

PRODUCT MONOGRAPH  
INCLUDING PATIENT MEDICATION INFORMATION

<sup>Pr</sup>**JAMP-PIP/TAZ**

**(PIPERACILLIN/TAZOBACTAM FOR INJECTION)**

Sterile piperacillin sodium and tazobactam sodium

Lyophilized Powder for Injection

For Intravenous Use Only

Piperacillin 4 g (as piperacillin sodium) and Tazobactam 0.5 g (as tazobactam sodium) per vial

Antibiotic/ $\beta$ -lactamase Inhibitor

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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	Lyophilized Powder for Injection.  4.5 g/vial (4 g piperacillin as piperacillin sodium, 0.50 g tazobactam as tazobactam sodium)	None.

**INDICATIONS AND CLINICAL USE**

JAMP-PIP/TAZ (sterile piperacillin sodium and tazobactam sodium) is indicated for the treatment of patients with systemic and/or local bacterial infections, caused by piperacillin resistant, piperacillin/tazobactam susceptible,  $\beta$ -lactamase producing strains of the designated microorganisms in the specified conditions listed below:

**a) INTRA-ABDOMINAL INFECTIONS**

Appendicitis (complicated by rupture or abscess) and peritonitis caused by piperacillin resistant  $\beta$ -lactamase producing strains of *Escherichia coli* or members of the *Bacteroides fragilis* group.

**b) SKIN AND SKIN STRUCTURE INFECTIONS**

Uncomplicated and complicated skin and skin structure infections, including cellulitis, cutaneous abscess, acute ischemic/diabetic foot infections caused by piperacillin resistant,  $\beta$ -lactamase producing strains of *Staphylococcus aureus* (not methicillin-resistant strains).

**c) GYNECOLOGICAL INFECTIONS**

Postpartum endometritis or pelvic inflammatory disease caused by piperacillin resistant,  $\beta$ -lactamase producing strains of *Escherichia coli*.

d) **COMMUNITY-ACQUIRED LOWER RESPIRATORY TRACT INFECTIONS**

Community-acquired pneumonia (moderate severity only) caused by piperacillin resistant,  $\beta$ -lactamase producing strains of *Haemophilus influenzae*.

e) **NOSOCOMIAL PNEUMONIA**

Nosocomial pneumonia (moderate to severe) caused by piperacillin resistant,  $\beta$ -lactamase producing strains of *Staphylococcus aureus* and by piperacillin/tazobactam-susceptible *Acinetobacter baumannii*, *Haemophilus influenzae*, *Klebsiella pneumoniae*, and *Pseudomonas aeruginosa* (Nosocomial pneumonia caused by *P. aeruginosa* should be treated in combination with an aminoglycoside) (see DOSAGE AND ADMINISTRATION).

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

While JAMP-PIP/TAZ is indicated only for the conditions listed above, infections caused by piperacillin susceptible organisms are also amenable to JAMP-PIP/TAZ treatment due to its piperacillin content. The tazobactam component of this combination product does not decrease the activity of the piperacillin component against piperacillin susceptible organisms. Therefore, the treatment of polymicrobial infections caused by piperacillin susceptible organisms and  $\beta$ -lactamase producing organisms susceptible to JAMP-PIP/TAZ should not require the addition of another antibiotic.

Piperacillin/tazobactam may be useful as presumptive therapy in the indicated conditions prior to identification of causative organisms because of its broad spectrum of bactericidal activity against gram-positive and gram-negative aerobic and anaerobic organisms.

Appropriate cultures should usually be performed before initiating antimicrobial treatment in order to isolate and identify the organisms causing infection and to determine their susceptibility to JAMP-PIP/TAZ. Antimicrobial therapy should be adjusted, if appropriate, once results of culture(s) and antimicrobial susceptibility testing are known.

**Geriatrics (> 65 years of age):**

Patients over 65 years of age are not at an increased risk of developing adverse effects solely because of age. However, dosage should be adjusted in the presence of renal insufficiency (see WARNINGS AND PRECAUTIONS, Special Populations, Geriatrics and DOSAGE AND ADMINISTRATION, Recommended Dose and Dosage Adjustment, Renal Insufficiency).

**Pediatrics (< 12 years of age):**

Safety and efficacy in children below the age of 12 years have not been established (see WARNINGS AND PRECAUTIONS, Special Populations, Pediatrics).

## CONTRAINDICATIONS

The use of JAMP-PIP/TAZ (sterile piperacillin sodium/tazobactam sodium) is contraindicated in:

- Patients who are hypersensitive to this drug or to any ingredient in the formulation or component of the container. For a complete listing, see the DOSAGE FORMS, COMPOSITION AND PACKAGING section.
- Patients with a history of allergic reactions to any of the penicillins and/or cephalosporins or  $\beta$ -lactamase inhibitors.

## WARNINGS AND PRECAUTIONS

### Serious Warnings and Precautions

- Serious and occasionally fatal hypersensitivity (anaphylactoid reaction, anaphylactic reaction, anaphylactoid shock, anaphylactic shock) reactions have been reported in individuals receiving therapy with penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens. There have been reports of individuals with a history of penicillin hypersensitivity who have experienced severe hypersensitivity reactions when treated with cephalosporins.
- Before initiating therapy with JAMP-PIP/TAZ, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, or other allergens. If an allergic reaction occurs during therapy with piperacillin/tazobactam, the antibiotic should be discontinued and appropriate therapy instituted. Serious anaphylactoid reactions require immediate emergency treatment with epinephrine, oxygen and intravenous steroids and airway management, including intubation, should also be administered as indicated.

### General

As with other semisynthetic penicillins, piperacillin therapy has been associated with an increased incidence of fever and rash in cystic fibrosis patients.

Because of chemical instability, JAMP-PIP/TAZ should not be used for intravenous administration with solutions containing **only** sodium bicarbonate (see DOSAGE AND ADMINISTRATION, Administration, Reconstitution).

JAMP-PIP/TAZ should not be added to blood products or albumin hydrolysates.

Use of JAMP-PIP/TAZ with other drugs may lead to drug-drug interactions (see DRUG

INTERACTIONS, Drug-Drug Interactions).

### **Ability to Drive and use Machines**

No studies on the effect of ability to drive or use machines have been performed.

### **Carcinogenesis and Mutagenesis**

Long-term carcinogenicity studies in animals have not been conducted with piperacillin/tazobactam, piperacillin, or tazobactam (see TOXICOLOGY).

### **Gastrointestinal**

#### ***Clostridium difficile*-Associated Disease**

*Clostridium difficile*-associated disease (CDAD) has been reported with use of many antibacterial agents, including piperacillin/tazobactam. CDAD may range in severity from mild diarrhea to fatal colitis. It is important to consider this diagnosis in patients who present with diarrhea, or symptoms of colitis, pseudomembranous colitis, toxic megacolon, or perforation of colon subsequent to the administration of any antibacterial agent. CDAD has been reported to occur over 2 months after the administration of antibacterial agents.

Treatment with antibacterial agents may alter the normal flora of the colon and may permit overgrowth of *Clostridium difficile*. *Clostridium difficile* produces toxins A and B, which contribute to the development of CDAD. CDAD may cause significant morbidity and mortality. CDAD can be refractory to antimicrobial therapy.

If the diagnosis of CDAD is suspected or confirmed, appropriate therapeutic measures should be initiated. Mild cases of CDAD usually respond to discontinuation of antibacterial agents not directed against *Clostridium difficile*. In moderate to severe cases, consideration should be given to management with fluids and electrolytes, protein supplementation, and treatment with an antibacterial agent clinically effective against *Clostridium difficile*. Surgical evaluation should be instituted as clinically indicated, as surgical intervention may be required in certain severe cases (see ADVERSE REACTIONS).

### **Hematologic**

Bleeding manifestations or significant leukopenia following prolonged administration have occurred in some patients receiving  $\beta$ -lactam antibiotics, including piperacillin. These reactions have sometimes been associated with abnormalities of coagulation tests such as clotting time, platelet aggregation and prothrombin time and are more likely to occur in patients with renal failure. If bleeding manifestations occur, the antibiotic should be discontinued and appropriate therapy instituted.

Leukopenia and neutropenia may occur, especially during prolonged therapy. Therefore, periodic assessment of hematopoietic function should be performed (see WARNINGS AND PRECAUTIONS, Monitoring and Laboratory Tests).

### **Neurologic**

As with other penicillins, patients may experience neuromuscular excitability or convulsions if higher than recommended doses are given intravenously (particularly in the presence of renal

failure).

### **Renal**

In patients with creatinine clearance <40 mL/min and dialysis patients [hemodialysis and chronic ambulatory peritoneal dialysis (CAPD)], the intravenous dose should be adjusted to the degree of renal function impairment (see DOSAGE AND ADMINISTRATION, Recommended Dose and Dosage Adjustment, Renal Insufficiency). Also see Hematologic and Neurologic above.

### **Sexual Function/Reproduction**

Studies in animals have shown reproductive and developmental toxicity in rats at maternally toxic doses when administered intravenously or intraperitoneally but have not shown teratogenicity of the piperacillin/tazobactam combination when administered intravenously (see TOXICOLOGY).

### **Skin Reactions**

Serious skin reactions, such as Stevens-Johnson Syndrome (SJS), Toxic Epidermal Necrolysis (TEN) and Drug Reactions with Eosinophilia and Systemic Symptoms (DRESS) have been reported in patients receiving piperacillin/tazobactam (see ADVERSE REACTIONS). If patients develop a skin rash they should be monitored closely and piperacillin/tazobactam discontinued if lesions progress.

### **Susceptibility/Resistance**

The possibility of the emergence of resistant organisms that might cause superinfections should be kept in mind. If this occurs, appropriate measures should be taken.

Prescribing JAMP-PIP/TAZ in the absence of a proven or strongly suspected bacterial infections is unlikely to provide benefit to the patient and risks the development of drug-resistant bacteria.

