

## **PRODUCT MONOGRAPH**

**Pr pms-VORICONAZOLE**  
Voriconazole

Lyophilized Powder for Injection 200 mg / vial  
(10 mg/mL when reconstituted)

**Antifungal Agent**

**PHARMASCIENCE INC.**  
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**PART I: HEALTH PROFESSIONAL INFORMATION**

**SUMMARY PRODUCT INFORMATION**

<b>Route of Administration</b>	<b>Dosage Form / Strength</b>	<b>Clinically Relevant Nonmedicinal Ingredients</b>
Intravenous injection	Lyophilized powder for reconstitution: 200 mg/vial, 10 mg/mL reconstituted	SBECD (sulfobutylether- $\beta$ -cyclodextrin sodium). For complete listing see DOSAGE FORMS, COMPOSITION AND PACKAGING.

**INDICATIONS AND CLINICAL USE**

pms-VORICONAZOLE (voriconazole) is indicated in the treatment of:

- Invasive aspergillosis;
- Candidemia in non-neutropenic patients and the following Candida infections: disseminated infections in skin and infections in abdomen, kidney, bladder wall and wounds (see CLINICAL TRIALS and MICROBIOLOGY).

**Geriatrics**

Evidence from clinical studies and experience suggests that safety and effectiveness of voriconazole are similar in geriatric and adult subjects (see WARNINGS AND PRECAUTIONS, DOSAGE AND ADMINISTRATION and DETAILED PHARMACOLOGY).

**Pediatrics**

Safety and effectiveness of pms-VORICONAZOLE in pediatric subjects below the age of twelve years have not been established (see WARNINGS AND PRECAUTIONS, CLINICAL TRIALS and DETAILED PHARMACOLOGY).

## CONTRAINDICATIONS

pms-VORICONAZOLE is contraindicated in patients with known hypersensitivity to voriconazole or its excipients. For a complete listing see DOSAGE FORMS, COMPOSITION AND PACKAGING section of the product monograph. There is no information regarding cross-sensitivity between voriconazole and other azole antifungal agents. Caution should be used when prescribing voriconazole to patients with hypersensitivity to other azoles.

pms-VORICONAZOLE is a substrate and inhibitor of cytochrome P450 isozymes CYP2C19, CYP2C9 and CYP3A4. Thus, coadministration of voriconazole is contraindicated with drugs that are highly dependent on these isozymes for clearance and for which elevated plasma concentrations are associated with serious and/or life threatening events. In addition, coadministration of voriconazole is contraindicated with drugs that significantly decrease voriconazole plasma concentrations due to induction of these isozymes (see DRUG INTERACTIONS).

Coadministration of voriconazole is contraindicated with drugs that are CYP450 substrates and for which elevated plasma levels may result in serious and/or life-threatening events. These drugs are listed in Table 1.

Coadministration of voriconazole is contraindicated with drugs that are CYP450 inducers where significantly reduced voriconazole plasma levels may be associated with the potential for serious and/or life-threatening events. These drugs are listed in Table 1.

**Table 1: Drugs That Are Contraindicated with Voriconazole**

<b>Drug class</b>	<b>Drugs within class that are Contraindicated with pms-VORICONAZOLE</b>	<b>Clinical comment</b>
Antiarrhythmic agents	quinidine	CONTRAINDICATED due to potential for serious and/or life-threatening reactions such as cardiac arrhythmias
Anticonvulsants	carbamazepine, long acting barbiturates	CONTRAINDICATED due to potential to significantly reduce plasma voriconazole concentrations
Antihistamines	astemizole*, terfenadine*	CONTRAINDICATED due to potential for serious and/or life-threatening reactions such as cardiac arrhythmias
Antimycobacterial	rifampin, rifabutin	CONTRAINDICATED due to effect in significantly reducing plasma concentration of voriconazole
Antipsychotic	pimozide	CONTRAINDICATED due to potential for serious and/or life-threatening reactions such as cardiac arrhythmias
Ergot derivatives	ergotamine, dihydroergotamine	CONTRAINDICATED due to potential for serious and/or life-threatening reactions such as egotism
Gastrointestinal (GI) Motility Agent	cisapride*	CONTRAINDICATED due to potential for serious and/or

		life-threatening reactions such as cardiac arrhythmias
Herbal Products	St. John's Wort** (Hypericum perforatum)	CONTRAINDICATED due to its effect in significantly reducing plasma exposure of voriconazole
Immunosuppressant	sirolimus	CONTRAINDICATED due to voriconazole's effect in significantly increasing plasma exposure of sirolimus
Protease inhibitor	ritonavir (high dose)	CONTRAINDICATED due to its effect in significantly reducing plasma exposure of voriconazole
Non-nucleoside reverse transcriptase inhibitor (NNRTI)	efavirenz (doses of 400 mg once daily or higher)	CONTRAINDICATED due to its effect in significantly reducing plasma exposure of voriconazole

\* Not marketed in Canada

\*\* also P-gp inducer

## WARNINGS AND PRECAUTIONS

### Serious Warnings and Precautions

- **Drug Interactions** (see CONTRAINDICATIONS and DRUG INTERACTIONS)- pms-VORICONAZOLE significantly increases plasma concentrations of CYP450 substrates which may lead to serious or life threatening events - coadministration with CYP450 inducers significantly decreases plasma concentrations of voriconazole.
- **Cardiovascular effects** - QT interval prolongation pms-VORICONAZOLE has been associated with prolongation of the QT interval of the electrocardiogram in some patients. Prolongation of QT interval may increase the risk of arrhythmia. During the clinical development and post-marketing surveillance, there have been rare cases of arrhythmias (including ventricular arrhythmia such as *torsades de pointes*), cardiac arrests and sudden deaths in patients taking voriconazole. These cases usually involved patients with risk factors and concomitant medications that may have been contributory. Caution should be exercised if voriconazole is used in patients taking other drugs that may prolong the QT interval (see WARNINGS AND PRECAUTIONS, Cardiovascular).
- **Visual disturbances:** Voriconazole may cause visual symptoms including photophobia, altered/enhanced visual perception, blurred vision and/or color vision change (see WARNINGS AND PRECAUTIONS, Ophthalmologic).
- **Hepatic toxicity:** In clinical trials, there have been uncommon cases of serious hepatic reactions during treatment with pms-VORICONAZOLE (including clinical hepatitis, cholestasis, and fulminant hepatic failure, including fatalities). Instances of hepatic reactions were noted to occur primarily in patients with serious underlying medical conditions. Hepatic reactions, including hepatitis and jaundice, have occurred among patients with no other identifiable risk factors. Liver dysfunction has usually been reversible on discontinuation of therapy (see WARNINGS AND PRECAUTIONS,

Hepatic).

- **Dermatological reactions:** There have been cases of exfoliative cutaneous reactions, such as Stevens-Johnson Syndrome, toxic epidermal necrolysis and erythema multiforme that have been observed during treatment with voriconazole. If a patient develops an exfoliative cutaneous reaction, voriconazole should be discontinued (see WARNINGS AND PRECAUTIONS, Skin).
- **Teratogenic in the rat:** Voriconazole can cause fetal harm when administered to a pregnant woman. If this drug is used in pregnancy, or if the patient becomes pregnant while taking this drug, the patient should be apprised of the potential hazard to the fetus (see WARNINGS AND PRECAUTIONS, Special Populations, Pregnant Women, **and** TOXICOLOGY).
- **Skeletal adverse events:** Fluorosis and periostitis have been reported in transplant patients during long-term voriconazole therapy. If a patient develops skeletal pain and radiologic findings compatible with fluorosis or periostitis, voriconazole should be discontinued (see WARNINGS AND PRECAUTIONS, Skeletal Adverse Events).

## **Cardiovascular**

### **QT Interval Prolongation**

pms-VORICONAZOLE has been associated with prolongation of the QT interval of the electrocardiogram in some patients. Prolongation of QT interval may increase the risk of arrhythmia (see DETAILED PHARMACOLOGY). During clinical development and post-marketing surveillance, there have been rare cases of arrhythmias (including ventricular arrhythmias such as *torsades de pointes*), cardiac arrests and sudden deaths in patients taking voriconazole. These cases usually involved patients with risk factors such as history of cardiotoxic chemotherapy, cardiomyopathy, hypokalemia and concomitant medications that may have been contributory.

Due to limited clinical experience, voriconazole should be administered with caution to patients with potentially proarrhythmic conditions such as cardiomyopathy (in particular when heart failure is present), existing symptomatic arrhythmias, hypokalemia, clinically significant sinus bradycardia, acute myocardial ischemia, congestive heart failure or congenital or acquired prolongation of QT.

Caution should be exercised if voriconazole is used in patients taking other drugs that may prolong the QT interval, such as antipsychotics, tricyclic antidepressants, erythromycin, Class IA (e.g. procainamide, quinidine) Class III (e.g. amiodarone, sotalol) antiarrhythmic agents (see DRUG INTERACTIONS).

There is a report of a life-threatening syncopal episode in a patient receiving concomitant voriconazole and methadone (see DRUG INTERACTIONS – Overview).

Drugs metabolized by the hepatic cytochrome P450 isoenzymes CYP2C19, CYP2C9 and CYP3A4 may also affect, or be affected by, voriconazole levels, with possible resulting QT effects. Such drugs include tacrolimus, HIV protease inhibitors, and macrolide antibiotics (see DRUG INTERACTIONS).

### **Ophthalmologic**

Voriconazole may cause visual symptoms including photophobia altered/enhanced visual perception, blurred vision and/or color vision change. The majority of visual symptoms appeared to spontaneously resolve within 60 minutes. **The effect of pms-VORICONAZOLE on visual function is not known if treatment continues beyond 28 days.** If treatment continues beyond 28 days, visual function including visual acuity, visual field and color perception should be monitored.

There has been a small number of postmarketing reports of vision loss (including decreased visual acuity or visual fields) where a relationship to voriconazole could not be excluded. These events mostly occurred in medically complex patients, where underlying disease processes and the primary infections themselves confound interpretation (see ADVERSE REACTIONS and DETAILED PHARMACOLOGY- Animal Pharmacology).

There have been post-marketing reports of prolonged visual adverse events, including optic neuritis and papilledema. These events occurred primarily in severely ill patients who had underlying conditions and/or concomitant medications which may have caused or contributed to these events (see POST-MARKET ADVERSE DRUG REACTIONS).

### **Effects on Ability to Drive and Operating Machines**

Voriconazole may cause visual symptoms including blurring and/or photophobia. The majority of visual symptoms appeared to spontaneously resolve within 60 minutes. Patients on voriconazole must avoid potentially hazardous tasks, such as driving or operating machinery if they perceive any change in vision. Patients should not drive at night while taking voriconazole.

### **Hepatic**

**In clinical trials, there have been uncommon cases of serious hepatic reactions during treatment with pms-VORICONAZOLE (including clinical hepatitis, cholestasis, and fulminant hepatic failure, including fatalities).** Instances of hepatic reactions were noted to occur primarily in patients with serious underlying medical conditions (predominantly hematological malignancy). Hepatic reactions, including hepatitis and jaundice, have occurred among patients with no other identifiable risk factors. Liver dysfunction has usually been reversible on discontinuation of therapy.

Patients who develop abnormal liver function tests during voriconazole therapy should be monitored for the development of more severe hepatic injury. Discontinuation of voriconazole must be considered if clinical signs and symptoms consistent with liver disease develop that may be attributable to voriconazole (see Patients with Hepatic Impairment, ADVERSE REACTIONS, DOSAGE AND ADMINISTRATION and DETAILED PHARMACOLOGY).

### **Infusion Related Reactions**

During infusion of the intravenous formulation of voriconazole in healthy subjects, anaphylactoid-type reactions, including flushing, fever, sweating, tachycardia, chest tightness, dyspnea, faintness, nausea, pruritus and rash, have occurred uncommonly. Symptoms appeared immediately upon initiating the infusion. Consideration should be given to stopping the infusion should these reactions occur. Other symptoms, including hypotension, were considered to be infusion related in the clinical trial setting.

### **Pancreatic**

Adults and children with risk factors for acute pancreatitis (e.g. recent chemotherapy, hematopoietic stem cell transplantation [HSCT]) should be monitored for development of pancreatitis during voriconazole treatment.

### **Renal**

Acute renal failure has been observed in severely ill patients undergoing treatment with voriconazole. Patients being treated with voriconazole are likely to be treated concomitantly with nephrotoxic medications and have concurrent conditions that may result in decreased renal function.

### **Sensitivity and Resistance**

Voriconazole does not have activity against Zygomycete spp *in vitro* (see MICROBIOLOGY). Cases of breakthrough zygomycosis, most fatal, have been reported in patients who had received voriconazole (see references 5, 10, 14, 26 and 27).

### **Skin**

There have been cases of exfoliative cutaneous reactions, such as Stevens-Johnson Syndrome (uncommon), toxic epidermal necrolysis (rare) and erythema multiforme (rare) during treatment with voriconazole (see ADVERSE REACTIONS). Stevens-Johnson Syndrome and toxic epidermal necrolysis should be considered as a differential diagnosis if patients develop prodromal flu-like symptoms (fever, malaise, rhinitis, chest pain, vomiting, sore throat, cough, diarrhea, headache, myalgia and arthralgia). If a patient develops an exfoliative cutaneous reaction, voriconazole should be discontinued.

Photosensitivity reactions have been observed. It is recommended that patients, including children, avoid exposure to direct sunlight during voriconazole treatment and use measures such as protective clothing and sunscreen with high sun protection factor (SPF). In patients with photosensitivity skin reactions and additional risk factors, squamous cell carcinomas of the skin and melanoma have been reported during long-term therapy.

If phototoxic reactions occur, multidisciplinary advice should be sought and the patient should be referred to a dermatologist. Voriconazole discontinuation should be considered. Dermatologic evaluation should be performed on a systematic and regular basis, whenever voriconazole is continued despite the occurrence of phototoxicity-related lesions, to allow early detection and management of premalignant lesions.



If a patient develops a skin lesion consistent with premalignant skin lesions, squamous cell carcinoma or melanoma, voriconazole discontinuation should be considered.

There was a small number of post-marketing reports of squamous cell carcinoma, all of which were preceded by episodes of photosensitivity and/or phototoxicity.

The frequency of phototoxicity reactions is higher in the pediatric population. As an evolution towards squamous cell carcinoma has been reported, stringent measures for the photoprotection are warranted in this population of patients. In children experiencing photoaging injuries such as lentigines or ephelides, sun avoidance and dermatologic follow-up are recommended even after treatment discontinuation.

### **Skeletal Adverse Events**

Non-infectious periostitis with elevated fluoride and alkaline phosphatase levels has been reported in transplant patients. If a patient develops skeletal pain and radiologic findings compatible with fluorosis or periostitis, voriconazole should be discontinued.

### **Special Populations**

#### **Women of Child-Bearing Potential**

Women of child-bearing potential should always use effective contraception during treatment with voriconazole.

#### **Pregnant Woman**

There are no adequate and well-controlled studies in pregnant women. Voriconazole can cause fetal harm when administered to a pregnant woman. If this drug is used in pregnancy, or if the patient becomes pregnant while taking this drug, the patient should be apprised of the potential hazard to the fetus. Voriconazole must not be used during pregnancy unless the benefits to the mother clearly outweigh the potential risk to the fetus.

In reproduction studies in rats, voriconazole was teratogenic (cleft palate, hydronephrosis / hydroureter) from 10 mg/kg (0.3 times the human exposure based on body surface area comparisons) and above. Plasma estradiol in pregnant rats was reduced at all dose levels. Voriconazole treatment in rats produced increased gestational length and dystocia which was associated with increased perinatal pup mortality at the 10 mg/kg dose. In rabbits, voriconazole increased embryoletality, and reduced fetal weight (see TOXICOLOGY- Reproductive Toxicology).

#### **Nursing Woman**

Breast-feeding must be stopped on initiation of treatment with voriconazole. The excretion of voriconazole in breast milk has not been investigated.

