vomiting Nausea	Abdominal pain Dyspepsia Flatulence Constipation		Diarrhoea – haemorrhagic which in very rare cases may be indicative of enterocolitis including pseudomembranous colitis (see section 4.4) Pancreatitis
Hepatobiliary disorders	Hepatic enzyme increased (ALT/AST, alkaline phosphatase GGT)	Blood bilirubin increased		Jaundice and severe liver injury, including cases with fatal acute liver failure, primarily in patients with severe underlying diseases (see section 4.4)

				Hepatitis
Skin and subcutaneous tissue disorders <sup>b</sup>		Rash Pruritus Urticaria Hyperhidrosis		Toxic epidermal necrolysis Stevens-Johnson syndrome Erythema multiforme Photosensitivity reaction (see section 4.4) Leukocytoclastic vasculitis Stomatitis
Musculoskeletal and connective tissue disorders		Arthralgia Myalgia	Tendon disorders (see sections 4.3 and 4.4) including tendinitis (e.g. Achilles tendon) Muscular weakness which may be of special importance in patients with myasthenia gravis (see section 4.4)	Rhabdomyolysis Tendon rupture (e.g. Achilles tendon) (see sections 4.3 and 4.4) Ligament rupture Muscle rupture Arthritis
Renal and urinary disorders		Blood creatinine increased	Renal failure acute (e.g. due to interstitial nephritis)	
General disorders and administration site conditions	<i>Applies to iv form only:</i> Infusion site reaction (pain, reddening)	Asthenia	Pyrexia	Pain (including pain in back, chest and extremities)

<sup>a</sup> Anaphylactic and anaphylactoid reactions may sometimes occur even after the first dose

<sup>b</sup> Mucocutaneous reactions may sometimes occur even after the first dose

Other undesirable effects which have been associated with fluoroquinolone administration include:

- attacks of porphyria in patients with porphyria.

### 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 IMB Pharmacovigilance, Earlsfort Terrace, IRL - Dublin 2; Tel: +353 1 6764971; Fax: +353 1 6762517. Website: [www.imb.ie](http://www.imb.ie); e-mail: [imbpharmacovigilance@imb.ie](mailto:imbpharmacovigilance@imb.ie),

## 4.9 Overdose

According to toxicity studies in animals or clinical pharmacology studies performed with supra-therapeutic doses, the most important signs to be expected following acute overdose of levofloxacin are central nervous system symptoms

such as confusion, dizziness, impairment of consciousness, and convulsive seizures, increases in QT interval.

CNS effects including confusional state, convulsion, hallucination, and tremor have been observed in post marketing experience.

In the event of overdose, symptomatic treatment should be implemented. ECG monitoring should be undertaken, because of the possibility of QT interval prolongation. Haemodialysis, including peritoneal dialysis and CAPD, are not effective in removing levofloxacin from the body. No specific antidote exists.

## 5 PHARMACOLOGICAL PROPERTIES

### 5.1 Pharmacodynamic properties

Pharmacotherapeutic group: quinolone antibacterials, fluoroquinolones  
ATC code: J01MA12

Levofloxacin is a synthetic antibacterial agent of the fluoroquinolone class and is the S (-) enantiomer of the racemic active substance ofloxacin.

#### Mechanism of action

As a fluoroquinolone antibacterial agent, levofloxacin acts on the DNA-DNA-gyrase complex and topoisomerase IV.

#### PK/PD relationship

The degree of the bactericidal activity of levofloxacin depends on the ratio of the maximum concentration in serum (C<sub>max</sub>) or the area under the curve (AUC) and the minimal inhibitory concentration (MIC).

#### Mechanism of resistance

Resistance to levofloxacin is acquired through a stepwise process by target site mutations in both type II topoisomerases, DNA gyrase and topoisomerase IV. Other resistance mechanisms such as permeation barriers (common in *Pseudomonas aeruginosa*) and efflux mechanisms may also affect susceptibility to levofloxacin.

Cross-resistance between levofloxacin and other fluoroquinolones is observed. Due to the mechanism of action, there is generally no cross-resistance between levofloxacin and other classes of antibacterial agents.

#### Breakpoints

The EUCAST recommended MIC breakpoints for levofloxacin, separating susceptible from intermediately susceptible organisms and intermediately susceptible from resistant organisms are presented in the below table for MIC testing (mg/l).