### **Special Populations**

**Pregnant Women:** Studies in animals have shown reproductive and developmental toxicity, but no evidence of teratogenicity, at doses that are maternally toxic (see TOXICOLOGY). There are no adequate and well-controlled studies with the piperacillin/tazobactam combination or with piperacillin or tazobactam alone in pregnant women. Piperacillin and tazobactam cross the placenta. Because animal reproduction studies are not always predictive of human response, pregnant women should be treated with JAMP-PIP/TAZ only if the expected benefit outweighs the possible risks to the pregnant woman and fetus.

**Nursing Women:** Caution should be exercised when piperacillin/tazobactam is administered to nursing mothers. Piperacillin is excreted in low concentrations in human milk; tazobactam concentrations in milk have not been studied. Women who are breast-feeding should be treated only if the expected benefit outweighs the possible risks to the woman and child.

**Pediatrics (< 12 years of age):** Safety and efficacy in children below the age of 12 have not been established.

**Geriatrics (> 65 years of age):** Patients over 65 years of age are not at an increased risk of

developing adverse effects solely because of age. However, dosage should be adjusted in the presence of renal insufficiency (see DOSAGE AND ADMINISTRATION, Recommended Dose and Dosage Adjustment, Renal Insufficiency).

In general, dose selection for an elderly patient should be approached with caution, usually starting at the low end of the dosing range, reflecting the greater frequency of decreased hepatic, renal, or cardiac function, and of concomitant disease or other drug therapy.

JAMP-PIP/TAZ contains 64 mg (2.79 mEq) of sodium per gram of piperacillin in the combination product. At the usual recommended doses, patients would receive between 768 and 1024 mg/day (33.5 and 44.6 mEq) of sodium. The geriatric population may respond with a blunted natriuresis to salt loading. This may be clinically important with regard to diseases such as congestive heart failure.

Piperacillin/tazobactam is known to be substantially excreted by the kidney, and the risk of toxic reactions to this drug may be greater in patients with impaired renal function. Elderly patients are more likely to have decreased renal function and therefore care should be taken in dose selection. It may be useful to monitor renal function.

### **Monitoring and Laboratory Tests**

JAMP-PIP/TAZ contains a total of 2.79 mEq (64 mg) of sodium (Na<sup>+</sup>) per gram of piperacillin in the combination product. This should be considered when treating patients requiring restricted salt intake. Periodic electrolyte determinations should be performed in patients with low potassium reserves, and the possibility of hypokalemia should be kept in mind with patients who have potentially low potassium reserves and who are receiving cytotoxic therapy or diuretics.

Periodic assessment of hematopoietic function should be performed, especially with prolonged therapy (see WARNINGS AND PRECAUTIONS, Hematologic and ADVERSE REACTIONS, Abnormal Hematologic and Clinical Chemistry Findings).

Coagulation parameters should be tested more frequently and monitored regularly, during simultaneous administration of JAMP-PIP/TAZ and high doses of heparin, oral anticoagulants and/or other drugs that may affect the blood coagulation system and/or the thrombocyte function (see DRUG INTERACTIONS, Drug-Drug Interactions).

Piperacillin may reduce the excretion of methotrexate. Therefore, to avoid drug toxicity, serum levels of methotrexate should be monitored in patients simultaneously treated with JAMP-PIP/TAZ and methotrexate (see DRUG INTERACTIONS, Drug-Drug Interactions).

## **ADVERSE REACTIONS**

### **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.*

### ***Clinical Trials (except Nosocomial Pneumonia)***

During the clinical investigations, 2621 patients worldwide were treated with piperacillin/tazobactam in phase III trials. In the key North American clinical trials (n=830 patients), 90% of the adverse events reported were mild to moderate in severity and transient in nature. However, in 3.2% of the patients treated worldwide, piperacillin/tazobactam was discontinued because of adverse events primarily involving the skin (1.3%), including rash and pruritus; the gastrointestinal system (0.9%), including diarrhea, nausea, and vomiting; and allergic reactions (0.5%).

Adverse local reactions that were reported, irrespective of relationship to therapy with piperacillin/tazobactam, were phlebitis (1.3%), injection site reaction (0.5%), pain (0.2%), inflammation (0.2%), thrombophlebitis (0.2%), and edema (0.1%).

Based on patients from the North American trials (n=1063), the events with the highest incidence in patients, irrespective of relationship to piperacillin/tazobactam therapy, were diarrhea (11.3%); headache (7.7%); constipation (7.7%); nausea (6.9%); insomnia (6.6%); rash (4.2%), including maculopapular, bullous, urticarial, and eczematoid; vomiting (3.3%); dyspepsia (3.3%); pruritus (3.1%); stool changes (2.4%); fever (2.4%); agitation (2.1%); pain (1.7%); moniliasis (1.6%); hypertension (1.6%); dizziness (1.4%); abdominal pain (1.3%); chest pain (1.3%); edema (1.2%); anxiety (1.2%); rhinitis (1.2%); and dyspnea (1.1%).

### **Nosocomial Pneumonia Trials**

In a completed study of nosocomial pneumonia, 222 patients were treated with piperacillin/tazobactam in a dosing regimen of 4.5 g every 6 hours in combination with an aminoglycoside and 215 patients were treated with a comparator in combination with an aminoglycoside. In this trial, treatment-emergent adverse events were reported by 402 patients, 204 (91.9%) in the piperacillin/tazobactam group and 198 (92.1%) in the comparator group. Twenty-five (25, 11.0%) patients in the piperacillin/tazobactam group and 14 (6.5%) in the comparator group (p>0.05) discontinued treatment due to an adverse event.

In this study of piperacillin/tazobactam in combination with an aminoglycoside, adverse events that occurred in more than 1% of patients and were considered by the investigator to be drug-related were: diarrhea (17.6%), fever (2.7%), vomiting (2.7%), urinary tract infection (2.7%), rash (2.3%), abdominal pain (1.8%), generalized edema (1.8%), moniliasis (1.8%), nausea (1.8%), oral moniliasis (1.8%), BUN increased (1.8%), creatinine increased (1.8%), peripheral edema (1.8%), abdomen enlarged (1.4%), headache (1.4%), constipation (1.4%), liver function tests abnormal (1.4%), thrombocythemia (1.4%), excoriations<sup>1</sup> (1.4%), and sweating (1.4%).

### **Less Common Clinical Trial Adverse Drug Reactions (<1%)**

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<sup>1</sup> These were coded under the COSTART term skin necrosis in CSR-44881, Supportive Table 10-3.

### **Clinical Trials (except Nosocomial Pneumonia)**

Additional adverse systemic clinical events reported in 1.0% or less of the patients are listed below within each body system:

Blood and lymphatic system disorders: mesenteric embolism, purpura, epistaxis, pulmonary embolism (See WARNINGS AND PRECAUTIONS, Hematologic).

Cardiac disorders: tachycardia, including supraventricular and ventricular; bradycardia; arrhythmia, including atrial fibrillation, ventricular fibrillation, cardiac arrest, cardiac failure, circulatory failure, myocardial infarction.

Ear and labyrinth disorders: vertigo, tinnitus.

Eye disorders: photophobia.

Gastrointestinal disorders: ileus, melena, flatulence, hemorrhage, gastritis, hiccough, ulcerative stomatitis.

Pseudomembranous colitis was reported in one patient during the clinical trials. The onset of pseudomembranous colitis symptoms may occur during or over 2 months after the administration of antibacterial treatment (See WARNINGS AND PRECAUTIONS, Gastrointestinal).

General disorders and administration site conditions: rigors, malaise, thirst.

Hepatobiliary disorders: jaundice.

Immune system disorders: anaphylaxis (including shock). Incidence of rash and fever is higher in patients with cystic fibrosis.

Infections and Infestations: candidiasis, vaginitis, pharyngitis.

Metabolism and nutrition disorders: symptomatic hypoglycemia.

Musculoskeletal and connective tissue and bone disorders: myalgia, arthralgia, back pain.

Nervous system disorders: syncope, tremor, convulsions, taste perversion.

Psychiatric disorders: confusion, hallucination, depression.

Renal and urinary disorders: retention, dysuria, oliguria, hematuria, incontinence.

Reproductive system and breast disorders: leucorrhea, genital pruritus.

Respiratory, thoracic and mediastinal disorders: pulmonary edema, bronchospasm, coughing.

Skin and subcutaneous tissue disorders: diaphoresis, toxic epidermal necrolysis.

Vascular disorders: flushing, hypotension.

### **Nosocomial Pneumonia Trials**

Drug-related adverse events reported in 1% or less of patients in the nosocomial pneumonia study of piperacillin/tazobactam with an aminoglycoside were: acidosis, acute kidney failure, agitation, alkaline phosphatase increased, anemia, asthenia, atrial fibrillation, chest pain, CNS depression, colitis, confusion, convulsion, cough increased, thrombocytopenia, dehydration, depression, diplopia, drug level decreased, dry mouth, dyspepsia, dysphagia, dyspnea, dysuria, eosinophilia, fungal dermatitis, gastritis, glossitis, grand mal convulsion, hematuria, hyperglycemia, hypernatremia, hypertension, hypertonia, hyperventilation, hypochromic anemia, hypoglycemia, hypokalemia, hyponatremia, hypophosphatemia, hypoxia, ileus, injection site edema, injection site pain, injection site reaction, kidney function abnormal, leukocytosis, leukopenia, local reaction to procedure, melena, pain, prothrombin decreased, pruritus, respiratory disorder, AST (SGOT) increased, ALT (SGPT) increased, sinus bradycardia, somnolence, stomatitis, stupor, tremor, tachycardia, ventricular extrasystoles, and ventricular tachycardia.

### **Abnormal Hematologic and Clinical Chemistry Findings**

Changes in laboratory parameters, without regard to drug relationship, were reported in all studies, including studies of nosocomial pneumonia in which a higher dose of piperacillin and tazobactam for injection was used in combination with an aminoglycoside. The changes in laboratory parameters include:

Hematologic: agranulocytosis, pancytopenia, anemia, decreases in hemoglobin and hematocrit, thrombocytopenia, increases in platelet count, eosinophilia, leukopenia, neutropenia. The leukopenia/neutropenia associated with piperacillin/tazobactam administration appears to be reversible and most frequently associated with prolonged administration, i.e.,  $\geq 21$  days of therapy. These patients were withdrawn from therapy; some had accompanying systemic symptoms (e.g., fever, rigors, chills).