#### **Pediatric (< 12 years)**

Safety and effectiveness in pediatric subjects below the age of twelve years have not been established. A limited number of pediatric subjects have received voriconazole at doses comparable

to those used in adults on a per kilogram body weight basis. There were no apparent differences in safety or efficacy of voriconazole compared to adults although post-marketing data suggest there might be a higher occurrence of skin reactions in the pediatric population compared to adults. A total of 22 patients aged 12 - 18 years of age with invasive aspergillosis were included in the therapeutic studies. Twelve out of 22 (55%) patients had successful response after treatment with a maintenance dose of voriconazole 4 mg/kg twice daily (see DETAILED PHARMACOLOGY).

### **Geriatrics (> 65 years)**

In multiple-dose therapeutic trials of voriconazole, 9.2% of patients were  $\geq 65$  years of age and 1.8% of patients were  $\geq 75$  years of age. In a clinical pharmacology study in healthy volunteers, some differences were seen in the pharmacokinetic parameters of elderly males compared to young males, and a relationship between plasma concentrations and age was observed in the patients in therapeutic studies. However, the overall safety profile of the elderly patients appeared similar to that of the young. Therefore, dosage adjustment does not appear to be required (see DETAILED PHARMACOLOGY and DOSAGE AND ADMINISTRATION).

### **Patients with Hepatic Impairment**

It is recommended that the standard loading dose regimens be used but that the maintenance dose be halved in patients with mild to moderate hepatic cirrhosis (Child-Pugh A and B) receiving voriconazole (see Hepatic, ADVERSE REACTIONS, DOSAGE AND ADMINISTRATION and DETAILED PHARMACOLOGY).

Safety and efficacy of reduced voriconazole dosing in this setting is not established.

Due to the small number of subjects studied, close clinical monitoring is advised.

Voriconazole has not been studied in patients with severe cirrhosis (Child-Pugh Class C). Voriconazole has been associated with elevations in liver function tests and clinical signs of liver damage, such as jaundice, and should only be used in patients with severe hepatic insufficiency if the benefit outweighs the potential risk. Patients with hepatic insufficiency must be carefully monitored for drug toxicity.

### **Patients with Renal Impairment**

In patients with moderate to severe renal dysfunction (creatinine clearance  $< 50$  mL/min), accumulation of the intravenous vehicle, SBECD, occurs. Oral voriconazole should be administered to these patients, unless an assessment of the benefit/risk to the patient justifies the use of intravenous voriconazole. Renal function (including serum creatinine levels and creatinine clearance) should be closely monitored in these patients, and if significant changes occur, consideration should be given to changing to oral voriconazole therapy (see DOSAGE AND ADMINISTRATION and DETAILED PHARMACOLOGY).

### **Monitoring and Laboratory Tests**

Patient management should include periodic laboratory evaluation of renal function (particularly serum creatinine).

Patients receiving voriconazole must be carefully monitored for hepatic toxicity. Clinical management should include laboratory evaluation of hepatic function (particularly liver function tests and bilirubin) at the initiation of treatment with voriconazole and at least weekly for the first month of treatment. If treatment is continued, monitoring frequency can be reduced to monthly if there are no changes in the liver function tests.

Electrolyte disturbances such as hypokalemia, hypomagnesemia and hypocalcemia should be monitored and corrected, if necessary, prior to initiation of and during voriconazole therapy (see DOSAGE AND ADMINISTRATION).

### **Carcinogenesis and Mutagenesis**

In patients with photosensitivity skin reactions and additional risk factors, squamous cell carcinomas of the skin and melanoma have been reported during long-term therapy. If a patient develops a skin lesion consistent with squamous cell carcinoma or melanoma, voriconazole discontinuation should be considered.

Voriconazole demonstrated clastogenic activity in human lymphocyte cultures *in vitro*. Voriconazole did not display mutagenic activity in bacterial or mammalian cells *in vitro*, or clastogenic activity *in vivo*.

For animal data regarding carcinogenesis and mutagenesis, see TOXICOLOGY.

## **ADVERSE REACTIONS**

### **Overview**

The most frequently reported adverse events (all causalities) in the therapeutic trials were visual disturbances, fever, rash, vomiting, nausea, diarrhea, headache, sepsis, peripheral edema, abdominal pain, and respiratory disorder. The treatment-related adverse events which most often led to discontinuation of voriconazole therapy were elevated liver function tests, rash, and visual disturbances (see WARNINGS AND PRECAUTIONS and DETAILED PHARMACOLOGY).

### **Clinical Trial Adverse Drug Reactions**

*Because clinical trials are conducted under very specific conditions the adverse reaction rates observed in the clinical trials may not reflect the rates observed in practice and should not be compared to the rates in the clinical trials of another drug. Adverse drug reaction information from clinical trials is useful for identifying drug-related adverse events and for approximating rates.*

The data described in the table below reflect exposure to voriconazole in 1655 patients in the therapeutic studies. This represents a heterogeneous population, including immunocompromised patients with hematological malignancy or HIV and non-neutropenic patients. This subgroup does not include healthy volunteers and patients treated in the compassionate use and non-therapeutic studies. This patient population was 62% male, had a mean age of 46 years (range 11 - 90,

including 51 patients aged 12 - 18 years), and was 78% white and 10% black. Five hundred sixty-one patients had duration of voriconazole therapy greater than 12 weeks, with 136 patients receiving voriconazole for over six months. Table 2 includes all adverse events which were reported at an incidence of  $\geq 2\%$  during voriconazole therapy in all therapeutic studies population, studies 307/602 and 608 combined, or study 305, as well as events of concern which occurred at an incidence of  $< 2\%$ .

In studies 307/602, 381 patients (196 on voriconazole, 185 on amphotericin B) were treated to compare voriconazole to amphotericin B followed by other licensed antifungal therapy in the primary treatment of patients with acute invasive aspergillosis. In study 608, 403 non-neutropenic patients with Candidemia were treated to compare voriconazole (272 patients) to the regimen of amphotericin B followed by fluconazole (131 patients). Study 305 evaluated the effects of oral voriconazole (200 patients) and oral fluconazole (191 patients) for another indication in immunocompromised (primarily HIV) patients. Laboratory test abnormalities are discussed under Clinical Laboratory Values below.

**Table 2: TREATMENT-EMERGENT ADVERSE EVENTS**  
**Rate  $\geq 2\%$  on Voriconazole or Adverse Events of Concern in All Therapeutic Studies Population, Studies 307/602-608 combined. Possibly Related to Therapy or Causality Unknown**

	All Therapeutic Studies	Studies 307/602 and 608 (Intravenous/oral therapy)		
	Voriconazole  N = 1655  N (%)	Voriconazole  N = 468  N (%)	Ampho B*  N = 185  N (%)	Ampho $\rightarrow$ Fluconazole  N = 131  N (%)
<b>  Special Senses</b>				
Abnormal vision	310 (18.7)	63 (13.5)	1 (0.5)	0
Photophobia	37 (2.2)	8 (1.7)	0	0
Chromatopsia	20 (1.2)	2 (0.4)	0	0
<b>  Body as a Whole</b>				
Fever	94 (5.7)	8 (1.7)	25 (13.5)	5 (3.8)
Chills	61 (3.7)	1 (0.2)	36 (19.5)	8 (6.1)
Headache	49 (3.0)	9 (1.9)	8 (4.3)	1 (0.8)
<b>  Cardiovascular System</b>				
Tachycardia	39 (2.4)	6 (1.3)	5 (2.7)	0
<b>  Digestive System</b>				
Nausea	89 (5.4)	18 (3.8)	29 (15.7)	2 (1.5)
Vomiting	72 (4.4)	15 (3.2)	18 (9.7)	1 (0.8)
Liver function tests abnormal	45 (2.7)	15 (3.2)	4 (2.2)	1 (0.8)
Cholestatic jaundice	17 (1.0)	8 (1.7)	0	1 (0.8)
<b>  Metabolic and Nutritional Systems</b>				
Alkaline phosphatase increased	59 (3.6)	19 (4.1)	4 (2.2)	3 (2.3)
Hepatic enzymes increased	30 (1.8)	11 (2.4)	5 (2.7)	1 (0.8)
SGOT increased	31 (1.9)	9 (1.9)	0	1 (0.8)
SGPT increased	29 (1.8)	9 (1.9)	1 (0.5)	2 (1.5)
Hypokalemia	26 (1.6)	3 (0.6)	36 (19.5)	16 (12.2)
Bilirubinemia	15 (0.9)	5 (1.1)	3 (1.6)	2 (1.5)
Creatinine increased	4 (0.2)	0	59 (31.9)	10 (7.6)
<b>  Nervous System</b>				
Hallucinations	39 (2.4)	13 (2.8)	1 (0.5)	0

<b>Skin and Appendages</b>				
Rash	88 (5.3)	20 (4.3)	7 (3.8)	1 (0.8)
<b>Urogenital</b>				
Kidney function abnormal	10 (0.6)	6 (1.3)	40 (21.6)	9 (6.9)
Acute kidney failure	7 (0.4)	2 (0.4)	11 (5.9)	7 (5.3)

\* Amphotericin B followed by other licensed antifungal therapy

### **Visual Disturbances**

In clinical trials, Voriconazole treatment-related visual disturbances were common. In these studies, approximately 21% of patients experienced altered/enhanced visual perception, blurred vision, color vision change and/or photophobia. These visual disturbances were generally mild and rarely resulted in discontinuation. Visual disturbances may be associated with higher plasma concentrations and/or doses.

The mechanism of action of the visual disturbances is unknown, although the site of action is most likely to be within the retina. The majority of visual symptoms appeared to spontaneously resolve within 60 minutes. The serious conditions of the patients treated in Phase 3 studies did not generally allow rigorous testing of visual function. In a study in healthy volunteers investigating the effect of 28 days treatment with voriconazole on retinal function, voriconazole caused a decrease in the electroretinogram (ERG) waveform amplitude, a decrease in the visual field and an alteration in colour perception. The ERG measures electrical currents in the retina. The effects were noted early in administration and continued through the course of study drug dosing. Fourteen days after the end of dosing, ERG, visual fields and colour perception returned to normal (see WARNINGS AND PRECAUTIONS and DETAILED PHARMACOLOGY).

### **Dermatological Reactions**

Dermatological reactions were common in the patients treated with voriconazole. The mechanism underlying these dermatologic adverse events remains unknown. In clinical trials, rashes considered related to therapy were reported by 7% (110/1655) of voriconazole-treated patients. The majority of rashes were of mild to moderate severity. Cases of photosensitivity reactions appear to be more likely to occur with long term treatment. Patients have developed serious cutaneous reactions, including Stevens Johnson syndrome (uncommon), toxic epidermal necrolysis (rare) and erythema multiforme (rare) during treatment with voriconazole. Stevens-Johnson Syndrome and toxic epidermal necrolysis should be considered as a differential diagnosis if patients develop prodromal flu-like symptoms (fever, malaise, rhinitis, chest pain, vomiting, sore throat, cough, diarrhea, headache, myalgia and arthralgia).

Patients should be closely monitored at the first appearance of a skin rash and voriconazole should be discontinued if lesions progress. It is recommended that patients avoid strong, direct sunlight during voriconazole therapy (see WARNINGS AND PRECAUTIONS).

### **Less Common Adverse Events**

The following adverse events occurred in < 2% of all voriconazole-treated patients, in all therapeutic studies (N = 1655). This listing includes events where a causal relationship to voriconazole cannot be ruled out or those which may help the physician in managing the risks to the patients. The list does not include events included in Table 2 above and does not include every event reported in the voriconazole clinical program.

## **Body as a Whole**

Abdomen enlarged, abdominal pain, allergic reaction, anaphylactoid reaction (see CONTRAINDICATIONS), ascites, asthenia, back pain, chest pain, cellulitis, edema, face edema, flank pain, flu syndrome, graft versus host reaction, granuloma, infection, bacterial infection, fungal infection, injection site pain, injection site infection/inflammation, mucous membrane disorder, multi-organ failure, pain, pelvic pain, peritonitis, sepsis, substernal chest pain.

## **Cardiovascular**

A fatal case of ventricular fibrillation occurred where a relationship to voriconazole could not be ruled out. There have been rare cases of *torsades de pointes* in which a causal relationship to voriconazole could not be excluded.

Atrial arrhythmia, atrial fibrillation, AV block complete, bigeminy, bradycardia, bundle branch block, cardiomegaly, cardiomyopathy, cerebral hemorrhage, cerebral ischemia, cerebrovascular accident, congestive heart failure, deep thrombophlebitis, endocarditis, extrasystoles, heart arrest, hypertension, hypotension, myocardial infarction, nodal arrhythmia, palpitation, phlebitis, postural hypotension, pulmonary embolus, QT interval prolonged, supraventricular extrasystoles, supraventricular tachycardia, syncope, thrombophlebitis, vasodilatation, ventricular arrhythmia, ventricular fibrillation, ventricular tachycardia (including *torsades de pointes*).

## **Digestive**

Anorexia, cheilitis, cholecystitis, cholelithiasis, constipation, diarrhea, dry mouth, duodenal ulcer perforation, duodenitis, dyspepsia, dysphagia, esophageal ulcer, esophagitis, flatulence, gastroenteritis, gastrointestinal hemorrhage, GGT/LDH elevated, gingivitis, glossitis, gum hemorrhage, gum hyperplasia, hematemesis, hepatic coma, hepatic failure, hepatitis, intestinal perforation, intestinal ulcer, jaundice, enlarged liver, melena, mouth ulceration, pancreatitis, parotid gland enlargement, periodontitis, proctitis, pseudomembranous colitis, rectal disorder, rectal hemorrhage, stomach ulcer, stomatitis, tongue edema.

## **Endocrine**

Adrenal cortex insufficiency, diabetes insipidus, hyperthyroidism, hypothyroidism.

## **Hemic and Lymphatic**

Agranulocytosis, anemia (macrocytic, megaloblastic, microcytic, normocytic), aplastic anemia, hemolytic anemia, bleeding time increased, cyanosis, DIC, ecchymosis, eosinophilia, hypervolemia, leukopenia, lymphadenopathy, lymphangitis, marrow depression, pancytopenia, petechia, purpura, enlarged spleen, thrombocytopenia, thrombotic thrombocytopenic purpura.

## **Metabolic and Nutritional:**

Albuminuria, BUN increased, creatine phosphokinase increased, edema, glucose tolerance decreased, hypercalcemia, hypercholesteremia, hyperglycemia, hyperkalemia, hypomagnesemia, hyponatremia, hyperuricemia, hypocalcemia, hypoglycemia, hypomagnesemia, hyponatremia, hypophosphatemia, peripheral edema, uremia.

## **Musculoskeletal**

Arthralgia, arthritis, bone necrosis, bone pain, leg cramps, myalgia, myasthenia, myopathy, osteomalacia, osteoporosis.

## **Nervous System**

Abnormal dreams, acute brain syndrome, agitation, akathisia, amnesia, anxiety, ataxia, brain edema, coma, confusion, convulsion, delirium, dementia, depersonalization, depression, diplopia, dizziness, encephalitis, encephalopathy, euphoria, Extrapyrarnidal Syndrome, grand mal convulsion, Guillain-Barré syndrome, hypertonia, hypesthesia, insomnia, intracranial hypertension, libido decreased, neuralgia, neuropathy, nystagmus, oculogyric crisis, paresthesia, psychosis, somnolence, suicidal ideation, tremor, vertigo.

## **Respiratory System**

Cough increased, dyspnea, epistaxis, hemoptysis, hypoxia, lung edema, pharyngitis, pleural effusion, pneumonia, respiratory disorder, respiratory distress syndrome, respiratory tract infection, rhinitis, sinusitis, voice alteration.

## **Skin and Appendages**

Alopecia, angioedema, contact dermatitis, discoid lupus erythematosus, eczema, erythema multiforme, exfoliative dermatitis, fixed drug eruption, furunculosis, herpes simplex, maculopapular rash, melanosis, photosensitivity skin reaction, psoriasis, pruritus, pseudoporphyria, skin discoloration, skin disorder, skin dry, sweating, toxic epidermal necrolysis, urticaria.

## **Special Senses**

Abnormality of accommodation, blepharitis, color blindness, conjunctivitis, corneal opacity, deafness, ear pain, eye pain, eye hemorrhage, hypoacusis, dry eyes, keratitis, keratoconjunctivitis, mydriasis, night blindness, optic atrophy, optic neuritis, otitis externa, papilledema, retinal hemorrhage, retinitis, scleritis, taste loss, taste perversion, tinnitus, uveitis, visual field defect.