EUCAST clinical MIC breakpoints for levofloxacin (version 2.0, 2012-01-01):

Pathogen	Susceptible	Resistant
Enterobacteriaceae	≤1 mg/l	>2 mg/l
<i>Pseudomonas spp.</i>	≤1 mg/l	>2 mg/l
<i>Acinetobacter spp.</i>	≤1 mg/l	>2 mg/l
<i>Staphylococcus spp.</i>	≤1 mg/l	>2 mg/l
<i>S.pneumoniae</i> <sup>1</sup>	≤2 mg/l	>2 mg/l
<i>Streptococcus</i> A,B,C,G	≤1 mg/l	>2 mg/l
<i>H.influenzae</i> <sup>2,3</sup>	≤1 mg/l	>1 mg/L

<i>M.catarrhalis</i> <sup>3</sup>	≤1 mg/l	>1 mg/L
Non-species related breakpoints <sup>4</sup>	≤1 mg/l	>2 mg/L
<p>1. The breakpoints for levofloxacin relate to high dose therapy.</p> <p>2. Low-level fluoroquinolone resistance (ciprofloxacin MICs of 0.12-0.5 mg/l) may occur but there is no evidence that this resistance is of clinical importance in respiratory tract infections with <i>H. influenzae</i>.</p> <p>3. Strains with MIC values above the susceptible breakpoint are very rare or not yet reported. The identification and antimicrobial susceptibility tests on any such isolate must be repeated and if the result is confirmed the isolate must be sent to a reference laboratory. Until there is evidence regarding clinical response for confirmed isolates with MIC above the current resistant breakpoint they should be reported resistant.</p> <p>4. Breakpoints apply to an oral dose of 500 mg x 1 to 500 mg x 2 and an intravenous dose of 500 mg x 1 to 500 mg x 2.</p>		

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. As necessary, expert advice should be sought when the local prevalence of resistance is such that the utility of the agent in at least some types of infections is questionable.

#### **Commonly susceptible microorganisms**

##### **Aerobic Gram-positive bacteria**

*Bacillus anthracis*  
*Staphylococcus aureus* methicillin-susceptible  
*Staphylococcus saprophyticus*  
Streptococci, group C and G  
*Streptococcus agalactiae*  
*Streptococcus pneumoniae*  
*Streptococcus pyogenes*

##### **Aerobic Gram- negative bacteria**

*Eikenella corrodens*  
*Haemophilus influenzae*  
*Haemophilus para-influenzae*  
*Klebsiella oxytoca*  
*Moraxella catarrhalis*  
*Pasteurella multocida*  
*Proteus vulgaris*  
*Providencia rettgeri*

##### **Anaerobic bacteria**

*Peptostreptococcus*

##### **Other**

*Chlamydophila pneumoniae*  
*Chlamydophila psittaci*  
*Chlamydia trachomatis*  
*Legionella pneumophila*  
*Mycoplasma pneumoniae*  
*Mycoplasma hominis*  
*Ureaplasma urealyticum*

**Species for which acquired resistance may be a problem****Aerobic Gram-positive bacteria***Enterococcus faecalis**Staphylococcus aureus* methicillin-resistant<sup>#</sup>Coagulase negative *Staphylococcus spp***Aerobic Gram- negative bacteria***Acinetobacter baumannii**Citrobacter freundii**Enterobacter aerogenes**Enterobacter cloacae**Escherichia coli**Klebsiella pneumoniae**Morganella morganii**Proteus mirabilis**Providencia stuartii**Pseudomonas aeruginosa**Serratia marcescens***Anaerobic bacteria***Bacteroides fragilis***Inherently Resistant Strains****Aerobic Gram-positive bacteria***Enterococcus faecium*

<sup>#</sup> Methicillin-resistant *S. aureus* are very likely to possess co-resistance to fluoroquinolones, including levofloxacin.

**5.2 Pharmacokinetic properties*****Absorption***

Orally administered levofloxacin is rapidly and almost completely absorbed with peak plasma concentrations being obtained within 1 - 2 h. The absolute bioavailability is 99 - 100 %.

Food has little effect on the absorption of levofloxacin.

Steady state conditions are reached within 48 hours following a 500 mg once or twice daily dosage regimen.

***Distribution***

Approximately 30 - 40 % of levofloxacin is bound to serum protein.

The mean volume of distribution of levofloxacin is approximately 100 l after single and repeated 500 mg doses, indicating widespread distribution into body tissues.

***Penetration into tissues and body fluids:***

Levofloxacin has been shown to penetrate bronchial mucosa, epithelial lining fluid, alveolar macrophages, lung tissue, skin (blister fluid), prostatic tissue and urine. However, levofloxacin has poor penetration into cerebro-spinal fluid.

***Biotransformation***

Levofloxacin is metabolised to a very small extent, the metabolites being desmethyl-levofloxacin and levofloxacin N-oxide. These metabolites account for < 5 % of the dose and are excreted in urine. Levofloxacin is stereochemically stable and does not undergo chiral inversion.

***Elimination***

Following oral and intravenous administration of levofloxacin, it is eliminated relatively slowly from the plasma ( $t_{1/2}$ : 6

- 8 h). Excretion is primarily by the renal route (> 85 % of the administered dose).