Coagulation: positive direct Coombs test, prolonged prothrombin time, activated partial thromboplastin time prolonged, bleeding time prolonged.

Hepatic: Increase of AST (SGOT), ALT (SGPT), alkaline phosphatase, blood bilirubin, gamma-glutamyltransferase.

Renal: increases in serum creatinine, blood urea nitrogen, renal failure.

Urinalysis: proteinuria, hematuria, pyuria.

Additional laboratory events include abnormalities in electrolytes (i.e., increases and decreases in sodium, potassium, and calcium), hyperglycemia, decreases in albumin, protein total decreased. In individuals with liver disease or those receiving cytotoxic therapy or diuretics, piperacillin/tazobactam has been reported rarely to produce a decrease in serum potassium levels at high doses of piperacillin.

The following adverse reactions have also been reported for sterile piperacillin sodium:

Hepatobiliary disorders: cholestatic hepatitis.

Nervous system disorders: prolonged muscle relaxation (see DRUG INTERACTIONS, Drug-Drug Interactions, Vecuronium).

Renal and urinary disorders: rarely tubulointerstitial nephritis.

Skin and subcutaneous tissue disorders: erythema multiforme and Stevens-Johnson syndrome, rarely reported.

### **Post-Market Adverse Drug Reactions**

Additional adverse events reported from worldwide marketing experience with piperacillin/tazobactam occurring under circumstances where causal relationship to piperacillin/tazobactam is uncertain:

Blood and lymphatic system disorders: hemolytic anemia, anemia, thrombocytosis, agranulocytosis, pancytopenia.

Hepatobiliary disorders: hepatitis, cholestatic jaundice.

Immune system disorders: hypersensitivity, anaphylactoid reaction, anaphylactic reaction, anaphylactoid shock, anaphylactic shock.

Infections and infestations: candidiasis.

Renal and urinary disorders: tubulointerstitial nephritis, renal failure.

Skin and subcutaneous tissue disorders: erythema multiforme, Stevens-Johnson Syndrome (SJS), Toxic Epidermal Necrolysis (TEN), Drug Reactions with Eosinophilia and Systemic Symptoms (DRESS), dermatitis bullous.

## **DRUG INTERACTIONS**

### **Drug-Drug Interactions**

#### Aminoglycosides

The mixing of beta-lactam antibiotics with aminoglycosides *in vitro* can result in substantial inactivation of the aminoglycoside. Therefore, JAMP-PIP/TAZ and the aminoglycoside must be administered separately, when concomitant therapy with aminoglycosides is indicated.

(See DOSAGE AND ADMINISTRATION, Recommended Dose and Dosage Adjustment).

The inactivation of aminoglycosides in the presence of penicillin-class drugs has been recognized. It has been postulated that penicillin-aminoglycoside complexes form; these complexes are microbiologically inactive and of unknown toxicity. Sequential administration of piperacillin/tazobactam with tobramycin to patients with normal renal function and mild to moderate renal impairment has been shown to modestly decrease serum concentrations of tobramycin but does not significantly affect tobramycin pharmacokinetics. When aminoglycosides are administered in combination with piperacillin to patients with end-stage renal disease requiring hemodialysis, the concentrations of the aminoglycosides (especially tobramycin) may be significantly altered and should be monitored. Since aminoglycosides are not equally susceptible to inactivation by piperacillin, consideration should be given to the choice of the aminoglycoside when administered in combination with piperacillin to these patients.

#### Probenecid

Concomitant administration of piperacillin/tazobactam and probenecid results in prolonged half-life of piperacillin (21%), and tazobactam (71%) and lower renal clearance for both piperacillin and tazobactam; however, peak plasma concentrations of either drug are unaffected.

#### Vancomycin

No pharmacokinetic interactions are found between piperacillin/tazobactam and vancomycin.

#### Heparin

Coagulation parameters should be tested more frequently and monitored regularly, during simultaneous administration of high doses of heparin, oral anticoagulants and other drugs that may affect the blood coagulation system and/or the thrombocyte function (see WARNINGS AND PRECAUTIONS, Monitoring and Laboratory Tests).

#### Vecuronium

Piperacillin used concomitantly with vecuronium has been implicated in the prolongation of the neuromuscular blockade of vecuronium. Piperacillin/tazobactam could produce the same phenomenon if given along with vecuronium. Due to their similar mechanism of action, it is expected that the neuromuscular blockade produced by any of the non-depolarizing muscle relaxants could be prolonged in the presence of piperacillin. (See package insert for vecuronium bromide).

#### Methotrexate

Piperacillin may reduce the excretion of methotrexate; therefore, serum levels of methotrexate should be monitored in patients to avoid drug toxicity (see WARNINGS AND PRECAUTIONS, Monitoring and Laboratory Tests).

Lactated Ringer's Solution is not compatible with JAMP-PIP/TAZ (see DOSAGE AND ADMINISTRATION, Administration, Reconstitution).

Where piperacillin/tazobactam is administered concurrently with another antibiotic the drugs should not be mixed in the same solution but must be administered separately.

### **Drug-Food Interactions**

Interactions with food have not been established.

### **Drug-Herb Interactions**

Interactions with herbal products have not been established.

### **Drug-Laboratory Interactions**

As with other penicillins, the administration of piperacillin/tazobactam may result in a false-positive reaction for glucose in the urine using a copper-reduction method (CLINITEST<sup>®\*</sup>). It is recommended that glucose tests based on enzymatic glucose oxidase reactions (such as DIASTIX<sup>®\*</sup> or TES-TAPE<sup>®\*\*</sup>) be used.

There have been reports of positive test results using the Bio-Rad Laboratories Platelia Aspergillus EIA test in patients receiving piperacillin/tazobactam injection who were subsequently found to be free of Aspergillus infection. Cross-reactions with non-Aspergillus polysaccharides and polyfuranoses with Bio-Rad Laboratories Platelia Aspergillus EIA test have been reported. Therefore, positive test results in patients receiving piperacillin/tazobactam should be interpreted cautiously and confirmed by other diagnostic methods.

### **Drug-Lifestyle Interactions**

Interactions with lifestyle have not been established.

## **DOSAGE AND ADMINISTRATION**

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

Clinical trial data in the treatment of intra-abdominal infections support the efficacy of 4.5 g JAMP-PIP/TAZ (4 g piperacillin sodium/0.5 g tazobactam sodium) given every eight hours.

### **Nosocomial Pneumonia**

Initial presumptive treatment of patients with nosocomial pneumonia should start with piperacillin/tazobactam at a dosage of 4.5 g (4 g piperacillin sodium/0.5 g tazobactam sodium) every six hours plus an aminoglycoside, totalling 18 g (16 g piperacillin sodium/2 g tazobactam sodium). Treatment with the aminoglycoside should be continued in patients from whom *Pseudomonas aeruginosa* is isolated. If *Pseudomonas aeruginosa* is not isolated, the aminoglycoside may be discontinued at the discretion of the treating physician.

Due to the *in vitro* inactivation of the aminoglycoside by beta-lactam antibiotics, JAMP-PIP/TAZ and the aminoglycoside should be reconstituted, diluted, and administered separately when concomitant therapy with aminoglycosides is indicated (see DRUG INTERACTIONS, Drug-Drug Interactions, Aminoglycosides).

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\* CLINITEST<sup>®</sup> and DIASTIX<sup>®</sup> are registered trademarks of Ames Division, Miles Laboratories, Inc.

\*\* TES-TAPE<sup>®</sup> is a registered trademark of Eli Lilly and Company.

When concomitant therapy with an aminoglycoside is indicated, JAMP-PIP/TAZ and the aminoglycoside should be administered separately.

### Renal Insufficiency

In patients with renal insufficiency, the intravenous dose of JAMP-PIP/TAZ should be adjusted to the degree of actual renal function impairment. In patients with nosocomial pneumonia receiving concomitant aminoglycoside therapy, the aminoglycoside dosage should be adjusted according to the recommendations of the aminoglycoside used. The recommended daily doses of piperacillin/tazobactam for patients with renal insufficiency are as follows:

### **Recommended Dosing of JAMP-PIP/TAZ in Patients with Normal Renal Function and Renal Insufficiency (As total grams of piperacillin/tazobactam)**

<b>Renal Function (Creatinine Clearance, mL/min)</b>	<b>All Indications (except Nosocomial Pneumonia)</b>	<b>Nosocomial Pneumonia</b>
>40 mL/min	3.375 q6h	4.5 q6h
20-40 mL/min*	2.25 q6h	3.375 q6h
<20 mL/min*	2.25 q8h	2.25 q6h
Hemodialysis**	2.25 q12h	2.25 q8h
CAPD***	2.25 q12h	2.25 q8h
* Creatinine clearance for patients not receiving hemodialysis ** 0.75 g should be administered following each hemodialysis session on hemodialysis days *** CAPD: Continuous Ambulatory Peritoneal Dialysis		

For patients on hemodialysis, the maximum dose is 2.25 g piperacillin/tazobactam (2 g piperacillin sodium/0.25 g tazobactam sodium) given every twelve hours for all indications other than nosocomial pneumonia and 2.25 g (2 g piperacillin sodium/0.25 g tazobactam sodium) every eight hours for nosocomial pneumonia. In addition, because hemodialysis removes 30% to 40% of a piperacillin/tazobactam dose in four hours, one additional dose of 0.75 g piperacillin/tazobactam (0.67 g piperacillin sodium/0.08 g tazobactam sodium) should be administered following each dialysis period. For patients with renal failure, measurement of serum levels of piperacillin/tazobactam will provide additional guidance for adjusting dosage.

Dosage adjustment is based on pharmacokinetic data. Clinical studies with piperacillin/tazobactam have not been performed in patients with impaired renal function.

### **Duration of Therapy**

The usual duration of JAMP-PIP/TAZ treatment is from seven to ten days. However, the recommended duration of piperacillin/tazobactam treatment of nosocomial pneumonia is 7 to 14 days. In all conditions, the duration of therapy should be guided by the severity of the infection and the patient's clinical and bacteriological progress.

### **Administration**

JAMP-PIP/TAZ should be administered by slow intravenous infusion over 30 minutes (See

ACTION AND CLINICAL PHARMACOLOGY, Pharmacokinetics).