## **Urogenital**

Anuria, blighted ovum, creatinine clearance decreased, dysmenorrhea, dysuria, epididymitis, glycosuria, hemorrhagic cystitis, hematuria, hydronephrosis, impotence, kidney pain, kidney tubular necrosis, metrorrhagia, nephritis, nephrosis, oliguria, scrotal edema, urinary incontinence, urinary retention, urinary tract infection, uterine hemorrhage, vaginal hemorrhage.

## **Clinical Laboratory Values**

The overall incidence of clinically significant transaminase abnormalities in all therapeutic studies was 12.4% (206/1655) of patients treated with voriconazole. Increased incidences of liver function test abnormalities may be associated with higher plasma concentrations and/or doses. The majority of abnormal liver function tests either resolved during treatment without dose adjustment or following dose adjustment, including discontinuation of therapy.

**In clinical trials, there have been uncommon cases of serious hepatic reactions during treatment with voriconazole (including clinical hepatitis, cholestasis, and fulminant hepatic failure, including fatalities).** Instances of hepatic reactions were noted to occur primarily in patients with serious underlying medical conditions (predominantly hematological malignancy).

Hepatic reactions, including hepatitis and jaundice, have occurred among patients with no other identifiable risk factors. Liver dysfunction has usually been reversible on discontinuation of therapy.

Liver function tests should be evaluated at the start of and during the course of voriconazole therapy. Patients who develop abnormal liver function tests should be monitored for the development of more severe hepatic injury. Patient management should include laboratory evaluation of hepatic function (particularly liver function tests and bilirubin). Discontinuation of voriconazole must be considered if clinical signs and symptoms consistent with liver disease develop that may be attributable to voriconazole (see WARNINGS AND PRECAUTIONS and DETAILED PHARMACOLOGY).

Acute renal failure has been observed in severely ill patients undergoing treatment with voriconazole. Patients being treated with voriconazole are likely to be treated concomitantly with nephrotoxic medications and have concurrent conditions that may result in decreased renal function. It is recommended that patients are monitored for the development of abnormal renal function. This should include laboratory evaluation, particularly serum creatinine.

Tables 3 and 4 show the number of patients with hypokalemia and clinically significant changes in renal and liver function tests in three randomized, comparative multicenter studies. In protocol 307/602, patients with definite or probable invasive aspergillosis were randomized to either voriconazole or amphotericin B therapy. In study 608, patients with Candidemia were randomized to either voriconazole or the regimen of amphotericin B followed by fluconazole.

**Table 3: Protocol 307/602 – Clinically Significant Laboratory Test Abnormalities**

	<b>Criteria *</b>	<b>VORICONAZOLE n/N (%)</b>	<b>AMPHOTERICIN B** n/N (%)</b>
T. Bilirubin	> 1.5x ULN	35/180 (19.4)	46/173 (26.6)
AST	> 3.0x ULN	21/180 (11.7)	18/174 (10.3)
ALT	> 3.0x ULN	34/180 (18.9)	40/173 (23.1)
Alk phos	> 3.0x ULN	29/181 (16.0)	38/173 (22.0)
Creatinine	> 1.3x ULN	39/182 (21.4)	102/177 (57.6)
Potassium	< 0.9x LLN	30/181 (16.6)	70/178 (39.3)

\*Without regard to baseline value

\*\*Amphotericin B followed by other licensed antifungal therapy

n = Number of patients with a clinically significant abnormality while on study therapy

N = Total number of patients with at least one observation of the given lab test while on study therapy

ULN = Upper limit of normal

LLN = Lower limit of normal

**Table 4: Protocol 608 – Clinically Significant Laboratory Test Abnormalities**

	<b>Criteria *</b>	<b>VORICONAZOLE n/N (%)</b>	<b>AMPHOTERICIN B followed by FLUCONAZOLE n/N (%)</b>
T. Bilirubin	> 1.5x ULN	50/261 (19.2)	31/115 (27.0)
AST	> 3.0x ULN	40/261 (15.3)	16/116 (13.8)
ALT	> 3.0x ULN	22/261 (8.4)	15/116 (12.9)
Alk phos	> 3.0x ULN	59/261 (22.6)	26/115 (22.6)



Creatinine	> 1.3x ULN	39/260 (15.0)	32/118 (27.1)
Potassium	< 0.9x LLN	43/258 (16.7)	35/118 (29.7)

\*Without regard to baseline value

n = Number of patients with a clinically significant abnormality while on study therapy

N = Total number of patients with at least one observation of the given lab test while on study therapy

ULN = Upper limit of normal

LLN = Lower limit of normal

### Post-Market Adverse Drug Reactions

During postmarketing surveillance, cases of severe hypoglycemia have been reported in patients receiving voriconazole and glipizide (see DRUG INTERACTIONS).

During post-marketing surveillance, there have been rare cases of arrhythmias (including ventricular arrhythmias such as *torsades de pointes*), cardiac arrests and sudden deaths in patients taking voriconazole. These cases usually involved patients with risk factors such as history of cardiotoxic chemotherapy, cardiomyopathy, hypokalemia and concomitant medications that may have been contributory (see WARNINGS AND PRECAUTIONS).

There have been post-marketing reports of pancreatitis in pediatric patients (see WARNINGS AND PRECAUTIONS).

There has been a small number of post-marketing reports of vision loss (including decreased visual acuity or visual fields) where a relationship to voriconazole could not be excluded. These events mostly occurred in medically complex patients, where underlying disease processes and the primary infections themselves confound interpretation (see WARNINGS AND PRECAUTIONS).

There have been post-marketing reports of prolonged visual adverse events (see WARNINGS AND PRECAUTIONS).

During post-marketing surveillance, there have been cases of hyponatremia and rare cases of peripheral neuropathy.

## DRUG INTERACTIONS

### Serious Drug Interactions

Contraindicated Drugs: astemizole, cisapride, pimozide, quinidine, terfenadine, carbamazepine, long acting barbiturates, efavirenz (doses of 400 mg once daily or higher), ergot alkaloids, rifabutin, rifampin, ritonavir (high dose), St. John's Wort and sirolimus (see CONTRAINDICATIONS).

Drugs whose concomitant use should be avoided: everolimus, fluconazole and ritonavir (low dose) (see Table 5 below).

Drugs whose concomitant use requires dose adjustment of voriconazole: phenytoin and efavirenz (doses of 300 mg once daily) (see Table 5 below).

Drugs whose concomitant use requires consideration of dose reduction at initiation of concomitant treatment and close therapeutic monitoring of drug levels during treatment: cyclosporine and tacrolimus (see Table 5 below).

Drugs whose concomitant use requires consideration of dose reduction and/or close monitoring for adverse events during treatment: anticoagulants (warfarin and other oral coumarins), benzodiazepines, calcium channel blockers, HIV protease inhibitors other than indinavir, methadone, non-nucleoside reverse transcriptase inhibitors (NNRTIs), non-steroidal anti-inflammatory drugs (NSAIDs), omeprazole, short and long acting opiates, statins, sulphonylureas and vinca alkaloids (see Table 5 below).

## **Overview**

### **Potential for Other Drugs to Affect Voriconazole**

Voriconazole is metabolized by cytochrome P450 isoenzymes CYP2C19, CYP2C9, and CYP3A4. *In vitro*, the affinity for CYP3A4 is 100-fold lower than that for CYP2C9 and CYP2C19. Inhibitors or inducers of these isoenzymes may increase or decrease voriconazole plasma concentrations, respectively.

### **Potential for Voriconazole to Affect Other Drugs**

Voriconazole inhibits the activity of cytochrome P450 isoenzymes CYP2C19, CYP2C9, and CYP3A4. Therefore, there is potential for pms-VORICONAZOLE to increase the plasma concentrations of drugs metabolized by these CYP450 isoenzymes. In patients who are CYP2C19 poor metabolizers, there may be more reliance on CYP3A4 for elimination.

## **Drug-Drug Interactions**

Interactions between voriconazole and other medicinal products are listed in Table 5 (once daily as "QD", twice daily as "BID", three times daily as "TID" and not determined as "ND"). The direction of the arrow for each pharmacokinetic parameter is based on the 90% confidence interval of the geometric mean ratio being within ( $\leftrightarrow$ ), below ( $\downarrow$ ) or above ( $\uparrow$ ) the 80 to 125% range. The asterisk (\*) indicates a two-way interaction.  $AUC_{\tau}$ ,  $AUC_t$  and  $AUC_{0-\infty}$  represent area under the curve over a dosing interval, from time zero to the time with detectable measurement and from time zero to infinity, respectively.

The interactions in the table are presented in the following order: contraindications, those requiring dose adjustment and careful clinical and/or biological monitoring, and finally those that have no significant pharmacokinetic interaction but may be of clinical interest in this therapeutic field.

Unless otherwise specified, drug interaction studies have been performed in healthy adult male subjects using multiple dosing to steady state with oral voriconazole at 200 mg BID. These results are relevant to other populations and routes of administration.

**Table 5: Summary of Drug-Drug Interactions between Voriconazole and Other Drugs**

Medicinal product [Mechanism of Interaction]	Interaction Geometric mean changes (%)	Recommendations concerning co-administration
Astemizole, cisapride, pimozone, quinidine and terfenadine [CYP3A4 substrates]	Although not studied, increased plasma concentrations of these medicinal products can lead to QTc prolongation and rare occurrences of <i>torsades de pointes</i> .	<b>Contraindicated</b>
Carbamazepine and long-acting barbiturates (e.g., phenobarbital, mephobarbital) [potent CYP450 inducers]	Although not studied, carbamazepine and long-acting barbiturates are likely to significantly decrease plasma voriconazole concentrations.	<b>Contraindicated</b>
<p>Efavirenz (non-nucleoside reverse transcriptase inhibitor) [CYP450 inducer; CYP3A4 inhibitor and substrate]</p> <p>Efavirenz 400 mg QD, coadministered with voriconazole 200 mg BID*</p> <p>Efavirenz 300 mg QD, co-administered with voriconazole 400 mg BID*</p>	<p>Efavirenz <math>C_{max}</math> ↑ 38% Efavirenz AUC<math>\tau</math> ↑ 44%</p> <p>Voriconazole <math>C_{max}</math> ↓ 61% Voriconazole AUC<math>\tau</math> ↓ 77%</p> <p>Compared to efavirenz 600 mg QD.</p> <p>Efavirenz <math>C_{max}</math> ↔ Efavirenz AUC<math>\tau</math> ↑ 17%</p> <p>Compared to voriconazole 200 mg BID.</p> <p>Voriconazole <math>C_{max}</math> ↑ 23% Voriconazole AUC<math>\tau</math> ↓ 7%</p>	<p>Use of standard doses of voriconazole with efavirenz doses of 400 mg QD or higher is <b>contraindicated</b> due to significant decrease in voriconazole exposure.</p> <p>Voriconazole may be co-administered with efavirenz if the voriconazole maintenance dose is increased to 400 mg BID and the efavirenz dose is decreased to 300 mg QD. When voriconazole treatment is stopped, the initial dose of efavirenz should be restored.</p>
Other Non-Nucleoside Reverse Transcriptase Inhibitors (NNRTIs) (e.g., delavirdine, nevirapine)* [CYP3A4 substrates, inhibitors or CYP450 inducers]	<p>Not studied clinically. <i>In vitro</i> studies show that the metabolism of voriconazole may be inhibited by NNRTIs and voriconazole may inhibit the metabolism of NNRTIs.</p> <p>The findings of the effect of efavirenz on voriconazole suggest that the metabolism of voriconazole may be induced by a NNRTI.</p>	Careful monitoring for any occurrence of drug toxicity and/or lack of efficacy, and dose adjustment may be needed.
Ergot alkaloids (e.g., ergotamine and dihydroergotamine) [CYP3A4 substrates]	Although not studied, voriconazole is likely to increase the plasma concentrations of ergot alkaloids and lead to ergotism.	<b>Contraindicated</b>

<b>Medicinal product</b> <i>[Mechanism of Interaction]</i>	<b>Interaction</b> <b>Geometric mean changes (%)</b>	<b>Recommendations concerning co-administration</b>
Rifabutin <i>[potent CYP450 inducer]</i> 300 mg QD  300 mg QD (co-administered with voriconazole 400 mg BID)*	Voriconazole C <sub>max</sub> ↓ 69% Voriconazole AUC <sub>τ</sub> ↓ 78%  Rifabutin C <sub>max</sub> ↑ 195% Rifabutin AUC <sub>τ</sub> ↑ 331%  Compared to voriconazole 200 mg BID.  Voriconazole C <sub>max</sub> ↑ 104% Voriconazole AUC <sub>τ</sub> ↑ 87%	<b>Contraindicated</b> due to significant decrease in voriconazole exposure during co-administration.
Rifampicin (600 mg QD) <i>[potent CYP450 inducer]</i>	Voriconazole C <sub>max</sub> ↓ 93% Voriconazole AUC <sub>τ</sub> ↓ 96%	<b>Contraindicated</b> due to significant decrease in voriconazole exposure during co-administration.
Ritonavir (protease inhibitor) <i>[potent CYP450 inducer; CYP3A4 inhibitor and substrate]</i>  High dose (400 mg BID)  Low dose (100 mg BID)*	Ritonavir C <sub>max</sub> and AUC <sub>τ</sub> ↔ Voriconazole C <sub>max</sub> ↓ 66% Voriconazole AUC <sub>τ</sub> ↓ 82%  Ritonavir C <sub>max</sub> ↓ 25% Ritonavir AUC <sub>τ</sub> ↓ 13% Voriconazole C <sub>max</sub> ↓ 24% Voriconazole AUC <sub>τ</sub> ↓ 39%	Co-administration of voriconazole and high doses of ritonavir (400 mg BID and higher) is <b>contraindicated</b> due to significant decrease in voriconazole exposure.  Co-administration of voriconazole and low dose ritonavir (100 mg BID) should be avoided, unless an assessment of the benefit/risk to the patient justifies the use of voriconazole.
Other HIV Protease Inhibitors (e.g., atazanavir, amprenavir, darunavir, lopinavir, nelfinavir and saquinavir)* <i>[CYP3A4 substrates and inhibitors]</i> <u>boosted with low dose ritonavir 100 mg BID</u>	Although not studied, low dose ritonavir (100 mg BID) could decrease voriconazole level.	Co-administration of voriconazole and low dose ritonavir (100 mg BID) boosted protease inhibitors should be avoided since low dose ritonavir could decrease voriconazole exposure, unless an assessment of the benefit/risk to the patient justifies the use of voriconazole.

<b>Medicinal product</b> <i>[Mechanism of Interaction]</i>	<b>Interaction</b> <b>Geometric mean changes (%)</b>	<b>Recommendations concerning co-administration</b>
Other HIV Protease Inhibitors (e.g., atazanavir, amprenavir, darunavir, lopinavir, nelfinavir and saquinavir)* <i>[CYP3A4 substrates and inhibitors]</i>	Not studied clinically. <i>In vitro</i> studies show that voriconazole may inhibit the metabolism of HIV protease inhibitors (amprenavir, nelfinavir, saquinavir) and the metabolism of voriconazole may also be inhibited by HIV protease inhibitors.  Although not studied, voriconazole is likely to inhibit the metabolism of other protease inhibitors (atazanavir, darunavir, lopinavir) and the metabolism of voriconazole is also likely to be inhibited by these protease inhibitors.	Careful monitoring for any occurrence of drug toxicity and/or lack of efficacy, and dose adjustment may be needed.
St John's Wort <i>[CYP450 inducer; P-gp inducer]</i> 300 mg TID (co-administered with voriconazole 400 mg single dose)	In an independent published study, Voriconazole AUC <sub>∞</sub> ↓ 59%	<b>Contraindicated</b> due to significant decrease in voriconazole exposure during co-administration.
Everolimus <i>[CYP3A4 substrate, P-gP substrate]</i>	Although not studied, voriconazole is likely to significantly increase the plasma concentrations of everolimus.	Co-administration of voriconazole and everolimus is not recommended because voriconazole is expected to significantly increase everolimus concentrations.
Fluconazole (200 mg QD) <i>[CYP2C9, CYP2C19 and CYP3A4 inhibitor]</i>	Voriconazole C <sub>max</sub> ↑ 57% Voriconazole AUC <sub>τ</sub> ↑ 79% Fluconazole C <sub>max</sub> ND Fluconazole AUC <sub>τ</sub> ND	The reduced dose and/or frequency of voriconazole and fluconazole that would eliminate this effect have not been established. Monitoring for voriconazole-associated adverse events is recommended if voriconazole is used sequentially after fluconazole.
Phenytoin <i>[CYP2C9 substrate and potent CYP450 inducer]</i>  300 mg QD  300 mg QD (co-administered with voriconazole 400 mg BID)*	Voriconazole C <sub>max</sub> ↓ 49% Voriconazole AUC <sub>τ</sub> ↓ 69% Phenytoin C <sub>max</sub> ↑ 67% Phenytoin AUC <sub>τ</sub> ↑ 81%  Compared to voriconazole 200 mg BID.  Voriconazole C <sub>max</sub> ↑ 34% Voriconazole AUC <sub>τ</sub> ↑ 39%	Concomitant use of voriconazole and phenytoin should be avoided unless the benefit outweighs the risk. Careful monitoring of phenytoin plasma levels is recommended.  Phenytoin may be co-administered with voriconazole if the maintenance dose of voriconazole is increased to 5 mg/kg IV BID or from 200 mg to 400 mg oral BID, (100 mg to 200 mg oral BID in patients less than 40 kg).