The mean apparent total body clearance of levofloxacin following a 500 mg single dose was 175 +/-29.2 ml/min.

There are no major differences in the pharmacokinetics of levofloxacin following intravenous and oral administration, suggesting that the oral and intravenous routes are interchangeable.

#### **Linearity**

Levofloxacin obeys linear pharmacokinetics over a range of 50 to 1000 mg.

#### **Special populations**

##### **Subjects with renal insufficiency**

The pharmacokinetics of levofloxacin are affected by renal impairment. With decreasing renal function renal elimination and clearance are decreased, and elimination half-lives increased as shown in the table below:

Pharmacokinetics in renal insufficiency following single oral 500 mg dose

Cl <sub>cr</sub> [ml/min]	< 20	20 - 49	50 - 80
Cl <sub>R</sub> [ml/min]	13	26	57
t <sub>1/2</sub> [h]	35	27	9

##### **Elderly subjects**

There are no significant differences in levofloxacin kinetics between young and elderly subjects, except those associated with differences in creatinine clearance.

##### **Gender differences**

Separate analysis for male and female subjects showed small to marginal gender differences in levofloxacin pharmacokinetics. There is no evidence that these gender differences are of clinical relevance.

## **5.3 Preclinical safety data**

Non-clinical data reveal no special hazard for humans based on conventional studies of single dose toxicity, repeated dose toxicity, carcinogenic potential and toxicity to reproduction and development.

Levofloxacin caused no impairment of fertility or reproductive performance in rats and its only effect on fetuses was delayed maturation as a result of maternal toxicity.

Levofloxacin did not induce gene mutations in bacterial or mammalian cells but did induce chromosome aberrations in Chinese hamster lung (CHL) cells *in vitro*. These effects can be attributed to inhibition of topoisomerase II. *In vivo* tests (micronucleus, sister chromatid exchange, unscheduled DNA synthesis, dominant lethal tests) did not show any genotoxic potential.

Studies in the mouse showed levofloxacin to have phototoxic activity only at very high doses. Levofloxacin did not show any genotoxic potential in a photomutagenicity assay, and it reduced tumour development in a photocarcinogenicity assay.

In common with other fluoroquinolones, levofloxacin showed effects on cartilage (blistering and cavities) in rats and dogs. These findings were more marked in young animals.

## **6 PHARMACEUTICAL PARTICULARS**

### **6.1 List of excipients**

Sodium chloride,

Hydrochloric acid (for pH adjustment)

Sodium hydroxide (for pH adjustment)

Water for injection

## 6.2 Incompatibilities

This medicinal product should not be mixed with heparin or alkaline solutions (e.g. sodium bicarbonate).

This medicinal product must not be mixed with other medicinal products except those mentioned in section 6.6.

## 6.3 Shelf life

Shelf life as packaged for sale: 36 months

Shelf life after removal of the outer packaging: 24 hours (under indoor light conditions)

Shelf-life after further dilution with compatible solutions: Chemical and physical in-use stability has been demonstrated for 8 hours at 25°C.

From a microbiological point of view, unless the method of opening/dilution precludes the risk of microbial contamination, the product should be used immediately. If not used immediately, in-use storage times and conditions prior to use are the responsibility of the user.

## 6.4 Special precautions for storage

Keep the bag in its outer carton in order to protect from light.

For storage conditions after dilution of the medicinal product see section 6.3.

## 6.5 Nature and contents of container

100 ml, low density polyethylene bag containing 100 ml or 50 ml of solution for infusion. Packs of 1, 5 and 20 bags are available.

Not all pack sizes may be marketed.

## 6.6 Special precautions for disposal and other handling

Preparation for administration:

1. Inspect the bag before use. It must only be used if the solution is a clear, greenish- yellow solution, practically free from particles.
2. Hold the plastic bag with the connection ports uppermost.
3. Twist off the protection cap from the connection port.
4. Insert the piercing pin of the i.v. set into the connection port with a twisting motion.
5. Suspend the bag from the hanger.

See the carton box of the product for diagram.

No protection from light is necessary during infusion.

For single use only. Discard any unused solution.

*Mixture with other solutions for infusion:*

Levofloxacin 5 mg/ml solution for infusion is compatible with the following solutions for infusion:

sodium chloride 9 mg/ml (0.9%)  
glucose 50 mg/ml (5%)  
glucose 25 mg/ml (2.5%) in Ringer's solution

See section 6.2 for incompatibilities.

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

## **7 MARKETING AUTHORISATION HOLDER**

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Ava. Santa Eulalia 240 - 242  
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## **8 MARKETING AUTHORISATION NUMBER**

PA 1391/002/001

## **9 DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUTHORISATION**

Date of first authorisation: 27 August 2010

## **10 DATE OF REVISION OF THE TEXT**

November 2014