**Reconstitution:**

Reconstitute JAMP-PIP/TAZ with at least 5 mL of a suitable diluent per gram of piperacillin from the list of diluents provided below. Swirl until dissolved. It should be further diluted to the desired final volume with an acceptable diluent.

**Reconstitution**

Vial Size (piperacillin/tazobactam)	Volume of diluent to be added to vial	Approximate available volume	Nominal concentration per mL
4.50 g (4 g/0.50 g)	20 mL	23.15 mL	0.194 g/mL (0.172 g/mL/0.022 g/mL)

Reconstitute JAMP-PIP/TAZ per gram of piperacillin with 5 mL of a <i>Compatible Reconstitution Diluent</i> (listed below)	Further dilute the reconstituted JAMP-PIP/TAZ with 50 mL to 150 mL of a <i>Compatible Intravenous Solution</i> (listed below)
0.9% Sodium Chloride Injection Sterile Water for Injection 5% Dextrose Injection	0.9% Sodium Chloride Injection Sterile Water for Injection* 5% Dextrose Injection  * Maximum recommended volume per dose of Sterile Water for Injection is 50 mL.
Bacteriostatic Sodium Chloride Injection (with benzyl alcohol) Bacteriostatic Water for Injection (with benzyl alcohol) Bacteriostatic Water for Injection (with parabens)	0.9% Sodium Chloride Injection

**Lactated Ringer’s solution is not compatible with Piperacillin/Tazobactam for Injection (see DRUG INTERACTIONS, Drug-Drug Interactions).**

**Intermittent Intravenous Infusion** - Reconstitute as previously described, with 5 mL of an acceptable diluent per 1 gram of piperacillin and then further dilute in the desired volume (at least 50 mL). This diluted solution must be used immediately. Administer by infusion over a period of at least 30 minutes. During the infusion it is desirable to discontinue the primary infusion solution.

**Stability of JAMP-PIP/TAZ Following Reconstitution** JAMP-PIP/TAZ is stable in glass and plastic containers (plastic syringes, IV bags and tubing) when reconstituted with acceptable diluents.



Stability studies of piperacillin/tazobactam in glass vials have demonstrated chemical stability [potency, pH of reconstituted solution, appearance and description, and clarity of solution] for up to 24 hours at room temperature (between 20 and 25°C) and up to 48 hours at refrigerated temperatures (between 2 and 8°C). Discard unused portions after storage for 24 hours at room temperature or 48 hours when refrigerated.

DUE TO MICROBIAL CONSIDERATIONS, INTRAVENOUS ADMIXTURES ARE USUALLY RECOMMENDED FOR USE WITHIN A MAXIMUM OF 24 HOURS AT ROOM TEMPERATURE OR 72 HOURS WHEN REFRIGERATED (2–8°C).

Stability studies of JAMP-PIP/TAZ in polyolefin IV bags have demonstrated chemical stability (potency, appearance and description and clarity of solution) for up to 24 hours at room temperature and up to 72 hours at refrigerated temperatures. Stability and compatibility of JAMP-PIP/TAZ in PVC IV. bags have not been established. JAMP-PIP/TAZ contains no preservatives. Appropriate consideration of aseptic technique should be used.

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.

### **Incompatibilities**

Not to be added to blood products or albumin hydrolysates.

Because of chemical instability, JAMP-PIP/TAZ should not be used for intravenous administration with solutions containing sodium bicarbonate alone. It may be used with intravenous admixtures containing other ingredients as well as sodium bicarbonate for up to 24 hours at room temperature and 48 hours refrigerated.

Solutions containing JAMP-PIP/TAZ and protein hydrolysates or amino acids should be used within 12 hours if stored at room temperature and 24 hours if refrigerated.

JAMP-PIP/TAZ should not be mixed with other drugs in a syringe or infusion bottle since compatibility has not been established.

### **OVERDOSAGE**

For management of a suspected drug overdose, contact your regional Poison Control Centre immediately.
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There have been post-marketing reports of overdose with sterile piperacillin sodium/tazobactam sodium. The majority of those events experienced including nausea, vomiting, and diarrhea have also been reported with the usual recommended dosages. Patients may experience neuromuscular excitability or convulsions if higher than recommended doses are given intravenously (particularly in the presence of renal failure).

Treatment should be supportive and symptomatic according to the patient's clinical presentation.

Excessive serum levels of either tazobactam or piperacillin may be reduced by hemodialysis, although no specific antidote is known. As with other penicillins, neuromuscular excitability or convulsions have occurred following large intravenous doses, primarily in patients with impaired renal function.

In the case of motor excitability or convulsions, general supportive measures, including administration of anticonvulsive agents (e.g., diazepam or barbiturates) may be considered.

## **ACTION AND CLINICAL PHARMACOLOGY**

### **Mechanism of Action**

JAMP-PIP/TAZ is an injectable antibacterial combination of the semisynthetic antibiotic piperacillin sodium and the  $\beta$ -lactamase inhibitor tazobactam sodium for intravenous administration. Thus, piperacillin/tazobactam combines the properties of a broad-spectrum antibiotic and a  $\beta$ -lactamase inhibitor.

Piperacillin sodium exerts bactericidal activity by inhibiting septum formation and cell wall synthesis. Piperacillin and other  $\beta$ -lactam antibiotics block the terminal transpeptidation step of cell wall peptidoglycan biosynthesis in susceptible organisms by interacting with the penicillin binding proteins (PBPs), the bacterial enzymes that carry out this reaction. *In vitro*, piperacillin is active against a variety of gram-positive and gram-negative aerobic and anaerobic bacteria.

### **Pharmacodynamics**

Tazobactam sodium has little clinically relevant *In vitro* activity against bacteria due to its reduced affinity to penicillin-binding proteins. It is, however, a  $\beta$ -lactamase inhibitor of the Richmond-Sykes class III (Bush class 2b & 2b') penicillinases and cephalosporinases. It varies in its ability to inhibit class II and IV (2a & 4) penicillinases. Tazobactam does not induce chromosomally-mediated  $\beta$ -lactamases at tazobactam concentrations achieved with the recommended dosage regimen.

### **Pharmacokinetics**

**Absorption:** Peak plasma concentrations of tazobactam and piperacillin are attained immediately after completion of an intravenous infusion of piperacillin/tazobactam. Piperacillin plasma concentrations, following a 30 minute infusion of piperacillin/tazobactam are similar to those obtained when equivalent doses of piperacillin are administered alone, with mean peak plasma concentrations of approximately 134, 242, and 298 mcg/mL for the 2 g/0.25 g, 3 g/0.375 g and 4 g/0.5 g (piperacillin sodium/tazobactam sodium) doses, respectively. The corresponding mean peak plasma concentrations of tazobactam are 15, 24 and 34 mcg/mL.

After 3 g/0.375 g (piperacillin sodium/tazobactam sodium) 30 minute IV infusions administered every 6 hours, steady state plasma concentrations of tazobactam and piperacillin are similar to those obtained after the first dose. In like manner, after 4 g/0.5 g or 2 g/0.25 g piperacillin sodium/tazobactam sodium 30 minute infusions given every 6 hours, from those obtained after

the first dose. Steady state plasma concentrations after 30 minute infusions every 6 hours are provided in Table 1 (A, B), respectively.

**TABLE 1 (A, B)**

**STEADY STATE MEAN PLASMA CONCENTRATIONS IN ADULTS AFTER 30-MINUTE INTRAVENOUS INFUSION OF PIPERACILLIN/TAZOBACTAM EVERY 6 HOURS**

**A) TAZOBACTAM**

Dose*	PLASMA CONCENTRATIONS (mcg/mL)						AUC (mcg·h/mL)
	30 min	1 h	2 h	3 h	4 h	6 h	AUC 0-6
<b>2 g/0.25 g</b>	14.8 (14)	7.2 (22)	2.6 (30)	1.1 (35)	0.7 (6) <sup>b</sup>	<0.5	16.0 (21)
<b>3 g/0.375 g</b>	24.2 (14)	10.7 (7)	4.0 (18)	1.4 (21)	0.7 (16) <sup>a</sup>	<0.5	25.0 (8)
<b>4 g/0.5 g</b>	33.8 (15)	17.3 (16)	6.8 (24)	2.8 (25)	1.3 (30)	<0.5	39.8 (15)

\* Piperacillin/tazobactam

<sup>a</sup> N=4

<sup>b</sup> N=3

**B) PIPERACILLIN**

Dose*	PLASMA CONCENTRATIONS (mcg/mL)						AUC (mcg·h/mL)
	30 min	1 h	2 h	3 h	4 h	6 h	AUC 0-6
<b>2 g/0.25 g</b>	134 (14)	57 (14)	17.1 (23)	5.2 (32)	2.5 (35)	0.9 (14) <sup>a</sup>	131 (14)
<b>3 g/0.375 g</b>	242 (12)	106 (8)	34.6 (20)	11.5 (19)	5.1 (22)	1.0 (10)	242 (10)
<b>4 g/0.5 g</b>	298 (14)	141 (19)	46.6 (28)	16.4 (29)	6.9 (29)	1.4 (30)	322 (16)

\* piperacillin/tazobactam

<sup>a</sup> N=4

24 (2.25 g and 4.5 g) and 22 (3.375 g) subjects were enrolled in the study and all were evaluable for pharmacokinetic analysis.

In healthy subjects, following single or multiple piperacillin/tazobactam doses, the plasma half-lives of tazobactam and piperacillin range from 0.7 to 1.2 hours and are unaffected by dose or duration of infusion.

**Distribution:** Tazobactam and piperacillin are widely distributed into tissues and body fluids including, but not limited to, intestinal mucosa, gallbladder, lung, female reproductive tissues (uterus, ovary and fallopian tube), interstitial fluid and bile. Mean tissue concentrations were generally 50-100% of those in plasma. Distribution of tazobactam and piperacillin into cerebrospinal fluid is low in subjects with non-inflamed meninges, as with other penicillins.

**Metabolism:** Piperacillin is metabolized to a minor microbiologically active desethyl metabolite. Tazobactam is metabolized to a single metabolite which lacks pharmacological and antibacterial activities.