Medicinal product [Mechanism of Interaction]	Interaction Geometric mean changes (%)	Recommendations concerning co-administration
<p>Anticoagulants</p> <p>Warfarin (30 mg single dose, co-administered with 300 mg BID voriconazole)</p> <p>[CYP2C9 substrate]</p> <p>Other oral coumarins (e.g., phenprocoumon, acenocoumarol)</p> <p>[CYP2C9 and CYP3A4 substrates]</p>	<p>Co-administration of voriconazole (300 mg BID) with warfarin (30 mg single dose) increased maximum prothrombin time by 93%. Maximum increase in prothrombin time was approximately 2-fold.</p> <p>Although not studied, voriconazole may increase the plasma concentrations of coumarins that may cause an increase in prothrombin time.</p>	<p>Close monitoring of prothrombin time or other suitable anticoagulation tests is recommended, and the dose of anticoagulants should be adjusted accordingly.</p>
<p>Benzodiazepines (e.g., midazolam, triazolam, alprazolam)</p> <p>[CYP3A4 substrates]</p>	<p>Although not studied clinically, voriconazole is likely to increase the plasma concentrations of benzodiazepines that are metabolised by CYP3A4 and lead to a prolonged sedative effect.</p>	<p>Dose reduction of benzodiazepines should be considered.</p>
<p>Calcium channel blockers [CYP3A4 substrates]</p>	<p>Although not studied clinically, voriconazole has been shown to inhibit felodipine metabolism <i>in vitro</i> (human liver microsomes). Therefore, voriconazole may increase the plasma concentrations of calcium channel blockers that are metabolized by CYP3A4.</p>	<p>Frequent monitoring for adverse events and toxicity related to calcium channel blockers is recommended during co-administration. Dose adjustment of the calcium channel blocker may be needed.</p>
<p>Immunosuppressants [CYP3A4 substrates]</p> <p>Sirolimus (2 mg single dose)</p> <p>Cyclosporine (In stable renal transplant recipients receiving chronic cyclosporin therapy)</p> <p>Tacrolimus (0.1 mg/kg single dose)</p>	<p>In an independent published study, Sirolimus <math>C_{max}</math> ↑6.6-fold Sirolimus <math>AUC_{\infty}</math> ↑11-fold</p> <p>Cyclosporine <math>C_{max}</math> ↑13% Cyclosporin <math>AUC_{\tau}</math> ↑70%</p> <p>Tacrolimus <math>C_{max}</math> ↑117% Tacrolimus <math>AUC_t</math> ↑221%</p>	<p>Co-administration of voriconazole and sirolimus is <b>contraindicated</b> due to significant increase in sirolimus exposure.</p> <p>When initiating voriconazole in patients already on cyclosporine it is recommended that the cyclosporine dose be halved and cyclosporine level carefully monitored. Increased cyclosporine levels have been associated with nephrotoxicity. <u>When voriconazole is discontinued, cyclosporine levels must be carefully monitored and the dose increased as necessary.</u></p> <p>When initiating voriconazole in patients already on tacrolimus, it is recommended that the</p>

Medicinal product [Mechanism of Interaction]	Interaction Geometric mean changes (%)	Recommendations concerning co-administration
		tacrolimus dose be reduced to a third of the original dose and tacrolimus level carefully monitored. Increased tacrolimus levels have been associated with nephrotoxicity. <u>When voriconazole is discontinued, tacrolimus levels must be carefully monitored and the dose increased as necessary.</u>
Long Acting Opiates [CYP3A4 substrates]  Oxycodone (10 mg single dose)	In an independent published study, Oxycodone C <sub>max</sub> ↑ 1.7-fold Oxycodone AUC <sub>∞</sub> ↑ 3.6-fold	Dose reduction in oxycodone and other long-acting opiates metabolized by CYP3A4 (e.g., hydrocodone) should be considered. Frequent monitoring for opiate-associated adverse events may be necessary.
Methadone (32-100 mg QD) [CYP3A4 substrate]	R-methadone (active) C <sub>max</sub> ↑ 31% R-methadone (active) AUC <sub>τ</sub> ↑ 47% S-methadone C <sub>max</sub> ↑ 65% S-methadone AUC <sub>τ</sub> ↑ 103%	Frequent monitoring for adverse events and toxicity related to methadone, including QT prolongation, is recommended. Dose reduction of methadone may be needed.
Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) [CYP2C9 substrates] Ibuprofen (400 mg single dose) Diclofenac (50 mg single dose)	S-Ibuprofen C <sub>max</sub> ↑ 20% S-Ibuprofen AUC <sub>∞</sub> ↑ 100%  Diclofenac C <sub>max</sub> ↑ 114% Diclofenac AUC <sub>∞</sub> ↑ 78%	Frequent monitoring for adverse events and toxicity related to NSAIDs is recommended. Dose reduction of NSAIDs may be needed.
Omeprazole (40 mg QD)* [CYP2C19 inhibitor; CYP2C19 and CYP3A4 substrate]	Omeprazole C <sub>max</sub> ↑ 116% Omeprazole AUC <sub>∞</sub> ↑ 280%  Voriconazole C <sub>max</sub> ↑ 15% Voriconazole AUC <sub>τ</sub> ↑ 41%  Other proton pump inhibitors that are CYP2C19 substrates may also be inhibited by voriconazole and may result in increased plasma concentrations of these medicinal products.	No dose adjustment of voriconazole is recommended.  When initiating voriconazole in patients already receiving omeprazole doses of 40 mg or above, it is recommended that the omeprazole dose be halved.
Oral Contraceptives* [CYP3A4 substrate; CYP2C19 inhibitor]  Norethisterone/ethinylestradiol (1 mg/0.035 mg QD)	Ethinylestradiol C <sub>max</sub> ↑ 36% Ethinylestradiol AUC <sub>τ</sub> ↑ 61%  Norethisterone C <sub>max</sub> ↑ 15% Norethisterone AUC <sub>τ</sub> ↑ 53%  Voriconazole C <sub>max</sub> ↑ 14% Voriconazole AUC <sub>τ</sub> ↑ 46%	Monitoring for adverse events related to oral contraceptives, in addition to those for voriconazole, is recommended.

<b>Medicinal product</b> <i>[Mechanism of Interaction]</i>	<b>Interaction</b> <b>Geometric mean changes (%)</b>	<b>Recommendations concerning co-administration</b>
Short Acting Opiates <i>[CYP3A4 substrates]</i>  Alfentanil (20 mcg/kg single dose, with concomitant naloxone)  Fentanyl (5 mcg/kg single dose)	In an independent published study, Alfentanil $AUC_{\infty}$ ↑ 6-fold  In an independent published study, Fentanyl $AUC_{\infty}$ ↑ 1.34-fold	Dose reduction of alfentanil, fentanyl and other short acting opiates similar in structure to alfentanil and metabolised by CYP3A4 (e.g., sufentanil) should be considered. Extended and frequent monitoring for respiratory depression and other opiate-associated adverse events is recommended.
Statins (e.g., lovastatin) <i>[CYP3A4 substrates]</i>	Although not studied clinically, voriconazole is likely to increase the plasma concentrations of statins that are metabolised by CYP3A4 and could lead to rhabdomyolysis.	Dose reduction of statins should be considered.
Sulfonylureas (e.g., tolbutamide, glipizide, glyburide) <i>[CYP2C9 substrates]</i>	Although not studied, voriconazole is likely to increase the plasma concentrations of sulfonylureas and cause hypoglycemia.	Careful monitoring of blood glucose is recommended. Dose reduction of sulfonylureas should be considered.
Vinca alkaloids (e.g., vincristine and vinblastine) <i>[CYP3A4 substrates]</i>	Although not studied, voriconazole is likely to increase the plasma concentrations of vinca alkaloids and lead to neurotoxicity.	Dose reduction of vinca alkaloids should be considered.
Cimetidine (400 mg BID) <i>[non-specific CYP450 inhibitor and increases gastric pH]</i>	Voriconazole $C_{max}$ ↑ 18% Voriconazole $AUC_{\tau}$ ↑ 23%	No dose adjustment
Digoxin (0.25 mg QD) <i>[P-gp substrate]</i>	Digoxin $C_{max}$ ↔ Digoxin $AUC_{\tau}$ ↔	No dose adjustment
Indinavir (protease inhibitor) (800 mg TID) <i>[CYP3A4 inhibitor and substrate]</i>	Indinavir $C_{max}$ ↔ Indinavir $AUC_{\tau}$ ↔ Voriconazole $C_{max}$ ↔ Voriconazole $AUC_{\tau}$ ↔	No dose adjustment
Macrolide antibiotics Erythromycin (1 g BID) <i>[CYP3A4 inhibitor]</i> Azithromycin (500 mg QD)	Voriconazole $C_{max}$ and $AUC_{\tau}$ ↔  Voriconazole $C_{max}$ and $AUC_{\tau}$ ↔  The effect of voriconazole on either erythromycin or azithromycin is unknown.	No dose adjustment
Mycophenolic acid (1 g single dose) <i>[UDP-glucuronyl transferase substrate]</i>	Mycophenolic acid $C_{max}$ ↔ Mycophenolic acid $AUC_{\tau}$ ↔	No dose adjustment
Prednisolone (60 mg single dose) <i>[CYP3A4 substrate]</i>	Prednisolone $C_{max}$ ↑ 11% Prednisolone $AUC_{\infty}$ ↑ 34%	No dose adjustment
Ranitidine (150 mg BID) <i>[increases gastric pH]</i>	Voriconazole $C_{max}$ and $AUC_{\tau}$ ↔	No dose adjustment

The asterisk (\*) indicates a two-way interaction.



### **Drug-Food Interactions**

Interactions with food have not been established.

### **Drug-Herb Interactions**

Interactions with herbal products such as St-John's Wort (*Hypericum perforatum*) significantly reduced plasma exposure of voriconazole. Because long-term use of St. John's Wort could lead to reduced voriconazole exposure, **concomitant use of pms-VORICONAZOLE with St. John's Wort is contraindicated** (see CONTRAINDICATIONS).

### **Drug-Laboratory Interactions**

Interactions with laboratory tests have not been established.

## **DOSAGE AND ADMINISTRATION**

### **Dosing Considerations**

- **Therapy should be initiated with the specified loading dose regimen.**
- **Dosage is based on weight.**
- **Dose can be adjusted if patient response is inadequate or patient is unable to tolerate treatment.**
- **In patients with mild to moderate hepatic impairment, the maintenance dose should be halved.**
- **In patients with moderate to severe renal insufficiency (CrCl < 50 mL/min), ORAL voriconazole should be used because accumulation of the intravenous vehicle SBECD occurs.**
- **When pms-VORICONAZOLE is taken concomitantly with other drugs, the dosage of pms-VORICONAZOLE or the concomitant drugs may need to be adjusted (see DRUG INTERACTIONS).**

### **Recommended Dose and Dosage Adjustment**

#### ***Dosage***

##### **Use in Adults**

Therapy must be initiated with the specified loading dose regimen of intravenous pms-VORICONAZOLE to achieve adequate plasma concentrations on Day 1. If treatment is initiated with intravenous administration, it should be continued for at least 7 days before switching to oral treatment.

Cumulative dosing of the IV formulation should not extend beyond 6 months. Detailed information on dosage recommendations is provided in the following table.

**Table 6: Voriconazole Dosage and Administration**

	Loading Dose Regimen (first 24 hours)	Maintenance Dose (after first 24 hours)
	IV	IV
<b>Invasive Aspergillosis<sup>a</sup></b>	6 mg/kg BID <sup>1</sup>	4 mg/kg BID <sup>1</sup>
<b>Candidemia and Invasive Candidiasis</b>	6 mg/kg BID <sup>1</sup>	3-4 mg/kg BID* <sup>1</sup>

\* In clinical trials, patients with Candidemia received 3 mg/kg every 12 hours as primary therapy, while patients with invasive candidiasis received 4 mg/kg as salvage therapy. Appropriate dose should be based on the severity and nature of the infection.

<sup>1</sup> BID = twice daily (12 hours apart).

<sup>a</sup> In the pivotal clinical study of invasive aspergillosis, the median duration of IV voriconazole therapy was 10 days (range 2-85 days).

### **Dosage Adjustment**

If patients are unable to tolerate 4 mg/kg intravenously, reduce the intravenous maintenance dose to 3 mg/kg every 12 hours.

Treatment duration depends upon the patient's clinical and mycological response. Patients with Candidemia should be treated for at least 14 days following resolution of symptoms or following last positive culture, whichever is longer.

### **Administration**

pms-VORICONAZOLE requires reconstitution and dilution prior to administration as an infusion at a maximum rate of 3 mg/kg per hour over 1 - 2 hours (see below under Reconstitution).

### **NOT FOR INTRAVENOUS BOLUS INJECTION**

Electrolyte disturbances such as hypokalemia, hypomagnesemia and hypocalcemia should be monitored and corrected, if necessary, prior to initiation of and during voriconazole therapy (see WARNINGS AND PRECAUTIONS - Laboratory Tests).

### **Missed Dose**

Patients who miss taking a dose should take their regular dose next time it is due. Patients should not take a double dose to make up for the forgotten dose.

### **Reconstitution**

The powder is reconstituted with 19 mL of "Water for Injection" to obtain an extractable volume of 20 mL of clear concentrate containing 10 mg/mL of voriconazole. It is recommended that a standard 20 mL (non-automated) syringe be used to ensure that the exact amount (19.0 mL) of water for injection is dispensed. Discard the vial if a vacuum does not pull the diluent into the vial. Shake the vial until all the powder is dissolved.

## **Dilution for Infusion**

pms-VORICONAZOLE must be infused over 1 - 2 hours, at a concentration of 5 mg/mL or less. Therefore, the required volume of the 10 mg/mL pms-VORICONAZOLE concentrate should be further diluted as follows (appropriate diluents listed below):

1. Calculate the volume of 10 mg/mL pms-VORICONAZOLE concentrate required based on the patient's weight (Table 7)
2. In order to allow the required volume of pms-VORICONAZOLE concentrate to be added, withdraw and discard at least an equal volume of diluent from the infusion bag or bottle to be used. The volume of diluent remaining in the bag or bottle should be such that when the 10 mg/mL pms-VORICONAZOLE concentrate is added, the final concentration is not less than 0.5 mg/mL or greater than 5 mg/mL.
3. Using a suitable size syringe and aseptic technique, withdraw the required volume of pms-VORICONAZOLE concentrate from the appropriate number of vials and add to the infusion bag or bottle. DISCARD PARTIALLY USED VIALS.

The final pms-VORICONAZOLE solution must be infused over 1 to 2 hours at a maximum rate of 3 mg/kg per hour.