**Excretion:** Both tazobactam and piperacillin are eliminated by the kidney via glomerular filtration and tubular secretion. Tazobactam and its metabolite are eliminated primarily by renal excretion with 80% of the dose as unchanged drug and the remainder as the single metabolite. Piperacillin is excreted rapidly as unchanged drug, with 68% of the dose in the urine. Piperacillin, tazobactam and desethyl piperacillin are also secreted into the bile.

### **Special Populations and Conditions**

**Hepatic Insufficiency:** Tazobactam and piperacillin half-lives increase by approximately 18% and 25% respectively, in patients with hepatic cirrhosis compared to healthy subjects. However, dosage adjustment of JAMP-PIP/TAZ due to hepatic cirrhosis is not necessary.

**Renal Insufficiency:** In subjects with renal impairment, the half-lives of tazobactam and piperacillin, after single doses, increase with decreasing creatinine clearance. At creatinine clearance below 20 mL/min., the increase in half-life is four-fold for tazobactam and two-fold for piperacillin compared to subjects with normal renal function. Dosage adjustments for JAMP-PIP/TAZ are recommended when creatinine clearance is below 40 mL/min in patients receiving the recommended daily dose of JAMP-PIP/TAZ (see DOSAGE AND ADMINISTRATION, Recommended Dose and Dosage Adjustment, Renal Insufficiency).

Hemodialysis removes 30-40% of a piperacillin/tazobactam dose with an additional 5% of the tazobactam dose removed as the tazobactam metabolite. Peritoneal dialysis removes approximately 21% and 6% of the tazobactam and piperacillin doses, respectively, with up to 16% of the tazobactam dose removed as the tazobactam metabolite. For dosage recommendations for patients undergoing hemodialysis, see DOSAGE AND ADMINISTRATION, Recommended Dose and Dosage Adjustment, Renal Insufficiency.

## **STORAGE AND STABILITY**

JAMP-PIP/TAZ vials should be stored at controlled room temperature between 15°C and 30°C.

Single-dose vials. Discard unused portions.

## **SPECIAL HANDLING INSTRUCTIONS**

There are no special handling instructions.

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

JAMP-PIP/TAZ (sterile piperacillin sodium and tazobactam sodium) is available in the following dosage form:

- JAMP-PIP/TAZ 4.5 g vial: Each vial provides piperacillin sodium equivalent to 4 grams of piperacillin and tazobactam sodium equivalent to 0.5 grams of tazobactam. Each vial contains 9.39 mEq (216 mg) sodium  
4.5 g vial – 10 per carton.

## PART II: SCIENTIFIC INFORMATION

### PHARMACEUTICAL INFORMATION

#### Drug Substance

Piperacillin Monohydrate and Tazobactam Acid are converted to their sodium salts during manufacture of the drug product.

#### Proper name:

Tazobactam Acid  
Tazobactam Sodium

#### Chemical name:

Tazobactam Acid  
(2*S*,3*S*,5*R*)-3-Methyl-7-oxo-3-(1*H*-1,2,3-triazol-1-ylmethyl)-4-thia-1-azabicyclo[3.2.0]heptane-2-carboxylic acid, 4,4-dioxide

Tazobactam Sodium  
Sodium (2*S*,3*S*,5*R*)-3-methyl-7-oxo-3-(1*H*-1,2,3-triazol-1-ylmethyl)-4-thia-1-azabicyclo[3.2.0]heptane-2-carboxylate 4,4-dioxide

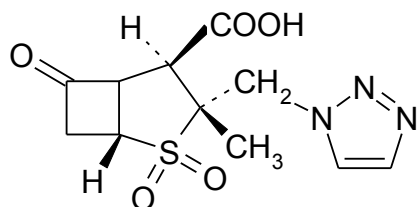
#### Molecular formula and molecular mass:

Tazobactam Acid:  
 $C_{10}H_{12}N_4O_5S$ ; 300.29 g/mol

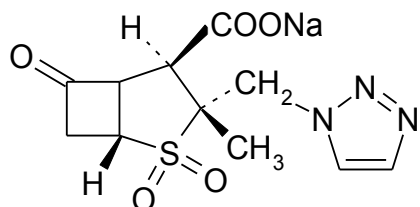
Tazobactam Sodium:  
 $C_{10}H_{11}N_4NaO_5S$ ; 322.29 g/mol

#### Structural formula:

Tazobactam Acid



## Tazobactam Sodium



### **Physicochemical properties:**

Tazobactam is a white to pale-yellow crystalline powder. Its solubility in water is 5.5 mg/mL with a resulting pH of 1.9, and the aqueous solubility of sodium salt is at least 500 mg/mL. There is no melting point; the material decomposes at above 176°C.

### **Proper name:**

Piperacillin Monohydrate  
Piperacillin Sodium

### **Chemical name:**

#### Piperacillin Monohydrate

(2*S*,5*R*,6*R*)-6-[(*R*)-2-(4-ethyl-2,3-dioxo-1-piperazinecarboxamido)-2-phenylacetamido]-3,3-dimethyl-7-oxo-4-thia-1-azabicyclo[3.2.0]heptane-2-carboxylic acid monohydrate

#### Piperacillin Sodium

Sodium (2*S*,5*R*,6*R*)-6-[(*R*)-2-(4-ethyl-2,3-dioxo-1-piperazine-carboxyamido)-2-phenylacetamido]-3,3-dimethyl-7-oxo-4-thia-1-azabicyclo[3.2.0]-heptane-2-carboxylate

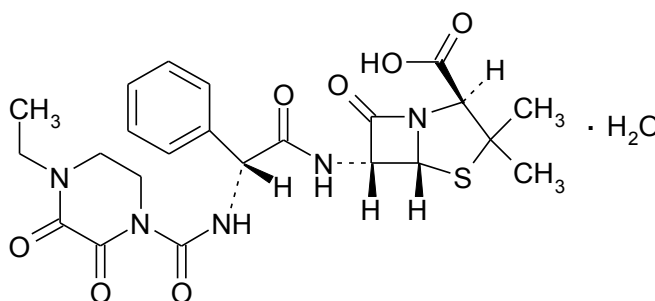
**Molecular formula and molecular mass:** Piperacillin Monohydrate

$C_{23}H_{27}N_5O_7S \cdot H_2O$ ; 537.57 g/mol

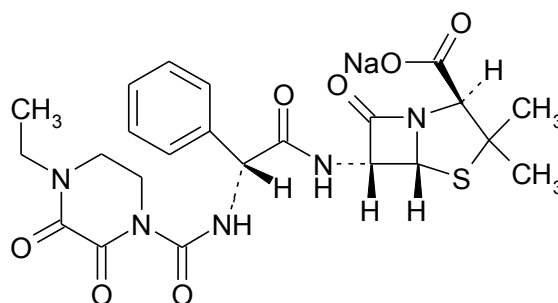
Piperacillin Sodium

$C_{23}H_{26}N_5NaO_7S$ ; 539.54 g/mol

**Structural formula:** Piperacillin Monohydrate



Piperacillin Sodium



### Physicochemical properties:

Piperacillin monohydrate is a white to off-white crystalline powder. The aqueous solubility of its sodium salt is 1 g/1.4 mL and the pH of 25% w/v solution is 5.5-7.0. The melting point of the piperacillin sodium is 183-185°C with decomposition.

### Composition:

Sterile piperacillin sodium/tazobactam sodium is a white to off-white cryodesiccated powder or cake consisting of tazobactam and piperacillin as their sodium salts packaged in glass vials.



## **DETAILED PHARMACOLOGY**

### **Animal Pharmacology**

#### Enzyme Induction:

Hepatic mixed function oxidase studies in the rat and dog indicated that tazobactam did not induce the hepatic drug metabolizing enzymes in these species.

#### Toxicokinetics:

Evaluation of the pharmacokinetic disposition of tazobactam and piperacillin following dose administration disclosed no evidence of alteration in the disposition of either agent. Plasma concentrations of tazobactam following intraperitoneal administration, the route of administration in rat toxicity studies, were proportional to the dose increment from 20 to 500 mg/kg. Similarly, plasma concentrations of piperacillin were dose proportional up to 1000 mg/kg but were greater than dose proportional at higher doses.

In pharmacokinetics studies, as well as in the acute and long-term rat and dog toxicity studies, the extent of piperacillin and tazobactam exposure was much higher than that observed in man. The disposition of tazobactam in the rat differed considerably from the disposition in the dog and man, with the dog closely resembling man in the extent of distribution, elimination half-life, and systemic clearance of tazobactam.

Both species employed in the safety assessment studies (rat, dog) produced a metabolite (M-1) from tazobactam. Plasma concentrations of M-1 following single IV doses of 25, 150, and 400 mg/kg of M-1 were dose proportional.

#### Placental Transfer:

The penetration of tazobactam and its metabolites through the placental barrier was moderate in pregnant rats. Tazobactam and its metabolites initially attained concentrations in the uterus, placenta, ovary, and amnion that were 20-50% of the plasma concentrations, while concentrations attained in the fetus were about 3%.

#### Excretion in Breast Milk:

Although drug related concentrations of radioactivity were detected in milk of lactating rats, the concentrations of unchanged tazobactam in pup plasma and tissues were very low.

The effects seen in these studies with piperacillin/tazobactam are similar to those seen with other  $\beta$ -lactam antibiotics in combination with  $\beta$ -lactamase inhibitors. Results of preclinical studies support the use of piperacillin/tazobactam in patients with infectious diseases.

### **Human Pharmacology**

#### Bioavailability

Twelve, healthy, male volunteers were given a single IM injection of 2 g piperacillin/0.25 g tazobactam to determine absolute bioavailability. Within one hour peak plasma concentrations of

125 mcg/mL and 15.6 mcg/mL for piperacillin and tazobactam, respectively, were attained. The absolute bioavailability (F) was 71% for piperacillin and 84% for tazobactam.

### Distribution

The distribution volume at steady-state ( $V_{ss}$ ) for tazobactam ranged from 12.8 to 15.8 L following a 30 minute infusion dose of 0.1 to 1 g. Co-administration of piperacillin significantly decreased tazobactam  $V_{ss}$  by approximately 16%. Piperacillin  $V_{ss}$  (range 12 to 17 L) following a 30 minute infusion dose of 4 g was unaffected by tazobactam. In studies using radio-labelled tazobactam, the blood to plasma concentration ratios of radioactivity were approximately 0.5 to 0.8 at each sampling time suggesting that tazobactam and its metabolite do not preferentially distribute into the cellular components of blood.

After a 30 minute IV infusion of piperacillin/tazobactam to subjects undergoing elective surgery, both compounds were well distributed into tissues with mean tissue concentrations generally 50 to 100% of plasma concentrations. Tissue concentrations of tazobactam and piperacillin were generally greater than 19 and 6 mcg/g, respectively, in lung, intestinal mucosa, gallbladder, and appendix for up to 2.5 hours after a dose of either 0.5 g/4 g or 0.5 g/2 g piperacillin/tazobactam. Similarly, after a 2 g/0.5 g piperacillin/tazobactam dose, concentrations up to 3.5 hours after dosing were greater than 5.6 mcg/g for piperacillin and 3.7 mcg/g for tazobactam in intestine, gallbladder and stomach mucosa.

A dose of 4 g piperacillin/0.5 g tazobactam produced peak concentrations of 94.2 mcg/g for piperacillin and 7.7 mcg/g for tazobactam in skin. Concentrations in bile from gallbladder aspirates ranged from 1.3 to 42.9 mcg/mL for tazobactam and from 220 to 1045 mcg/mL for piperacillin after an infusion dose of 3 g piperacillin/0.375 g tazobactam. Following a 4 g piperacillin/0.5 g tazobactam 30 minute infusion, peak blister levels of tazobactam and piperacillin were 11.3 and 77.2 mcg/mL, respectively. The blister fluid AUC was, on average, about 90% of the plasma AUC for either compound. As seen with other penicillins, concentrations in cerebral spinal fluid are low. They reached 2 to 3% of plasma values, 2 hours after start of a 5 g piperacillin/0.625 g tazobactam 30 minute infusion.

### Dose Proportionality

To investigate the change in  $C_{max}$  with increasing dosage, two single dose studies, involving 32 healthy volunteers, were performed using doses of 2 g/0.25 g, 3 g/0.375 g, 4 g/0.5 g piperacillin/tazobactam, given as either a 5 minute infusion or a 30 minute infusion. For both compounds, the increase in  $C_{max}$  was proportional. AUC was proportional between the 3 g/0.375 g and 4 g/0.5 g piperacillin/tazobactam doses. However, increases in AUC were more than proportional (up to 30%) as the dose increased from 2 g/0.25 g to 3 g/0.375 g or 4 g/0.5 g piperacillin/tazobactam.

### Metabolism and Excretion

Piperacillin undergoes biotransformation in the gastrointestinal tract, where minor (<1% total dose) microbiologically inactive metabolites are formed via bacterial hydrolysis.

Tazobactam is metabolized to a single metabolite (M1) which lacks pharmacological and

antibacterial activities and circulates at approximately 10% of the parent concentrations in subjects with normal renal function. Following an IV infusion of 3 g piperacillin and 0.377 g <sup>14</sup>C-tazobactam (60 microcuries), tazobactam was excreted about 80% as unchanged drug and the remainder as M1. Up to 4 hours post-dose, total radioactivity concentrations in plasma could be accounted for by unchanged tazobactam and M1 while, after 4 hours, they are primarily accounted for by M1.

Piperacillin from piperacillin/tazobactam is eliminated by renal pathways, and recovery of piperacillin from piperacillin/tazobactam in bile is < 1% (HPLC assay) of the dose administered. About 50% - 70% of the dose is excreted unchanged by the kidney. The excretion is unaffected by co-administration of tazobactam. Urine concentrations of piperacillin from piperacillin/tazobactam generally exceeded 1500 mcg/mL over the dosing interval following a 30 minute IV infusion of 3 g piperacillin/0.375 g tazobactam.

There are no significant changes in piperacillin pharmacokinetics due to tazobactam.

Tazobactam and its M1 metabolite are eliminated primarily by renal excretion. The magnitude of renal clearance of each compound suggests renal excretion is via glomerular filtration and net active tubular secretion. Urinary excretion of tazobactam is decreased in the presence of piperacillin, presumably due to competition for renal tubular secretion. Urinary concentrations generally exceeded 200 mcg/mL over the dosing interval after a 30 minute IV infusion of 3 g piperacillin/0.375 g tazobactam.

Following an IV infusion of 3 g piperacillin and 0.375 g tazobactam (60 microcuries), recovery of total radioactivity in urine and feces over the 5 day collection period was 94%. The majority (84%) of the radioactivity was recovered in urine within 6 hours postdose. Fecal recovery of radioactivity was <1% of the dose.

#### Protein Binding

Both piperacillin and tazobactam are approximately 30% bound to plasma proteins. The binding of both tazobactam and piperacillin was not affected by the presence of the other compound. The protein binding of M1 was negligible (< 3%) in human plasma.

#### Elimination Half-Life

In healthy subjects, following single or multiple doses, the plasma elimination T<sub>1/2</sub> of tazobactam and piperacillin ranged from 0.7 to 1.2 hours and was independent of dose level and duration of infusion. Given concomitantly, piperacillin T<sub>1/2</sub> was unchanged, whereas an increase of about 18% in tazobactam T<sub>1/2</sub> was observed. Following an IV infusion of 3 g piperacillin and 0.377 g <sup>14</sup>C-tazobactam (60 microcuries), the T<sub>1/2</sub> of total radioactivity in plasma was 3.2 hours reflecting the elimination of M1.

Piperacillin appears to reduce the rate of elimination of tazobactam.

#### Renal/Hepatic Impairment

Mean plasma concentrations of piperacillin and tazobactam in subjects with decreased renal

impairment are shown in Table 2 (A, B). With decreasing renal function from  $CL_{cr} >90$  to  $<20$  mL/min., peak plasma concentrations of both piperacillin and tazobactam increased approximately 30%, while the mean  $C_{max}$  of the M1 metabolite increased about 4-fold. Plasma clearance of piperacillin and tazobactam was decreased (up to 2.7- and 4.4-fold, respectively) and  $T_{1/2}$  increased (up to 2- and 4-fold, respectively) as renal function decreased. Dosage regimen adjustments are recommended at  $CL_{cr} <40$  mL/min.

**TABLE 2 (A, B)**

**MEAN PLASMA CONCENTRATION IN SUBJECTS WITH DECREASED RENAL FUNCTION FOLLOWING A 30 MINUTE INTRAVENOUS INFUSION**

**A) TAZOBACTAM**

Creatinine Clearance	Time (hours)								
	0.5	1	2	3	4	6	8	12	24
>90	23.6	12.5	5.2	2.3	1.3	BQL	BQL	BQL	BQL
60-90	29.4	16.7	8.1	4.7	3.0	1.6	BQL	BQL	BQL
40-59	31.5	19.5	11.0	7.3	4.9	2.4	1.6	BQL	BQL
20-39	28.8	21.1	14.9	10.6	7.6	4.0	2.2	1.4	BQL
<20	31.5	24.4	18.2	14.7	12.1	8.2	5.4	3.3	2.3

**B) PIPERACILLIN**

Creatinine Clearance	Time (hours)								
	0.5	1	2	3	4	6	8	12	24
>90	209	96.3	35.8	15.0	7.2	2.1	1.2	BQL	BQL
60-90	235	138	57.2	27.8	15.0	4.7	1.1	BQL	BQL
40-59	288	154	80.0	45.4	27.0	9.2	3.8	1.4	BQL
20-39	245	165	92.1	53.9	30.6	10.4	4.1	1.5	BQL
<20	253	179	120.0	84.3	56.3	28.8	15.9	6.0	1.4

BQL: Below Quantifiable Limit

Hemodialysis removed approximately 30 to 40% of the piperacillin and tazobactam doses, M1 was removed from the systemic circulation similarly to tazobactam. To maintain pre-dialysis plasma concentrations an additional one-third of the piperacillin/tazobactam unit dose is recommended following hemodialysis therapy. On average, peritoneal dialysis removed up to 6% and 21% of the dose for piperacillin and tazobactam with up to 16% of the tazobactam dose removed as M1. For dosage recommendations for patients undergoing hemodialysis, see DOSAGE AND ADMINISTRATION.

The single dose pharmacokinetic profiles of piperacillin and tazobactam are affected by cirrhosis with significantly lower  $CL_T$  (29%) and longer  $T_{1/2}$  (25%) for piperacillin. Similar changes in tazobactam  $CL_T$  (25%) and  $T_{1/2}$  (18%) were observed, although only the difference in  $CL_T$  was significant. Since the predicted steady-state plasma concentrations of both compounds after multiple dosing were only 10% different between cirrhotic and normal subjects, no adjustment in

dosage regimen is recommended due to cirrhosis.

### **Drug Interactions**

Probenecid, tobramycin and vancomycin were investigated for potential pharmacokinetic interaction with piperacillin/tazobactam.

Co-administration of a 1 g oral dose of probenecid did not significantly change  $C_{max}$  but lowered  $CL_R$  (20 to 25%) and increased  $T_{1/2}$  for piperacillin by 21% and tazobactam by 71%. Coadministration of probenecid did not result in any significant increase in the plasma concentration of piperacillin/tazobactam.

Vancomycin (500 mg) given as a 60 minute infusion prior to piperacillin/tazobactam did not significantly change the pharmacokinetic profiles for either piperacillin or tazobactam. Similarly, no significant change in vancomycin pharmacokinetics was observed.

These studies indicate that adjustment in dosage regimen for piperacillin/tazobactam, tobramycin or vancomycin is not warranted when these compounds are co-administered.

### **Neutropenic**

In neutropenic subjects, after 30 minute infusions of 3 g piperacillin/0.375 g tazobactam every 4 hours for 5 days, the elimination  $T_{1/2}$  was 40 to 80% longer and  $CL_T$  was 20 to 40% lower for both piperacillin and tazobactam. After multiple dosing, the mean  $C_{max}$  and  $AUC_{0-4}$  values were about 40% higher than after the first dose. However, this difference is not large enough to warrant adjustment of the dosage regimen in neutropenic patients.