**Table 7: Required Volumes of 10 mg/mL pms-VORICONAZOLE Concentrate**

Body Weight (kg)	Volume of pms-VORICONAZOLE Concentrate 10 mg /mL required for:					
	3 mg/kg dose (number of vials)		4 mg/kg dose (number of vials)		6 mg/kg dose (number of vials)	
30	9.0 mL	1	12 mL	1	18 mL	1
35	10.5 mL	1	14 mL	1	21 mL	2
40	12.0 mL	1	16 mL	1	24 mL	2
45	13.5 mL	1	18 mL	1	27 mL	2
50	15.0 mL	1	20 mL	1	30 mL	2
55	16.5 mL	1	22 mL	2	33 mL	2
60	18.0 mL	1	24 mL	2	36mL	2
65	19.5 mL	1	26 mL	2	39 mL	2
70	21.0 mL	2	28 mL	2	42 mL	3
75	22.5 mL	2	30 mL	2	45 mL	3
80	24.0 mL	2	32 mL	2	48 mL	3
85	25.5 mL	2	34 mL	2	51 mL	3
90	27.0 mL	2	36 mL	2	54 mL	3
95	28.5 mL	2	38 mL	2	57 mL	3
100	30.0 mL	2	40 mL	2	60 mL	3

pms-VORICONAZOLE is a single dose unpreserved sterile lyophile. Therefore, from a microbiological point of view, once reconstituted, 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 and should not be longer than 24 hours between 2 and 8°C (36°to 46°F). This medicinal product is for single use only and any unused solution should be discarded.

The reconstituted solution can be diluted with:

- 0.9% Sodium Chloride USP

- Lactated Ringers USP
- 5% Dextrose and Lactated Ringers USP
- 5% Dextrose and 0.45% Sodium Chloride USP
- 5% Dextrose USP
- 5% Dextrose and 20 mEq Potassium Chloride USP
- 0.45% Sodium Chloride USP
- 5% Dextrose and 0.9% Sodium Chloride USP

The compatibility of pms-VORICONAZOLE with diluents other than those described above is unknown (see Incompatibilities).

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

### **Incompatibilities**

- **Blood products and concentrated electrolytes:** Voriconazole must not be infused concomitantly with any blood product or any short-term infusion of concentrated electrolytes, even if the two infusions are running in separate intravenous lines (or cannulas).

Electrolyte disturbances such as hypokalemia, hypomagnesemia and hypocalcemia should be monitored and corrected, if necessary, prior to initiation of and during voriconazole therapy (see WARNINGS AND PRECAUTIONS - Laboratory Tests).

- **Intravenous solutions containing (non-concentrated) electrolytes:** Voriconazole can be infused at the same time as other intravenous solutions containing (non-concentrated) electrolytes, but must be infused through a separate line.
- **Total Parenteral Nutrition (TPN):** Voriconazole can be infused at the same time as total parenteral nutrition, but must be infused in a separate line. If infused through a multiple-lumen catheter, TPN needs to be administered using a different port from the one used for voriconazole.
- pms-VORICONAZOLE must not be diluted with 4.2% Sodium Bicarbonate Infusion. Compatibility with other concentrations is unknown.

As with all parenteral drug products, intravenous admixtures should be inspected visually for clarity, particulate matter, precipitate, discoloration and leakage prior to administration, whenever solution and container permit. Solutions showing haziness, particulate matter, precipitate, discoloration or leakage should not be used. Discard unused portion.

### **Special Populations**

#### **Use in Geriatrics**

Dosage adjustment does not appear to be required for elderly patients (see WARNINGS AND PRECAUTIONS and DETAILED PHARMACOLOGY).

#### **Use in Pediatrics**

See WARNINGS AND PRECAUTIONS and DETAILED PHARMACOLOGY.

### **Use in Patients with Renal Impairment**

Due to the small number of subjects studied, close clinical monitoring is advised.

In patients with moderate or severe renal insufficiency (creatinine clearance <50 mL/min), accumulation of the intravenous vehicle, SBECD, occurs. Oral voriconazole should be administered to these patients, unless an assessment of the benefit risk to the patient justifies the use of intravenous voriconazole. Renal function (including serum creatinine levels and creatinine clearance) should be closely monitored in these patients, and, if significant changes occur, consideration should be given to changing to oral voriconazole therapy (see WARNINGS AND PRECAUTIONS and DETAILED PHARMACOLOGY).

Voriconazole is hemodialyzed with clearance of 121 mL/min. The intravenous vehicle, SBECD, is hemodialyzed with clearance of 55 mL/min. The mean amount of voriconazole removed during a 4 hour hemodialysis session (8%, range 1 - 16%) is not enough to warrant dose adjustment.

### **Use in Patients with Hepatic Impairment**

Hepatic impairment is likely to result in increased voriconazole plasma levels in patients with mild to moderate hepatic cirrhosis (Child-Pugh A and B).

It is recommended that the standard loading dose regimens be used but that the maintenance dose be halved in patients with mild to moderate hepatic cirrhosis (Child-Pugh A and B).

Safety and efficacy of reduced voriconazole dosing in this setting is not established.

Due to the small number of subjects studied, close clinical monitoring is advised.

Voriconazole has not been studied in patients with severe hepatic cirrhosis (Child-Pugh C). pms-VORICONAZOLE should be used only if the benefit outweighs the potential risk. Patients should be carefully monitored for drug toxicity (see WARNINGS AND PRECAUTIONS and DETAILED PHARMACOLOGY).

## **OVERDOSAGE**

There is no known antidote to voriconazole; it is recommended that treatment of overdose is symptomatic and supportive.

EKG monitoring is recommended due to the possible prolongation of the QT interval and ensuing risk of arrhythmia.

Voriconazole is hemodialyzed with clearance of 121 mL/min. The intravenous vehicle, SBECD, is hemodialyzed with clearance of 55 mL/min. In an overdose, hemodialysis may assist in the removal of voriconazole and SBECD from the body.

In clinical trials, there were three cases of accidental overdose with voriconazole. All occurred in pediatric patients who received up to five times the recommended intravenous dose of voriconazole. A single adverse event of photophobia of 10 minutes duration was reported.

For management of a suspected drug overdose, please contact your regional Poison Control Centre.

## ACTION AND CLINICAL PHARMACOLOGY

### Mechanism of Action

Voriconazole is a triazole antifungal agent, which exhibits broad-spectrum *in vitro* activity and fungicidal activity against *Aspergillus* spp. as well as a range of other filamentous fungi (see MICROBIOLOGY). The primary mode of action of voriconazole is the inhibition of fungal cytochrome P450-mediated 14 $\alpha$ -sterol demethylation, an essential step in ergosterol biosynthesis. The subsequent loss of normal sterols correlates with the accumulation of 14 $\alpha$ -methyl sterols in fungi and may be responsible for its fungistatic / fungicidal activity.

The voriconazole clinical program included a total of 38 patients with *Scedosporium* spp. and 21 patients with *Fusarium* spp. This limited clinical data suggest that voriconazole may be effective against infections caused by these rare pathogens in patients intolerant of or refractory to other therapies (see CLINICAL TRIALS).

### **Absorption**

Voriconazole is rapidly and almost completely absorbed following oral administration, with maximum plasma concentrations (C<sub>max</sub>) achieved 1-2 hours after dosing.

### **Distribution**

The volume of distribution at steady-state for voriconazole is estimated to be 4.6 L/kg, suggesting extensive distribution into tissues. Plasma protein binding is estimated to be 58%.

### **Metabolism**

*In vitro* studies showed that voriconazole is metabolised by the hepatic cytochrome P450 isoenzymes, CYP2C19, CYP2C9 and CYP3A4.

The interindividual variability of voriconazole pharmacokinetics is high. Greater than proportional increase in exposure is observed; for example, increasing the intravenous dose from 3 mg/kg Q12h to 4 mg/kg Q12h produces a 2.3 fold increase in exposure (Table 8).

**Table 8: Population Pharmacokinetic Parameters of Voriconazole in Volunteers**

	3 mg/kg IV Q12h	4 mg/kg IV Q12h
AUC <sub>t</sub> * (mcg•h/mL)	21.81	50.40
(CV%)	(100%)	(83%)

\* Mean AUC<sub>t</sub> are predicted values from population pharmacokinetic analysis of data from 236 volunteers

The major metabolite of voriconazole is the N-oxide, which accounts for 72% of the circulating radiolabelled metabolites in plasma.

### **Elimination**

Voriconazole is eliminated primarily by hepatic metabolism with less than 2% of the dose excreted unchanged in the urine. The terminal half-life ( $T_{1/2}$ ) depends on the dose and is approximately 6 hours at 3 mg/kg (intravenously). Because of non-linear pharmacokinetics, the terminal half-life is not useful in predicting the accumulation or elimination of voriconazole.

## **STORAGE AND STABILITY**

**Unreconstituted vials:** store at controlled room temperature, 15°C to 30°C.

**Reconstituted solution:** pms-VORICONAZOLE is a single dose unpreserved sterile lyophile. From a microbiological point of view, following reconstitution of the lyophile with Water for Injection, the reconstituted solution should be used immediately. If not used immediately, in-use storage times and conditions prior to use are the responsibility of the user and would normally not be longer than 24 hours between 2°C and 8°C, unless reconstitution has taken place in controlled and validated aseptic conditions. Single dose vials. Discard unused portion.

Further diluted solutions should be used immediately.

## **DOSAGE FORMS, COMPOSITION AND PACKAGING**

### **Dosage Form and Packaging**

pms-VORICONAZOLE is supplied in a single use vial as a sterile lyophilized powder equivalent to 200 mg voriconazole and 3200 mg SBECD.

### **Composition**

pms-VORICONAZOLE is a white lyophilized powder containing nominally 200 mg voriconazole in a 30 mL Type I clear glass vial.

pms-VORICONAZOLE is intended for administration by intravenous infusion. It is a single dose product with no preservative agent. Vials containing 200 mg lyophilized voriconazole are intended for reconstitution with Water for Injection to produce a solution containing 10 mg/mL voriconazole and 160 mg/mL of Sulphobutylether- $\beta$ -Cyclodextrin Sodium (SBECD) as a molecular inclusion complex. The resultant solution is further diluted prior to administration as an intravenous infusion (see DOSAGE AND ADMINISTRATION).

## PART II: SCIENTIFIC INFORMATION

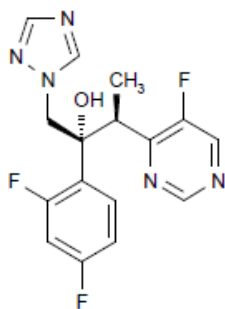
### PHARMACEUTICAL INFORMATION

#### Drug Substance

Common Name: Voriconazole

Chemical Name: (2R, 3S)-2-(2,4-difluorophenyl)-3-(5-fluoro-4-pyrimidinyl)-1-(1H-1,2,4-triazol-1-yl)-2-butanol

Structural Formula:



Molecular Formula:  $C_{16}H_{14}F_3N_5O$

Molecular Weight: 349.3 g/mol

#### Physicochemical Properties:

pKa: 1.6 (aqueous methanol at 25°C)

Description: voriconazole drug substance is a white to light-colored powder

Solubility: 3.2 mg/mL (0.1M HCl at 25°C)

Melting Point: 134°C



## CLINICAL TRIALS

### Invasive Aspergillosis

The efficacy of voriconazole compared to amphotericin B in the primary treatment of acute invasive aspergillosis was demonstrated in 277 patients treated for 12 weeks in Study 307/602. The majority of study patients had underlying hematologic malignancies, including bone marrow transplantation. The study also included patients with solid organ transplantation, solid tumors, and AIDS. The patients were mainly treated for definite or probable invasive aspergillosis of the lungs. Other aspergillosis infections included disseminated disease, CNS infections and sinus infections. Diagnosis of definite or probable invasive aspergillosis was made according to criteria modified from those established by National Institute of Allergy and Infectious Diseases Mycoses Study Group / European Organisation for Research and Treatment of Cancer (NIAID MSG/EORTC).

Voriconazole was administered intravenously with a loading dose of 6 mg/kg every 12 hours for the first 24 hours followed by a maintenance dose of 4 mg/kg every 12 hours for a minimum of seven days. Therapy could then be switched to the oral formulation at a dose of 200 mg BID. Median duration of intravenous voriconazole therapy was 10 days (range 2 - 85 days). After intravenous voriconazole therapy, the median duration of PO voriconazole therapy was 76 days (range 2 - 232 days).

Patients in the comparator group received conventional amphotericin B as a slow infusion at a daily dose of 1.0 - 1.5 mg/kg/day. Median duration of intravenous amphotericin therapy was 12 days (range 1 - 85 days). Treatment was then continued with other licensed antifungal therapy (OLAT), including itraconazole and lipid amphotericin B formulations. Although initial therapy with conventional amphotericin B was to be continued for at least two weeks, actual duration of therapy was at the discretion of the investigator. Patients who discontinued initial randomized therapy due to toxicity or lack of efficacy were eligible to continue in the study with OLAT. A satisfactory global response at 12 weeks (complete or partial resolution of all attributable symptoms, signs, radiographic/bronchoscopic abnormalities present at baseline) was seen in 53% of voriconazole treated patients compared to 32% of amphotericin B treated patients (Table 9). A benefit of voriconazole compared to amphotericin B on patient survival at Day 84 was seen with a 71% survival rate on voriconazole compared to 58% on amphotericin B (Table 9). Table 9 also summarizes the response (success) based on mycological confirmation and species.

**Table 9: Overall Efficacy and Success by Species in the Primary Treatment of Acute Invasive Aspergillosis Study 307/602**

	<b>Voriconazole</b> n/N (%)	<b>Ampho B<sup>c</sup></b> n/N (%)	<b>Stratified Difference</b> (95% CI) <sup>d</sup>
<b>Efficacy as Primary Therapy</b>			
Satisfactory Global Response <sup>a</sup>	76/144 (53)	42/133 (32)	21.8% (10.5%, 33.0%) p < 0.0001
Survival at Day 84 <sup>b</sup>	102/144 (71)	77/133 (58)	13.1 % (2.1%, 24.2%)
<b>Success by Species</b>			
	Success n/N (%)		

Overall success	76/144 (53)	42/133 (32)
Mycologically confirmed <sup>c</sup>	37/84 (44)	16/67 (24)
<i>Aspergillus</i> spp. <sup>f</sup>		
<i>A. fumigatus</i>	28/63 (44)	12/47 (26)
<i>A. flavus</i>	3/6	4/9
<i>A. terreus</i>	2/3	0/3
<i>A. niger</i>	1/4	0/9
<i>A. nidulans</i>	1/1	0/0

a Assessed by independent Data Review Committee (DRC)

b Proportion of subjects alive

c Amphotericin B followed by other licensed antifungal therapy

d Difference and corresponding 95% confidence interval are stratified by protocol

e Not all mycologically confirmed specimens were speciated

f Some patients had more than one species isolated at baseline

The results of this comparative trial (Study 307/602) confirmed the results of an earlier non-comparative trial in the primary and salvage treatment of patients with acute invasive aspergillosis (Study 304).

### Candidemia

Voriconazole was compared to the regimen of amphotericin B followed by fluconazole in Study 608, an open label, comparative study in non-neutropenic patients with Candidemia associated with clinical signs of infection. Patients were randomized in a 2:1 ratio to receive either voriconazole (n= 283) or the regimen of amphotericin B followed by fluconazole (n=139). Patients were treated with randomized study drug for a median of 15 days. Most of the Candidemia in patients evaluated for efficacy was caused by *C. albicans* (46%), followed by *C. tropicalis* (19%), *C. parapsilosis* (17%), *C. glabrata* (15%), and *C. krusei* (1%).

An independent Data Review Committee (DRC), blinded to study treatment, reviewed the clinical and mycological data from this study, and generated one assessment of response for each patient. A successful response required all of the following: resolution or improvement in all clinical signs and symptoms of infection, blood cultures negative for *Candida*, infected deep tissue sites negative for *Candida* or resolution of all local signs of infection, and no systemic antifungal therapy other than study drug. The primary analysis, which counted DRC-assessed successes at the fixed time point (12 weeks after End of therapy [EOT]), demonstrated that voriconazole was comparable to the regimen of amphotericin B followed by fluconazole (response rates of 40.72% and 40.70%, respectively) in the treatment of Candidemia. In a secondary analysis, which counted DRC-assessed successes at any time point (EOT, or 2, 6, or 12 weeks after EOT), the response rates were 65.48% for voriconazole and 71.33% for the regimen of amphotericin B followed by fluconazole.