## **MICROBIOLOGY**

Piperacillin sodium exerts bactericidal activity by inhibiting septum formation and cell wall synthesis of susceptible bacteria. Piperacillin and other  $\beta$ -lactam antibiotics block the terminal transpeptidation step of cell wall peptidoglycan biosynthesis in susceptible organisms by interacting with the penicillin binding proteins (PBPs), the bacterial enzymes that carry out this reaction. *In vitro*, piperacillin is active against a variety of gram-positive and gram-negative aerobic and anaerobic bacteria. Tazobactam sodium, which has very little intrinsic microbiologic activity due to its very low level of binding to penicillin-binding proteins, is a  $\beta$ -lactamase inhibitor of the Richmond-Sykes class III (Bush class 2b & 2b') penicillinases and cephalosporinases. It varies in its ability to inhibit class II and IV (2a & 4) penicillinases. Tazobactam does not induce chromosomally-mediated  $\beta$ -lactamases at tazobactam levels achieved with the recommended dosing regimen.

### **Mechanism of resistance:**

There are three major mechanisms of resistance to  $\beta$ -lactam antibiotics: changes in the target PBPs resulting in reduced affinity for the antibiotics, destruction of the antibiotics by bacterial  $\beta$ -lactamases, and low intracellular antibiotic levels due to reduced uptake or active efflux of the antibiotics.

In gram-positive bacteria, changes in PBPs are the primary mechanism of resistant to  $\beta$ -lactam antibiotics, including piperacillin/tazobactam. This mechanism is responsible for methicillin resistance in staphylococci and penicillin resistance in *Streptococcus pneumoniae* and viridans group streptococci. Resistance caused by changes in PBPs also occurs in fastidious gram-negative species such as *Haemophilus influenzae* and *Neisseria gonorrhoeae*.

Piperacillin/tazobactam is not active against strains in which resistance to  $\beta$ -lactam antibiotics is determined by altered PBPs. As indicated above, there are some  $\beta$ -lactamases that are not inhibited by tazobactam.

### **Spectrum of Activity**

Piperacillin/tazobactam has been shown to be **active against most strains** of the following microorganisms both *in vitro* and in clinical infections as described in the INDICATIONS AND CLINICAL USE section.

#### **Aerobic and facultative gram-positive microorganisms:**

*Staphylococcus aureus* (methicillin-susceptible strains only)

#### **Aerobic and facultative gram-negative microorganisms:**

*Acinetobacter baumannii*

*Escherichia coli*

*Haemophilus influenzae* (excluding  $\beta$ -lactamase negative, ampicillin-resistant isolates)

*Klebsiella pneumoniae*

*Pseudomonas aeruginosa* (given in combination with an aminoglycoside to which the isolate is susceptible)

Gram-negative anaerobes:

*Bacteroides fragilis* group (*B. fragilis*, *B. ovatus*, *B. thetaiotaomicron*, and *B. vulgatus*)

The following *in vitro* data are available, **but their clinical significance is unknown.**

At least 90% of the following microorganisms exhibit an *in vitro* minimum inhibitory concentration (MIC) less than or equal to the susceptible breakpoint for piperacillin/tazobactam. However, the safety and effectiveness of piperacillin/tazobactam in treating clinical infections due to these bacteria have not been established in adequate and well-controlled clinical trials.

#### **Aerobic and facultative gram-positive microorganisms:**

*Enterococcus faecalis* (ampicillin or penicillin-susceptible isolates only)

*Staphylococcus epidermidis* (methicillin-susceptible isolates only)

*Streptococcus agalactiae*<sup>†</sup>

*Streptococcus pneumoniae*<sup>†</sup> (penicillin-susceptible isolates only)

*Streptococcus pyogenes*<sup>†</sup>

Viridans group streptococci<sup>†</sup>

#### **Aerobic and facultative gram-negative microorganisms:**

*Citrobacter koseri*

*Moraxella catarrhalis*

*Morganella morganii*  
*Neisseria gonorrhoeae*  
*Proteus mirabilis*  
*Proteus vulgaris*  
*Serratia marcescens*  
*Providencia stuartii*  
*Providencia rettgeri*  
*Salmonella enterica*

**Gram-positive anaerobes:**

*Clostridium perfringens*

**Gram-negative anaerobes:**

*Bacteroides distasonis*  
*Prevotella melaninogenica*

† These are not  $\beta$ -lactamase producing bacteria and, therefore, are susceptible to piperacillin alone.

**Susceptibility Testing Methods**

As is recommended with all antimicrobials, the results of in vitro susceptibility tests, when available, should be provided to the physician as periodic reports, which describe the susceptibility profile of nosocomial and community-acquired pathogens. These reports should aid the physician in selecting the most effective antimicrobial.

**Dilution Techniques:**

Quantitative methods are used to determine antimicrobial minimum inhibitory concentrations (MICs). These MICs provide estimates of the susceptibility of bacteria to antimicrobial compounds. The MICs should be determined using a standardized procedure. Standardized procedures are based on a dilution method (broth or agar) or equivalent with standardized inoculum concentrations and standardized concentrations of piperacillin and tazobactam powders.<sup>23,24</sup> MIC values should be determined using serial dilutions of piperacillin combined with a fixed concentration of 4 mcg/mL tazobactam. For anaerobic bacteria, the susceptibility to piperacillin/tazobactam can be determined by the reference agar dilution method.<sup>25</sup> The MIC values obtained should be interpreted according to criteria provided in Table 3.

**Diffusion Techniques:**

Quantitative methods that require measurement of zone diameters also provide reproducible estimates of the susceptibility of bacteria to antimicrobial compounds. One such standardized procedure<sup>23,26</sup> requires the use of standardized inoculum concentrations. This procedure uses paper disks impregnated with 100 mcg of piperacillin and 10 mcg of tazobactam to test the susceptibility of microorganisms to piperacillin/tazobactam. The disk diffusion interpretation criteria are provided in Table 3.

TABLE 3 Susceptibility Interpretive Criteria for Piperacillin/Tazobactam						
Pathogen	Minimal Inhibitory Concentration (MIC) in mg/L of Piperacillin <sup>a</sup>			Disk <sup>b</sup> Diffusion Inhibition Zone (Diameter in mm)		
	S	I	R	S	I	R
<i>Enterobacteriaceae</i> and <i>Acinetobacter baumannii</i>	≤ 16	32 - 64	≥ 128	≥ 21	18 - 20	≤ 17
<i>Pseudomonas aeruginosa</i>	≤ 16	32 - 64	≥ 128	≥ 21	15 - 20	≤ 14
<i>Haemophilus influenzae</i> <sup>c</sup>	≤ 1	-	≥ 2	≥ 21	-	-
<i>Staphylococcus aureus</i>	≤ 8	-	≥ 16	≥ 18	-	≤ 17
<i>Bacteroides fragilis</i> group <sup>d</sup>	≤ 32	64	≥ 128	-	-	-

S = Susceptible. I = Intermediate. R = Resistant.  
<sup>a</sup> MICs are determined using a fixed concentration of 4 mg/L tazobactam  
<sup>b</sup> Interpretive criteria are based on disks containing 100 mcg of piperacillin and 10 mcg of tazobactam.  
<sup>c</sup> These interpretive criteria for *Haemophilus influenzae* are applicable only to tests performed using Haemophilus Test Medium inoculated with a direct colony suspension and incubated at 35°C in ambient air for 20 to 24 hours.  
<sup>d</sup> With the exception of *Bacteroides fragilis* itself MICs are determined by agar dilution only.

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

### Quality Control

Standardized susceptibility test procedures require the use of quality control microorganisms to control the technical aspects of the test procedures.<sup>23,24,25,26</sup> Standard piperacillin/tazobactam lyophilized powder should provide the following ranges of values noted in **Table 4**. Quality control microorganisms are specific strains with intrinsic biological properties relating to resistance mechanisms and their genetic expression within the microorganism; the specific strains used for susceptibility test quality control are not clinically significant.

**TABLE 4 QUALITY CONTROL RANGES FOR PIPERACILLIN/TAZOBACTAM TO BE USED IN CONJUNCTION WITH SUSCEPTIBILITY TEST INTERPRETIVE CRITERIA**

Quality Control Strain	Minimal Inhibitory Concentration Range in mg/L of piperacillin	Disk Diffusion Inhibition Zone Diameter Range in mm
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**TABLE 4 QUALITY CONTROL RANGES FOR PIPERACILLIN/TAZOBACTAM TO BE USED IN CONJUNCTION WITH SUSCEPTIBILITY TEST INTERPRETIVE CRITERIA**

Quality Control Strain	Minimal Inhibitory Concentration Range in mg/L of piperacillin	Disk Diffusion Inhibition Zone Diameter Range in mm
<i>Escherichia coli</i> ATCC 25922	1 – 4	24 - 30
<i>Escherichia coli</i> ATCC 35218	0.5 – 2	24 - 30
<i>Pseudomonas aeruginosa</i> ATCC 27853	1 - 8	25 - 33
<i>Haemophilus influenzae</i> <sup>a</sup> ATCC 49247	0.06 – 0.5	33 - 38
<i>Staphylococcus aureus</i> ATCC 29213	0.25 – 2	-
<i>Staphylococcus aureus</i> ATCC 25923	-	27 - 36
<i>Bacteroides fragilis</i> ATCC 25285	12 – 0.5 <sup>b</sup>	-
<i>Bacteroides thetaiotaomicron</i> ATCC 29741	4 – 16 <sup>b</sup>	-

<sup>a</sup> This quality control range for *Haemophilus influenzae* is applicable only to tests performed using Haemophilus Test Medium inoculated with a direct colony suspension and incubated at 35°C in ambient air for 20 to 24 hours.

<sup>b</sup> Agar dilution only.