In Studies 608 and 309/604 (non-comparative study in patients with invasive fungal infections who were refractory to, or intolerant of, other antifungal agents), voriconazole was evaluated in 35 patients with invasive candidiasis. A favorable response was seen in 4 of 7 patients with intraabdominal infections, 5 of 6 patients with kidney and bladder wall infections, 3 of 3 patients with deep tissue abscess or wound infection, 2 of 2 patients with pneumonia/pleural space infections, 2 of 4 patients with skin lesions, 1 of 1 patients with mixed intraabdominal and pulmonary infection, 1 of 2 patients with suppurative phlebitis, 1 of 3 patients with hepatosplenic

infection, 1 of 5 patients with osteomyelitis, 0 of 1 with liver infection, and 0 of 1 with cervical lymph node infection.

### **Other Serious Fungal Pathogens**

*Scedosporium* spp. and *Fusarium* spp.

Voriconazole clinical program included a total of 38 patients with *Scedosporium* spp. and 21 patients with *Fusarium* spp. This limited clinical data suggest that voriconazole may be effective against these rare pathogens in patients intolerant of or refractory to other therapies.

### **Pediatric Use**

Therapeutic trials included five patients aged 12 - 15 years. The remaining 56 patients received voriconazole in the compassionate use programs. Thus sixty-one (61) pediatric patients aged 9 months up to 15 years, who had definite or probable invasive fungal infections, were treated with voriconazole. The majority (57/61) had failed previous antifungal therapies. Underlying diseases in these patients included hematologic malignancies and aplastic anemia (27 patients) and chronic granulomatous disease (14 patients). The most commonly treated fungal infection was aspergillosis (43/61; 70%).

**Table 10: Clinical Outcome by Age in Pediatric Patients with Aspergillosis Infection**

Age	Success/Treated
< 2 yrs.	3/6
2 - < 12 years	11/23
12-15 years	3/14

## **DETAILED PHARMACOLOGY**

### **Pharmacokinetics**

#### **General Pharmacokinetic Characteristics**

The pharmacokinetics of voriconazole has been characterized in healthy subjects, special populations and patients. During oral administration of 200 mg or 300 mg BID for 14 days in patients at risk of aspergillosis (mainly patients with malignant neoplasms of lymphatic or hematopoietic tissue), the observed pharmacokinetic characteristics of rapid and consistent absorption, accumulation and non-linear pharmacokinetics were similar to those observed in healthy subjects.

The pharmacokinetics of voriconazole is non-linear due to saturation of its metabolism. Greater than proportional increase in exposure is observed with increasing dose. It is estimated that, on average, increasing the oral dose from 200 mg BID to 300 mg BID leads to an approximately 2.5-fold increase in exposure (AUC $\tau$ ), and increasing the intravenous dose from 3 mg/kg BID to 4 mg/kg BID produces a 2.3-fold increase in exposure.

The oral maintenance dose of 200 mg (or 100 mg for patients less than 40 kg) achieves a voriconazole exposure similar to 3 mg/kg intravenously. A 300 mg (or 150 mg for patients less

than 40 kg) oral maintenance dose achieves an exposure similar to 4 mg/kg intravenously (see table 11 below)

**Table 11: Voriconazole Pharmacokinetic Parameters in Adults Receiving Different Dosing Regimens**

Geometric mean (CV%) <sup>a</sup>	6 mg/kg IV (loading dose)	3 mg/kg IV Q12h	4 mg/kg IV Q12h	400 mg Oral (loading dose)	200 mg Oral Q12h	300 mg Oral Q12h
n	35	23	40	17	48	16
AUC <sub>12</sub> (mcg-h/mL)	13.9 (32)	13.7 (53)	33.9 (54)	9.31 (38)	12.4 (78)	34.0 (53)
C <sub>max</sub> (mcg/mL)	3.13 (20)	3.03 (25)	4.77 (36)	2.30 (19)	2.31 (48)	4.74 (35)
C <sub>min</sub> (mcg/mL)	--	0.46 (97)	1.73 (74)	--	0.46 (120)	1.63 (79)

<sup>a</sup> Parameters were estimated based on non-compartmental analysis from 5 pharmacokinetic studies. AUC<sub>12</sub> = area under the curve over a 12 hour dosing interval, C<sub>max</sub> = maximum plasma concentration, C<sub>min</sub> = minimum plasma concentration.

When the recommended intravenous or oral loading dose regimens are administered, plasma concentrations close to steady state are achieved within the first 24 hours of dosing (e.g, 6 mg/kg intravenously every 12 hours on day 1 followed by 3 mg/kg intravenously every 12 hours; 400 mg oral every 12 hours on day 1 followed by 200 mg oral every 12 hours). Without the loading dose, accumulation occurs during twice-daily multiple dosing with steady-state plasma voriconazole concentrations being achieved by day 6 in the majority of subjects.

### Absorption

Voriconazole is rapidly and almost completely absorbed following oral administration, with maximum plasma concentrations (C<sub>max</sub>) achieved 1-2 hours after dosing. The oral bioavailability of voriconazole is estimated to be 96%.

### Distribution

The volume of distribution at steady-state for voriconazole is estimated to be 4.6 L/kg, suggesting extensive distribution into tissues. Plasma protein binding is estimated to be 58%.

Voriconazole concentrations have been determined in cerebrospinal fluid (CSF) of a few patients. The range of CSF concentrations was similar to the range of plasma voriconazole concentrations observed in the overall patient population.

### Metabolism

*In vitro* studies showed that voriconazole is metabolised by the hepatic cytochrome P450 isoenzymes, CYP2C19, CYP2C9 and CYP3A4.

The interindividual variability of voriconazole pharmacokinetics is high.

*In vivo* studies indicated that CYP2C19 is significantly involved in the metabolism of voriconazole. This enzyme exhibits genetic polymorphism. For example, 15 - 20% of Asian populations may be expected to be poor metabolisers. For Caucasians and Blacks, the prevalence of poor metabolisers is 3 - 5%). Studies conducted in Caucasian and Japanese healthy subjects have shown that poor metabolisers have, on average, 4-fold higher voriconazole exposure (AUC<sub>τ</sub>) than their homozygous extensive metaboliser counterparts. Subjects who are

heterozygous extensive metabolisers have, on average, 2-fold higher voriconazole exposure than their homozygous extensive metaboliser counterparts.

The major metabolite of voriconazole is the N-oxide, which accounts for 72% of the circulating radiolabelled metabolites in plasma. Since this metabolite has minimal antifungal activity, it does not contribute to the overall efficacy of voriconazole.

### **Excretion**

Voriconazole is eliminated primarily by hepatic metabolism with less than 2% of the dose excreted unchanged in the urine. After administration of a radiolabelled dose of voriconazole, approximately 80% of the radioactivity is recovered in the urine after multiple intravenous dosing and 83% in the urine after multiple oral dosing. The majority (> 94%) of the total radioactivity is excreted in the first 96 hours after both oral and intravenous dosing.

The terminal half-life ( $T_{1/2}$ ) depends on the dose and is approximately 6 hours at 3 mg/kg (intravenously) or 200 mg (oral). Because of non-linear pharmacokinetics, the terminal half-life is not useful in predicting the accumulation or elimination of voriconazole.

### **Pharmacokinetic-pharmacodynamic (PK/PD) relationships**

Analysis of the median pharmacokinetic data from 10 therapeutic trials shows that the average and maximum plasma concentrations in individual subjects across the studies was 2425 ng/mL (interquartile range 1193 to 4380 ng/mL) and 3742 ng/mL (inter-quartile range 2027 to 6302 ng/mL), respectively. A positive association between mean, maximum or minimum plasma voriconazole concentration and efficacy in therapeutic studies was not found.

PK/PD analyses of clinical trial data identified positive associations between plasma voriconazole concentrations and both liver function test abnormalities and visual disturbances (see ADVERSE REACTIONS).

### **QT Prolongation**

The effect of 3 oral, single doses of voriconazole (800, 1200 and 1600 mg) and an active comparator (oral ketoconazole 800 mg) was investigated in healthy subjects (male and female, 18 - 65 yrs.) in a randomized, single-blind, placebo-controlled 5-way crossover study. At 1600 mg, voriconazole resulted in prolongation of the electrocardiogram QTcF (F=Fridericia's correction) by a mean maximum increase of 8.23 milliseconds (90% CI 6.01 to 10.45 milliseconds). The clinical significance of this change is unknown. No subject experienced a QTcF interval exceeding the potentially clinically relevant threshold of 500 msec. Six out of 75 subjects (8%), 6 out of 77 (7.8%) and 14 out of 74 (19%) had a prolongation of 30 to 60 milliseconds after dosing with 800, 1200 and 1600 mg voriconazole, respectively. In comparison, 12 subjects out of 75 (16%) following ketoconazole 800 mg and 1 subject out of 76 (1%) following placebo had increases of 30 to 60 msec. No subject had a QTcF prolongation of greater than 60 milliseconds. No clear relationship between plasma voriconazole concentration and QTcF was observed in this study. The effect on cardiac QTcF with multiple dosing is unknown.

## Pharmacokinetics in Special Populations

### Gender

In the clinical program, no dosage adjustment was made on the basis of gender. The safety profile and plasma concentrations observed in male and female subjects appeared similar (see results below).

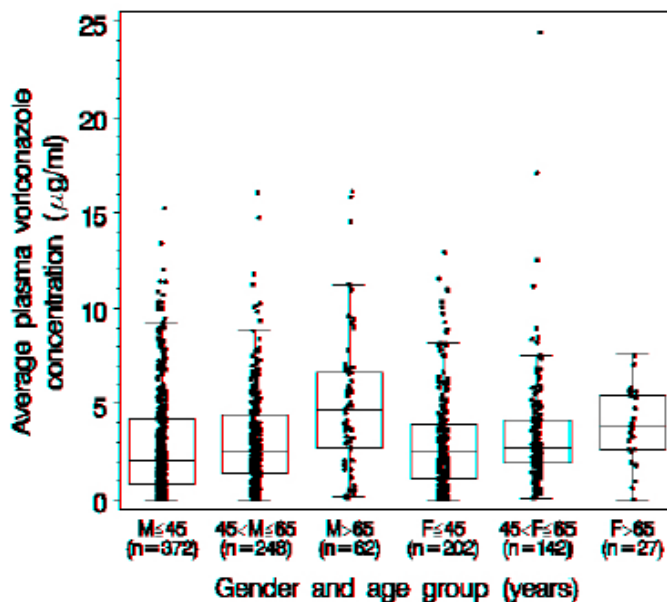
### Geriatric

In therapeutic studies, no dosage adjustment was made on the basis of age. A relationship between plasma concentrations and age was observed (see results below). However, the safety profile of voriconazole in young and elderly subjects appeared similar. Therefore, dosage adjustment does not appear to be required (see WARNINGS AND PRECAUTIONS and DOSAGE AND ADMINISTRATION).

**Table12: Phase 1 Pharmacokinetic Results in Groups of Young and Elderly, Male and Female Subjects are Indicated in the Table Below**

Voriconazole	Parameter *	Young males	Elderly males	Young females	Elderly females
Single IV dose	AUC <sub>t</sub> (ng•h/mL)	16518	34152	21723	21871
	C <sub>max</sub> (ng/mL)	5139	6196	4514	5455
SBECD Single IV dose	AUC (ng•h/mL)	942	1364	829	1324
	C <sub>max</sub> (ng/mL)	496	567	452	573

\* Means are geometric for AUC, AUC<sub>t</sub>, AUC<sub>τ</sub> and C<sub>max</sub>, arithmetic for T<sub>max</sub>.



**Figure 1: Plasma Voriconazole Concentrations in Individual Patients by Gender and Age Group\* - Phase 2/3 Therapeutic Studies**

The Phase 1 study indicates that there appears to be a significant effect of age and gender on the exposure of voriconazole with increased levels in elderly versus young and female versus males; however, the Phase 2/3 database indicates the differences in voriconazole pharmacokinetics

observed in the Phase 1 study are to a large extent negated for gender and there is a reduced effect of age.

### **Pediatric**

Preliminary pharmacokinetic data were obtained from eight immunocompromised children (aged 2 to 11 years) in a single intravenous dose study and 18 patients (fourteen aged 2 to 11 years and four aged 12 to 15 years) in the compassionate use program. Plasma concentrations in these children were similar to those in adults following administration of similar intravenous doses of voriconazole on a weight-corrected basis (3 or 4 mg/kg).

### **Renal Impairment**

Intravenous voriconazole should be avoided in patients with moderate or severe renal impairment (creatinine clearance < 50 mL/min), unless an assessment of the benefit risk to the patient justifies the use of intravenous voriconazole (see DOSAGE AND ADMINISTRATION).

In patients with moderate renal dysfunction (creatinine clearance 30 - 50 mL/min), accumulation of the intravenous vehicle, SBECD, occurs. The mean systemic exposure (AUC) and peak plasma concentrations of SBECD ( $C_{max}$ ) were increased by 4-fold and almost 50%, respectively, in the moderately impaired group compared to the normal control group.

A pharmacokinetic study in 6 subjects with renal failure undergoing hemodialysis showed that voriconazole is dialyzed with clearance of 121 mL/min. The intravenous vehicle, SBECD, is hemodialyzed with clearance of 55 mL/min. The mean amount of voriconazole removed during a 4 hour hemodialysis session (8%, range 1 - 16%) is not enough to warrant dose adjustment.

Due to the small number of subjects studied, close clinical monitoring is advised.

In a multiple dose study of intravenous voriconazole (6 mg/kg intravenous loading dose x 2, then 3 mg/kg intravenously x 5.5 days) in 7 patients with moderate renal dysfunction (creatinine clearance 30 - 50 mL/min), the systemic exposure (AUC) and peak plasma concentrations ( $C_{max}$ ) were not significantly different from those in 6 volunteers with normal renal function.

### **Hepatic Impairment**

Voriconazole should not be used in severe hepatic insufficiency. Hepatic impairment is likely to result in increased voriconazole plasma levels in patients with mild to moderate hepatic cirrhosis (Child-Pugh A and B). It is recommended that the standard loading dose regimens be used but that the maintenance dose be halved in patients with mild to moderate hepatic cirrhosis (Child-Pugh A and B) receiving voriconazole (see WARNINGS AND PRECAUTIONS and DOSAGE AND ADMINISTRATION).

Due to the small number of subjects studied, close clinical monitoring is advised.

## **Animal Pharmacology**

The pharmacological properties of voriconazole were investigated in a variety of tests designed to evaluate its effects, if any, on major organ systems, in particular the central nervous, peripheral nervous, cardiovascular, gastrointestinal, renal and respiratory systems.

In a rat symptomatology study, voriconazole was lethal following an oral dose of 300 mg/kg. A lower dose (100 mg/kg) caused a small increase in body temperature, a decrease in food intake and body weight gain, whereas 30 mg/kg was devoid of untoward effects. Thus, voriconazole is well tolerated by the rat after single oral doses up to 100 mg/kg and these data are consistent with observations in the acute toxicity studies.

Voriconazole did not affect motor co-ordination up to 30 mg/kg p.o. in the mouse. In the anaesthetised cat, voriconazole at doses up to 3 mg/kg intravenously did not display any sympathomimetic or ganglion stimulating or blocking activity. Furthermore, in the cat, voriconazole did not block  $\alpha$ - or  $\beta$ -adrenoceptors or cholinergic, histaminergic or serotonergic receptors. Voriconazole also did not affect gastrointestinal function up to 10 mg/kg p.o. or respiratory function up to 3 mg/kg intravenously in the rat.

In the saline-loaded female rat, voriconazole up to 10 mg/kg p.o. had no effect on renal function, however, a small reduction in the excretion of electrolytes and increase in urinary volume was observed following 30 mg/kg intravenously, but this was not associated with any other changes in renal function. Voriconazole concentrations up to 10 mcM did not display antihistaminic activity or affinity for a range of physiological receptors and binding sites, affect oxytocin-induced uterine contractions or inhibit the key enzymes acetylcholinesterase and Na/K-activated ATPase *in vitro*.

However, at voriconazole concentrations greater than 10 mcM, slight inhibition of spontaneous contractions of the rabbit isolated ileum and acetylcholine, histamine, 5HT and barium chloride-induced contractions of the guinea pig isolated ileum were observed. In mice, a potentiation of barbiturates-induced, but not alcohol-induced, sleeping times was observed with voriconazole at 3 and 10 mg/kg p.o. and 3 and 30 mg/kg intravenously. This is consistent with the drug's known ability to interact with cytochrome P450, a key enzyme in the metabolism of barbiturates. Also, voriconazole does not display a sedative activity as evidenced by the lack of effect on interaction with alcohol.

Administration of voriconazole (12 mg/kg for 14 days) achieved supratherapeutic free plasma concentrations (14.6 to 28.4 mcg/mL) in dogs chronically instrumented to record cardiovascular parameters. Voriconazole had no effect on cardiac contractility.

### **Cardiovascular Activity of Voriconazole**

The preclinical development of voriconazole involved three general pharmacology studies in anaesthetised dogs over a range of intravenous doses. Arrhythmias occurred in a single anaesthetised dog at very high free plasma voriconazole concentrations (42 mcg/mL; approximately 7 times the highest clinical concentration of around 5 mcg/mL) in one of the



escalating-dose studies. There were no predisposing factors identified in this animal. Arrhythmias were not seen in the other two studies.

From all available preclinical studies, it can be concluded that intravenous doses of voriconazole that are tolerated in a conscious dog at the maximum tolerated dose of 6 mg/kg had no effects on the ECG, either in anaesthetised or conscious dogs. Higher intravenous doses, yielding free exposure levels of up to 4.7 mcg/mL (13.3 mcM) in anaesthetised dogs, caused minor inconsistent changes in QTc interval of the ECG which were not detected in the toxicology program. Plasma concentrations increased with dose, as expected. Furthermore, voriconazole had no effect in *in vitro* assays, which may be predictive of effects on cardiac repolarisation.

### **Effects on Electroretinogram in the Anaesthetised Dog**

In order to understand the mechanism of visual disturbances seen in patients, we investigated the effect of intravenously administered voriconazole on the electroretinogram (ERG) of anaesthetized dogs. Voriconazole had an effect on the a-wave amplitude at a free steady state plasma concentration of 2.2 mcg/mL (the lowest dose examined), and an effect on the b-wave amplitude at 4.6 mcg/mL. These results confirm that the site of action of voriconazole is the retina.

Ophthalmological examinations have revealed no unusual findings in rats, mice or dogs treated in toxicology studies up to 24, 24 or 12 months respectively. The histopathological examination in these studies involved all the major structures and no histopathological evidence of toxicity to the visual pathways was observed. The peak plasma concentrations of free voriconazole in dogs used in toxicology studies (5 - 7 mcg/mL) exceed the exposure range expected in man (0.6 - 2.4 mcg/mL).

Thus, the effects on the ERG seen in humans have also been shown in dogs at similar plasma exposures of voriconazole. Despite exposure to plasma concentrations causing an effect on the ERG of the dog, the clinical, ophthalmoscopic, morphologic and morphometric data indicate that chronic treatment of rats and dogs with voriconazole was without detectable functional or anatomical changes to the retina.

Oral absorption of voriconazole is high (> 75%) in all species. The drug has a non-linear elimination profile in all species (including human), and consequently plasma clearance and volume of distribution data are of limited utility. However, apparent volume of distribution values greater than total body water indicate that voriconazole has some tissue affinity, in keeping with its moderately lipophilic nature. In addition, significant concentrations of voriconazole are obtained in CSF and CNS of guinea pigs. Clearance of voriconazole is predominantly by hepatic metabolism resulting in several oxidised and further conjugated metabolites. The major circulating metabolite in human, rat and dog is the N-oxide, UK-121,265, which has negligible therapeutic activity. The majority of dosed voriconazole was excreted over 48h, with both urine and faeces being important routes of elimination. Multiple administration of voriconazole leads to auto-induction of metabolism in most animal species, but this effect is not observed in human. A sex difference in clearance was observed in rodents only. Voriconazole metabolism in humans is mediated by CYP2C9, CYP2C19 and CYP3A4 and it has been shown to competitively inhibit the same isoenzymes. Therefore, voriconazole has the potential for

clinical interactions with co-administered drugs that are substrates for CYP2C9, CYP2C19 and CYP3A4. Since CYP2C19 exhibits genetic polymorphism, it is likely that poor metabolisers will be exposed to higher concentrations of voriconazole. Toxicokinetic data for voriconazole indicate that clinical exposure at the therapeutic maintenance doses is similar to or slightly lower than that seen in both rat and dog at doses without adverse effect in the 6-month toxicology studies.

## MICROBIOLOGY

### Activity *in vitro* and *in vivo*

Voriconazole demonstrated *in vitro* activity against *Aspergillus* species (*A. fumigatus*, *A. flavus*, *A. niger* and *A. terreus*) and *Candida* species (*C. albicans*, *C. glabrata*, *C. krusei*, *C. parapsilosis* and *C. tropicalis*). Variable *in vitro* activity has also been demonstrated against a variety of fungal pathogens. The *in vitro* susceptible organisms and Minimum Inhibitory Concentration (MIC<sub>90</sub>) values are summarized in Table 13.

Standardized techniques for susceptibility testing of antifungal agents have only been established for yeasts. Standardized testing for the filamentous fungi is ongoing. Results of such studies do not necessarily correlate with clinical outcome.

**Table 13: *In vitro* Voriconazole-Susceptible Organisms**

Pathogen	MIC <sub>90</sub> <sup>a</sup> range <sup>b</sup> (mcg/mL)	Pathogen	MIC <sub>90</sub> <sup>a</sup> range <sup>b</sup> (mcg/mL)
<i>Acremonium spp</i>	0.25	<i>Cladophialophora spp</i>	≤ 0.03-1.0
<i>Alternaria</i>	1.25	<i>Cladosporium spp</i>	0.06-1.0
<i>Aspergillus spp</i>		<i>Coccidioides immitis</i>	0.25
<i>A. flavus</i>	0.5-2.0	<i>Conidiobolus coronatus</i>	2.0 > 32.0
<i>A. fumigatus</i>	0.25-1.0	<i>Cryptococcus neoformans</i>	0.06-0.25
<i>A. terreus</i>	0.25-1.0	<i>Curvularia spp</i>	0.06-1.0
<i>A. niger</i>	0.5-1.0	<i>Exserohilum rostratum</i>	0.17
<i>A. nidulans</i>	0.5	<i>Exophiala spp</i>	0.06-2.0
<i>Bipolaris spp</i>		<i>Fonsecaea spp</i>	≤ 0.03-1.0
<i>B. australiensis</i>	0.2	<i>Fusarium spp</i>	
<i>B. hawaiiensis</i>	0.15-0.5	<i>F. oxysporum</i>	0.25-8.0
<i>B. spicifera</i>	0.29-2.0	<i>F. proliferatum</i>	1.0-2.0
<i>Blastomyces dermatitidis</i>	0.25	<i>F. solani</i>	2.0 > 8.0
<i>Blastoschizomyces capitatus</i>	0.12	<i>Hansenula anomala</i>	0.25
<i>Candida spp</i>		<i>Histoplasma capsulatum</i>	≤ 0.03-2.0
<i>C. albicans</i>	0.06-1.56	<i>Madurella mycetomatis</i>	0.05
<i>C. dubliniensis</i>	0.03-0.5	<i>Paecilomyces lilacinus</i>	0.12-0.5
<i>C. ciferrii</i>	0.25	<i>Paracoccidioides brasiliensis</i>	< 0.03-2.0
<i>C. famata</i>	≤ 0.03	<i>Penicillium marneffeii</i>	< 0.03
<i>C. glabrata</i>	0.25-8.0	<i>Phialophora spp</i>	0.125-2.0
<i>C. guilliermondii</i>	0.03-8.0	<i>Saccharomyces cerevisiae</i>	0.06-0.25
<i>C. kefyr</i>	< 0.03	<i>Scopulariopsis brevicaulis</i>	4.0
<i>C. krusei</i>	0.5-2.0	<i>Trichosporon spp</i>	0.25

<i>C. lambica</i>	< 0.03	<i>T. beigelii</i>	< 0.03
<i>C. lipolytica</i>	0.06	<i>Scedosporium spp</i>	
<i>C. lusitaniae</i>	0.06-0.5	<i>S. apiospermum</i>	0.5
<i>C. parapsilosis</i>	0.12-0.25	<i>S. prolificans</i>	0.5 - > 8
<i>C. rugosa</i>	0.06	<i>Wangiella dermatitidis</i>	0.12-0.25
<i>C. stellatoidea</i>	0.125		
<i>C. tropicalis</i>	0.26 - > 16.0		

<sup>a</sup> Minimal inhibitory concentration at which 90% of the strains tested are inhibited from growth

<sup>b</sup> Range is reported when > 1 study is conducted to detect the MIC<sub>90</sub>. MIC<sub>90</sub> used alone means that only one study was conducted or if > 1 study, the MIC<sub>90</sub> values are the same.

Voriconazole is active *in vivo* in guinea pig models of fungal infection including various systemic infections with *Aspergillus* species (including itraconazole-resistant *Aspergillus*) in either immune normal or immune compromised animals. In addition, voriconazole exhibits fungicidal activity against *Aspergillus* as evidenced by 100% cures at a dose of 10 mg/kg/p.o. BID for 4 days.

## **Clinical and Laboratory Standards Institute (CLSI) Breakpoints**

### **Breakpoint Criteria Established by CLSI**

#### **Susceptibility Testing Methods**

*Aspergillus* species and other filamentous fungi: No interpretive criteria have been established for *Aspergillus* species and other filamentous fungi.

*Candida* species: The interpretive standards for voriconazole against *Candida* species are applicable only to tests performed using Clinical and Laboratory Standards Institute (CLSI) microbroth dilution reference method M27 for MIC read at 48 hours or disk diffusion reference method M44 for zone diameter read at 24 hours.

Broth Dilution Techniques: Quantitative methods are used to determine antifungal MICs. These MICs provide estimates of the susceptibility of *Candida* species to antifungal agents. MICs should be determined using a standardized procedure at 48 hours. Standardized procedures are based on a dilution method (broth) with standardized inoculum concentrations and standardized concentrations of voriconazole powder. The MIC values should be interpreted according to the criteria provided in the table below.

Diffusion Techniques: Qualitative methods that require measurement of zone diameters also provide reproducible estimates of the susceptibility of *Candida* species to an antifungal agent. One such standardized procedure requires the use of standardized inoculum concentrations. This procedure uses paper discs impregnated with 1 microgram of voriconazole to test the susceptibility of yeasts to voriconazole. Disc diffusion interpretive criteria are also provided in the table below.

**Table 14: Susceptibility Interpretive Criteria for Voriconazole**

	Broth Dilution at 48 hours (MIC in mcg/mL)			Disk Diffusion at 24 hours (Zone diameters in mm)		
	Susceptible (S)	Susceptible-dose dependent (S-DD)	Resistant (R)	Susceptible (S)	Susceptible-dose dependent (S-DD)	Resistant (R)
Voriconazole	≤ 1.0	2.0	≥ 4.0	≥ 17	14-16	≤ 13

Note 1: Shown are the breakpoints (mcg/ml) for voriconazole against *Candida* species. If MICs are measured using a scale that yields results falling between categories, the next higher category is implied. Thus, an isolate with a voriconazole MIC of 1.5 mcg/mL would be placed in the S-DD category.

The susceptible category implies that isolates are inhibited by the usually achievable concentrations of antifungal agent tested when the recommended dosage is used for the site of infection. The susceptible-dose dependent category implies that an infection due to the isolate may be appropriately treated in body sites where the drugs are physiologically concentrated or when a high dosage of drug is used. The resistant category implies that isolates are not inhibited by the usually achievable concentrations of the agent with normal dosage schedules and clinical efficacy of the agent against the isolate has not been reliably shown in treatment studies.

**Quality Control**

Standardized susceptibility test procedures require the use of quality control organisms to control the technical aspects of the test procedures. Standard voriconazole powder and 1 mcg discs should provide the following range of values noted in the table below.

NOTE: Quality control microorganisms are specific strains of organisms with intrinsic biological properties relating to resistance mechanisms and their genetic expression within fungi; the specific strains used for microbiological control are not clinically significant.

**Table 15: Acceptable Quality Control Ranges for Voriconazole to Be Used in Validation of Susceptibility Test Results**

QC Strain	Broth Dilution (MIC in mcg/mL)		Disk Diffusion (Zone diameter in mm) at 24 hours
	@24-hour	@48-hour	
<i>Candida parapsilosis</i> ATCC 22019	0.016-0.12	0.03-0.25	28-37
<i>Candida krusei</i> ATCC 6258	0.06-0.5	0.12-1.0	16-25
<i>Candida albicans</i> ATCC 90028	*	*	31-42

\* Quality control ranges have not been established for this strain/antifungal agent combination due to their extensive interlaboratory variation during initial quality control studies.

ATCC is a registered trademark of the American Type Culture Collection.

## TOXICOLOGY

### Voriconazole

#### **Acute Toxicity**

The minimum lethal oral dose in mice and rats was 300 mg/kg or greater. The minimum lethal intravenous dose was greater than 100 mg/kg for both mice and rats. Clinical signs observed included mydriasis, titubation (loss of balance while moving), depressed behavior, prostration, partially closed eyes, and dyspnea.

#### **Long-Term Toxicity**

Long-term toxicity studies have been performed at exposures below and up to approximately the human exposure at the recommended clinical doses.

Repeat-dose oral studies in rats have shown the liver to be the target organ, with a range of adaptive and functional changes, slight increases in plasma enzyme, and at 80 mg/kg ( $AUC_{24h}=127.7 \text{ mcg}\cdot\text{h}\cdot\text{mL}$ ) (7 times the human exposure based on AUC comparisons), evidence of toxicity (small foci of coagulative necrosis). There was no evidence of hepatotoxicity at 50 mg/kg ( $AUC_{24h}=23.3 \text{ mcg}\cdot\text{h}\cdot\text{mL}$ ) in the 6-month study. Thyroid follicular cell hypertrophy in rats was shown to be secondary to the liver adaptive responses. Intravenous studies in rats up to doses of 20 mg/kg ( $AUC_{24h}=24.5 \text{ mcg}\cdot\text{h}\cdot\text{mL}$ ) did not demonstrate target organ toxicity. Hepatotoxicity occurred at plasma exposures similar to those obtained at therapeutic doses in humans.

Repeat-dose studies in dogs produced a similar spectrum of adaptive, functional and plasma enzymes changes in the liver as seen in rodents. Voriconazole administered for up to 1 month had no effect on transaminase activities, except at the toxic dose of 24 mg/kg ( $AUC_{24h}=171.1 \text{ mcg}\cdot\text{h}\cdot\text{mL}$ ) (28 times the human exposure based on AUC comparisons), where increases in AST and ALT accompanied systemic toxicity. Longer exposure to voriconazole in the 6- and 12-month studies at the high dose of 12 mg/kg ( $AUC_{24h}=56.8$  and  $64.1 \text{ mcg}\cdot\text{h}\cdot\text{mL}$ , respectively) (3 times the human exposure based on AUC comparisons) produced evidence of hepatotoxicity (single cell necrosis, increases in plasma ALT and alkaline phosphatase) but this was not seen at 8 mg/kg ( $AUC_{24h}=34.6$  and  $35.2 \text{ mcg}\cdot\text{h}\cdot\text{mL}$ , respectively). Intravenous administration of voriconazole to dogs resulted in transient severe clinical signs at 10 mg/kg ( $AUC_{24h}=50.6 \text{ mcg}\cdot\text{h}\cdot\text{mL}$ ), but not at 6 mg/kg ( $AUC_{24h}=31.3 \text{ mcg}\cdot\text{h}\cdot\text{mL}$ ).

#### **Reproductive Toxicology**

Reproduction toxicology studies indicate that voriconazole produces adverse effects on parturition and is teratogenic in the rat.

Voriconazole prolonged the duration of gestation and labor, and produced dystocia in pregnant rats at 10 mg/kg ( $AUC_{24h}=15.4 \text{ mcg}\cdot\text{h}\cdot\text{mL}$ ) (0.3 times the human exposure based on body surface area comparisons). These parturition disorders led to maternal mortality and a decrease in perinatal survival of pups. Similar effects (though without maternal mortality) were seen at 3 mg/kg ( $AUC_{24h}=7.8 \text{ mcg}\cdot\text{h}\cdot\text{mL}$ ) (0.1 times the human exposure based on body surface area comparisons). There was no perinatal mortality at 1 mg/kg.

A probable mechanism for the effects on parturition in rats is the fall in maternal plasma estradiol induced by voriconazole.

In rats, voriconazole was teratogenic (cleft palate, hydronephrosis/hydroureter) from 10 mg/kg (0.3 times the human exposure based on body surface area comparisons) and above. Other effects included reduced ossification of sacral and caudal vertebrae, skull pubic end hyoid bone, anomalies of the sternbrae and dilatation of the ureter/renal pelvis. Voriconazole treatment in rats produced increased gestational length and dystocia. These parturition disorders led to maternal mortality and a decrease in perinatal survival of pups. In rabbits, voriconazole increased embryoletality, reduced fetal weight and increased incidences of skeletal variations cervical ribs and extra sternbral ossification sites.

Possible mechanisms for the teratogenic responses to voriconazole are a reduction in maternal plasma estradiol and a direct effect on neural crest cells of the developing embryos.

Voriconazole administration induced no impairment of male or female fertility in rats at exposures similar to those obtained in humans at therapeutic doses.

### **Mutagenicity**

Voriconazole was subjected to a complete battery of mutagenicity tests.

Voriconazole did not display mutagenic activity in bacterial or mammalian cells *in vitro*, or clastogenic activity *in vivo*, although it demonstrated clastogenic activity in human lymphocyte cultures *in vitro*.

### **Carcinogenicity**

Two-year carcinogenicity studies have been performed in mice and rats at doses of 10, 30 or 100 mg/kg/day, and 6, 18 or 50 mg/kg/day, respectively. A statistically significant increase in the incidence of hepatocellular adenomas was observed in high-dose female rats; the incidence of hepatocellular carcinomas in male rats (6 and 50 mg/kg, 0.2 and 1.6 times human exposure based on body surface area comparisons) was slightly higher than both controls although the difference was not statistically significant. In mice, a spectrum of hepatic neoplastic (adenomas and carcinomas) and non-neoplastic changes (foci of cellular alteration) were observed. The incidence of hepatocellular adenomas was statistically significantly different compared to controls in male and female mice at the dose of 100 mg/kg (1.4x human exposure based on body surface area comparisons); the incidence of hepatocellular carcinomas was significantly increased in high-dose male mice (1.4x human exposure).

### **Sulfobutyl Ether beta-Cyclodextrin Sodium Salt (SBECD)**

#### **Acute Toxicity**

The administration of a single intravenous dose of SBECD indicated a minimal lethal dose greater than 2000 mg/kg.

### **Long-Term Toxicity**

In repeat dose studies in rats and dogs, the most noteworthy findings are renal tubular vacuolation, and foamy macrophages in the liver and lungs. Borderline toxicity in the kidney and liver (a consequence of massive vacuolation) occurred in rats at the maximum technically achievable dose of 3000 mg/kg. Doses up to 1500 mg/kg produced no histopathological evidence of toxicity in dogs. Even at these high doses, the effects were not associated with any clinical pathology findings. Five months after cessation of the treatment, there was marked regression, although not all findings were completely reversed. Renal vacuolation was not seen at 80 mg/kg in rats or at 30 mg/kg in dogs following treatment for 1 month.

Foamy macrophages were apparent after treatment for 1 month, in the lungs of the rat from 240 mg/kg (but not at 160 mg/kg) and completely regressed 1 month after cessation of the treatment. A wider range of tissues was not affected until doses of 1000 and 3000 mg/kg were administered. Two months after stopping treatment at higher doses, these findings were reversible, although they had not completely reversed in some tissues. In the dog, the appearance of foamy macrophages in the liver and lymph nodes occurred from 750 mg/kg, while at 300 mg/kg the effect was equivocal, being observed in one study but not in another. These findings were reversible but not completely resolved 5 months after the treatment was stopped.

A continuous infusion in rats at SBECD doses up to 10000 mg/kg/day was not well tolerated, due to problems associated with the infusion technique. However, widespread vacuolation was observed, as expected, and there was no toxicity associated with compound administration. There was no evidence of marked plasma accumulation.

### **Reproductive Toxicology / Mutagenicity**

SBECD has no adverse effects on fertility and has no teratogenic potential. SBECD did not induce mutations in bacterial or mammalian cells *in vitro*, nor did it cause clastogenic activity *in vivo* or *in vitro*.

### **Carcinogenicity**

Carcinogenicity studies have not been performed with SBECD.

### **Skin Sensitization**

SBECD showed evidence of skin sensitization (delayed contact hypersensitivity) in 18/20 guinea pigs. The incidence of positive responses was concentration dependent.

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**PART III: CONSUMER INFORMATION**

**Pr pms-VORICONAZOLE**

Voriconazole

Lyophilized powder for Injection 200 mg/vial  
(10 mg/mL when reconstituted)

This leaflet is part III of a three-part "Product Monograph" published when pms-VORICONAZOLE was approved for sale in Canada and is designed specifically for Consumers. This leaflet is a summary and will not tell you everything about pms-VORICONAZOLE. Contact your doctor or pharmacist if you have any questions about the drug. Read this entire leaflet carefully before you start taking this medicine.

- Keep this leaflet. You may need to read it again.
- If you have further questions, please ask your doctor or your pharmacist.
- This medicine has been prescribed for you personally and you should not pass it on to others. It may harm them, even if their symptoms are the same as yours.

**ABOUT THIS MEDICATION**

**What pms-VORICONAZOLE is used for:**

pms-VORICONAZOLE is prescribed by your doctor to treat certain fungal infections, specifically Aspergillus or Candida infections.

**What pms-VORICONAZOLE does:**

pms-VORICONAZOLE works by killing or interfering with the growth of fungi which helps stop the infection.

**When it should not be used:**

- If you are allergic to voriconazole or any of the other ingredients of pms-VORICONAZOLE (see below under "What are the nonmedicinal ingredients").
- If you are taking other medication that must not be taken with pms-VORICONAZOLE (see listing under "Interactions with this medication")

**What is the medicinal ingredient of pms-VORICONAZOLE and what dosage forms does it come in:**

- pms-VORICONAZOLE, 200 mg per vial

**What are the non-medicinal ingredients:**

Sulphobutylether-β-Cyclodextrin Sodium (SBECD)

pms-VORICONAZOLE has been prescribed for you. Do not allow anyone else to take it. This product should only be taken under the supervision of a doctor.

**WARNINGS AND PRECAUTIONS**

**Serious Warnings and Precautions**

- Some medications should not be taken during pms-VORICONAZOLE treatment (see listing under

**"Interactions with this medication")**

- pms-VORICONAZOLE may cause irregular heartbeat and rarely cardiac arrest and death
- pms-VORICONAZOLE may cause disturbances in vision
- pms-VORICONAZOLE may cause liver problems
- pms-VORICONAZOLE may cause severe skin reactions
- pms-VORICONAZOLE may cause harm to the fetus in pregnant woman

For more information, see warnings below and "Side Effects and what do to about them".

**Take special care with pms-VORICONAZOLE:**

**Before being treated with pms-VORICONAZOLE tell your doctor if:**

- you have any of the following conditions: history of heart disease, or an irregular heartbeat.
- you have had any drug allergies including allergic reactions to other azoles.
- you are suffering from, or have ever suffered from liver disease.
- you are suffering from, or have ever suffered from kidney disease.
- you are already being treated with certain medication (See "Interactions with this medication" )
- you are pregnant: pms-VORICONAZOLE must not be taken during pregnancy, unless indicated by your doctor. Effective contraception must be used in women of child-bearing potential. Contact your doctor immediately if you become pregnant while taking pms-VORICONAZOLE.
- you are breast-feeding: pms-VORICONAZOLE must not be taken during breast feeding. Ask your doctor or pharmacist for advise before taking any medicine while breast feeding.

**While being treated with pms-VORICONAZOLE:**

- tell your doctor immediately if you develop a severe skin rash or blisters.
- strong sunlight should be avoided while being treated with pms-VORICONAZOLE. Tell your doctor if you develop an increased sensitivity of skin to the sun.
- your doctor may wish to monitor the function of your liver and kidney by doing blood tests.

**INTERACTIONS WITH THIS MEDICATION**

**Taking other medicines with pms-VORICONAZOLE:**

It is very important that you inform your doctor or pharmacist if you are taking or have taken any other medicines, even those that are obtained without a prescription. Some medicines affect the way pms-VORICONAZOLE works and dosage adjustments or monitoring may be necessary, such as for the following:

- Cyclosporine (a medicine used in transplant patients)
- Tacrolimus (a medicine used in transplant patients)
- Tricyclic antidepressants

- Antiarrhythmics (drugs that stabilize heart function such as procainamide, amiodarone, quinidine, sotalol)
- Antipsychotic drugs
- HIV protease inhibitors
- Macrolide antibiotics
- Methadone
- Oral contraceptives
- Short-acting opiates (e.g. alfentanil, sufentanil)
- Long-acting opiates (e.g. oxycodone, fentanyl)
- Some oral anticoagulants (e.g. warfarin, coumarin)
- Fluconazole (used for fungal infections)
- Everolimus (used for treating advanced kidney cancer and in transplant patients)
- Benzodiazepines (e.g. midazolam, triazolam, alprazolam)
- Calcium channel blockers (heart medications)
- Sulfonylureas (e.g. glyburide, glipizide)

Tell your doctor if you are taking non-steroidal anti-inflammatories (NSAIDs) (used for treating pain and inflammation) including ibuprofen and diclofenac, as the NSAID dose may have to be adjusted.

The following list of medicines must not be taken during your course of pms-VORICONAZOLE treatment:

- Terfenadine<sup>+</sup> (a medicine for allergy)
- Astemizole<sup>+</sup> (a medicine for allergy)
- Cisapride<sup>+</sup> (a medicine for stomach problems)
- Pimozide (a medicine for treating mental illness)
- Quinidine (a medicine for irregular heart beat)
- Rifampin (a medicine for treating tuberculosis)
- Carbamazepine (a medicine used to treat seizures)
- Long acting barbiturates (medicines for severe insomnia and seizures) such as phenobarbital
- Sirolimus (used in transplant patients)
- Rifabutin (a medicine for fungal infections)
- Ergot Alkaloids: ergotamine and dihydroergotamine (a medicine for migraines)
- Ritonavir (doses of 400 mg twice daily or higher) and efavirenz (doses of 400 mg twice daily or higher) (medicines for the treatment of HIV)
- St. John's Wort (*Hypericum perforatum*)  
<sup>+</sup>Not marketed in Canada

## PROPER USE OF THIS MEDICATION

### Usual Adult dose:

Your doctor will determine your dose depending on your weight and the type of infection (or suspected infection) you have. Always take pms-VORICONAZOLE exactly as directed by your doctor. You should check with your doctor or pharmacist if you are unsure. Never change the dose yourself.

Therapy must be initiated with the specified loading dose regimen of voriconazole to achieve adequate plasma concentrations on Day 1.

During the first 24 hours, you will be administered 2 doses of 6 mg/kg (12 hours apart).

After the first 24 hours:

- If you have an Aspergillus infection, you will be administered 4 mg/kg, twice a day.
- If you have a Candida infection, you will be administered 3 mg/kg or 4 mg/kg, twice a day.

It has been shown that taking all doses at the appropriate times may greatly increase the effectiveness of your medicine.

If you have liver disease, your doctor may prescribe a lower dose of pms-VORICONAZOLE.

Your doctor may order periodic blood tests to monitor your liver function during pms-VORICONAZOLE treatment. Continue taking pms-VORICONAZOLE until your doctor tells you to stop. Do not stop treatment early because your infection may not be cured. Patients with a weakened immune system or those with difficult infections may require long term treatment to prevent the infection from returning.

### Overdose:

In case of a drug overdose, contact a health care practitioner, hospital emergency department or regional Poison Control Centre immediately, even if there are no symptoms.

### Missed Dose:

If you miss taking a dose of pms-VORICONAZOLE, just take the next dose when it is due. Do not take a double dose to make up for the forgotten dose.

## SIDE EFFECTS AND WHAT TO DO ABOUT THEM

Like all medicines, pms-VORICONAZOLE can have side effects. If any side effects occur, most are likely to be minor and temporary. However, some may be serious and need medical attention.

The most commonly reported side effects are visual disturbances (blurring of vision, reduced vision, colour vision change and increased sensitivity to light), fever, rash, nausea, vomiting, diarrhea, headache, swelling of the extremities and stomach pains.

Other reported side effects include: changes in heart rate or rhythm, changes in blood pressure, blood cell changes, blood chemistry changes, dizziness, itchiness, weakness, back pain, chest pain, flu-like symptoms, facial swelling, hallucinations and other nervous symptoms, tingling, cough, breathing difficulty, hair loss, pain and irritation of the eyes, joint pain.

The following side effects have also been reported with the use of voriconazole: peripheral neuropathy (nerve damage) with symptoms such as a burning pain, tingling, numbness, sensitivity to touch and weakness, and hyponatremia (low levels of sodium

in the blood) with symptoms such as nausea, vomiting, confusion, weakness, fatigue, cramps, decreased consciousness and seizures. Check with your doctor immediately if chills, fever, flushing, sweating, muscle aches or pains, or other flu-like symptoms occur, especially if they occur shortly before, or together with a skin rash. Also, contact your doctor in case of a fast heartbeat, chest tightness or faintness. Very rarely, these effects may be the first signs of a serious reaction to this medication.

Contact your doctor if you suffer persistent abdominal pain and tenderness or vomiting as this may be a sign of a serious condition (pancreatitis).

If you develop bone pain during treatment, contact your doctor.

**Driving and using machines**

pms-VORICONAZOLE may cause changes to vision, including blurring and/or photophobia (sensitivity to light). The majority of visual symptoms appeared to spontaneously resolve within 60 minutes. While being treated with pms-VORICONAZOLE, you must avoid potentially hazardous tasks, such as driving or operating machinery if you perceive any change in vision. You should not drive at night while taking pms-VORICONAZOLE.

If any of these side effects persist or are troublesome, please tell your doctor.

**HOW TO STORE IT**

- Keep pms-VORICONAZOLE out of the reach and sight of children.
- Store pms-VORICONAZOLE at room temperature (15°C to 30°C).
- Following reconstitution with Water for Injection, the reconstituted solution should be used immediately. If not used immediately, in-use storage times and conditions prior to use should not be longer than 24 hours at 2° to 8°C. It should be ensured that reconstitution has taken place in controlled and validated aseptic conditions.
- If further diluted, the solutions should be used immediately.
- Do not use after the expiry date stated on the label.

**REPORTING SUSPECTED SIDE EFFECTS**

You can report any suspected adverse reactions associated with the use of health products to the Canada Vigilance Program by one of the following 3 ways:

- Report online at [www.healthcanada.gc.ca/medeffect](http://www.healthcanada.gc.ca/medeffect)
- Call toll-free at 1-866-234-2345
- Complete a Canada Vigilance Reporting Form and:
  - Fax toll-free to 1-866-678-6789, or
  - Mail to: Canada Vigilance Program  
Health Canada  
Postal Locator 0701C  
Ottawa, ON K1A 0K9

Postage paid labels, Canada Vigilance Reporting Form and the adverse reaction reporting guidelines are available on the MedEffect™ Canada Web site at [www.healthcanada.gc.ca/medeffect](http://www.healthcanada.gc.ca/medeffect).

*NOTE: Should you require information related to the management of side effects, contact your health professional. The Canada Vigilance Program does not provide medical advice.*

**MORE INFORMATION**

This document plus the full product monograph, prepared for health professionals, can be obtained by contacting the sponsor, Pharmascience Inc. at, 1-888-550-6060.

This leaflet was prepared by  
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**SERIOUS SIDE EFFECTS, HOW OFTEN THEY HAPPEN AND WHAT TO DO ABOUT THEM**

Symptom / effect		Talk with your doctor or pharmacist		Stop taking drug and call your doctor or pharmacist
		Only if severe	In all cases	
Uncommon	Heart failure			✓
	Irregular heartbeat			✓
	Visual disturbances		✓	
	Severe skin reactions		✓	
	Liver problems (yellowing of the eyes or skin, itching, feeling more tired than usual or like you have the flu, stomach pains or nausea and vomiting)			✓

This is not a complete list of side effects. If you notice any unexpected side effects while using pms-VORICONAZOLE, please contact your doctor or pharmacist.