## TOXICOLOGY

### Acute Toxicity

In mice (10/sex), IV doses of 2000:500 mg/kg of piperacillin:tazobactam resulted in no mortality and no signs of toxicity or treatment-related effects while 4000:1000 mg/kg of piperacillin:tazobactam resulted in death in 1 of 10 male mice and 5 of 10 female mice within 6 hours after dosing. At this dose, muscular hypertonia, tachypnea and convulsions were observed. In mice, IV doses of 4500:562.5 mg/kg of piperacillin:tazobactam resulted in death of 2 of 10 males within 6 hours and 3 of 10 females (2 females died 2 days and 1 female died 7 days after dosing). At this dose, shallow and frequent respiration, muscular hypertonia, reduced mobility and convulsions were observed. In mice (10/sex), IV doses of tazobactam up to 3500 mg/kg resulted in no mortality and no signs of toxicity or treatment related effects while an IV piperacillin dose of 4500 mg/kg in mice resulted in death in 4 of 10 females within 6 hours after dosing. At this dose, shallow and frequent respiration, muscular hypertonia, reduced mobility and convulsions were observed. In 1 of 10 male mice, the right kidney was white in colour. In addition, partial papillary necrosis and partial tubular necrosis of the cortex accompanied by mononuclear leucocyte infiltration were observed.

In rats, IV doses of piperacillin:tazobactam resulted in death in 7 of 10 females at 2000:250 mg/kg, in 3 of 10 males at 2200:275 mg/kg, and in 10 of 10 males and 9 of 10 females at 2400:300 mg/kg, within 6 hours after dosing. In rats dosed IV, shallow and frequent respiration, muscular hypertonia, staggering, and convulsions were observed. Following administration of IP doses of 4000:1000 mg/kg of tazobactam:piperacillin, there was no mortality. At this IP dose, transient wet perianal area and decreased body-weight gain and food consumption in male rats occurred during the first week after dosing. Distended cecum occurred in two females.

In rats, IV doses of piperacillin resulted in death in 8 of 10 females at 1000 mg/kg (twice daily), 4 of 10 males and 8 of 10 females at 2200 mg/kg, and 8 of 10 males and 9 of 10 females at 2400 mg/kg, within 6 hours after dosing. At these doses, shallow and frequent respiration, muscular hypertonia, staggering and convulsions occurred. Following administration of IP doses of 5000 mg/kg of tazobactam, there was no mortality. At this dose, transient wet perianal area and decreased body-weight gain and food consumption in male and/or female rats occurred during the first week after dosing.

In dogs (1/sex), IV doses resulted in salivation at 2600:330 mg/kg of piperacillin:tazobactam; emesis, salivation and conjunctival congestion at 4000:500 mg/kg of piperacillin:tazobactam; and death in 1 male and 1 female within 2 hours after dosing at 5200:650 mg/kg of piperacillin:tazobactam.

In dogs, IV doses of tazobactam at 3000 or 5000 mg/kg resulted in no deaths. At these doses, erythema, edema, emesis, loose stools, slight changes in hematology (decreased red blood cell parameters, platelets and lymphocytes) and in serum chemistry (decreased potassium and increased AST) parameters occurred. In addition, salivation occurred at 3000 mg/kg of tazobactam and decreased motor activity occurred at 5000 mg/kg of tazobactam. An IV dose of 5200 mg/kg of piperacillin resulted in no deaths. At this dose, emesis and salivation occurred.

### **Long-Term Toxicity**

Long-term toxicity studies in the rat and dog established target organ toxicity. In both species, altered hepatocellular glycogen distribution, a well-known effect of  $\beta$ -lactamase inhibitors, was observed. This finding occurred in drug-treated rats in 5-day, 1-, 3-, and 6-month studies at doses  $\geq 80$  mg/kg/day of tazobactam alone or in combination with piperacillin. In dogs, it occurred with tazobactam alone or in combination with piperacillin at 3000 mg/kg/day for 5 days,  $\geq 40$  mg/kg/day for 1 and 3 months and  $\geq 80$  mg/kg/day for 6 months. Additionally, enlarged ceca were observed in rats. Enlarged ceca, caused by suppression of intestinal microflora, is a non-specific effect of antimicrobials in rodents. Other drug-related effects observed in rats and dogs in long-term toxicity studies were decreased red blood cell parameters and decreased cholesterol and serum triglycerides.

Decreased platelets and total protein, and increased alkaline phosphatase, ALT, and AST were also seen in dogs. The effect on red blood cell parameters, cholesterol and triglyceride levels, and altered distribution of hepatocellular glycogen were reversible or diminished following a recovery period.

### **Genotoxicity and Carcinogenicity**

Long-term studies in animals to evaluate carcinogenic potential have not been performed with piperacillin/tazobactam, piperacillin or tazobactam.

### **Piperacillin/tazobactam:**

Piperacillin/tazobactam was negative in microbial mutagenicity assays at concentrations up to 14.84/1.86 mcg/plate. Piperacillin/tazobactam was negative in the unscheduled DNA synthesis (UDS) test at concentrations up to 5689/711 mcg/mL. Piperacillin/tazobactam was negative in a mammalian point mutation (Chinese hamster ovary cell HPRT) assay at concentration up to

8000/1000 mcg/mL. Piperacillin/tazobactam was negative in a mammalian cell (BALB/c-3T3) transformation assay at concentrations up to 8/1 mcg/mL. *In vivo*, piperacillin/tazobactam did not induce chromosomal aberrations in rats dosed IV with 1500/187.5 mg/kg; this dose is similar to the maximum recommended human daily dose on a body-surface-area basis ( $\text{mg}/\text{m}^2$ ).

### **Piperacillin:**

Piperacillin was negative in microbial mutagenicity assays at concentrations up to 50 mcg/plate. There was no DNA damage in bacteria (Rec assay) exposed to piperacillin at concentrations up to 200 mcg/disc. Piperacillin was negative in the UDS test at concentrations up to 10,000 mcg/mL, which is 26 times the human plasma concentration of piperacillin. In mammalian point mutation (mouse lymphoma cells) assay, piperacillin was positive at concentrations  $\geq 2500$  mcg/mL, which is 7 times the human plasma concentration. Piperacillin was negative in a cell (BALB/c-3T3) transformation assay at concentrations up to 3000 mcg/mL, which is 8 times the human plasma concentration. *In vivo*, piperacillin did not induce chromosomal aberrations in mice at IV doses up to 2000 mg/kg/day or rats at IV doses up to 1500 mg/kg/day. These doses are 6 (mice) and 4 (rats) times the maximum recommended human daily dose based on body weight, and half (mice) or similar to (rats) the human dose based on body-surface area ( $\text{mg}/\text{m}^2$ ). In another *in vivo* test, there was no dominant lethal effect when piperacillin was given to rats at IV doses up to 2000 mg/kg/day, which is similar to the human dose based on body-surface area. When mice were given piperacillin at IV doses up to 2000 mg/kg/day, which is half the human dose based on body-surface area ( $\text{mg}/\text{m}^2$ ), urine from these animals was not mutagenic when tested in a microbial mutagenicity assay. Bacteria injected into the peritoneal cavity of mice given piperacillin at IV doses up to 2000 mg/kg/day did not show increased mutation frequencies.

### **Tazobactam:**

Tazobactam was negative in microbial mutagenicity assays at concentrations up to 333 mcg/plate. Tazobactam was negative in the UDS test at concentrations up to 2000 mcg/mL. Tazobactam was negative in a mammalian point mutation (Chinese hamster ovary cell HPRT) assay at concentrations up to 5000 mcg/mL. In another mammalian point mutation (mouse lymphoma cells) assay, tazobactam was positive at concentrations  $\geq 3000$  mcg/mL. Tazobactam was negative in a cell (BALB/c-3T3) transformation assay at concentrations up to 900 mcg/mL. In an *in vitro* cytogenetics (Chinese hamster lung cells) assay, tazobactam was negative at concentrations up to 3000 mcg/mL. *In vivo*, tazobactam did not induce chromosomal aberrations in rats at IV doses up to 5000 mg/kg, which is 23 times the human dose based on body-surface area ( $\text{mg}/\text{m}^2$ ).

### **Reproductive and Development Toxicity**

A fertility and general reproduction study in rats using intraperitoneal administration of tazobactam or the combination piperacillin/tazobactam reported a decrease in litter size and an increase in fetuses with ossification delays and variations of ribs (skeletal anomalies such as delays in bone ossification), concurrent with maternal toxicity. Fertility of the F1 generation and embryonic development of F2 generation were not impaired.

Teratogenicity studies using intravenous administration of tazobactam or the combination

piperacillin/tazobactam in mice and rats resulted in slight reductions in rat fetal weights at maternally toxic doses but did not show teratogenic effects.

Peri/postnatal development was impaired (reduced pup weights, increase in stillbirths, increase in pup mortality) concurrent with maternal toxicity after intraperitoneal administration of tazobactam or the combination piperacillin/tazobactam in the rat.

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**READ THIS FOR SAFE AND EFFECTIVE USE OF YOUR MEDICINE**

**PATIENT MEDICATION INFORMATION**

**PrJAMP-PIP/TAZ**

**Sterile piperacillin sodium/tazobactam sodium Lyophilized Powder for Injection  
For Intravenous Use Only**

Read this carefully before you start taking JAMP-PIP/TAZ and each time you get a refill. This leaflet is a summary and will not tell you everything about JAMP-PIP/TAZ. Talk to your healthcare professional about your medical condition and treatment and ask if there is any new information about JAMP-PIP/TAZ.

**Serious Warnings and Precautions**

**Notify your doctor if you are allergic to penicillin, cephalosporins or other allergens. If you have an allergic reaction during therapy with JAMP-PIP/TAZ stop taking the drug and seek immediate medical attention.**

**What is JAMP-PIP/TAZ used for?**

JAMP-PIP/TAZ is used by doctors to treat bacterial infections:

- of the appendix and lining of the abdomen (peritoneum)
- of the skin
- of the female reproductive system
- of the lungs and lower airways that are community- or hospital-acquired

Antibacterial drugs like JAMP-PIP/TAZ treat only bacterial infections. They do not treat viral infections. Although you may feel better early in treatment, JAMP-PIP/TAZ should be used exactly as directed. Misuse or overuse of JAMP-PIP/TAZ could lead to the growth of bacteria that will not be killed by JAMP-PIP/TAZ (resistance). This means that JAMP-PIP/TAZ may not work for you in the future.

**How does JAMP-PIP/TAZ work?**

This product is an injectable antibiotic that contains piperacillinsodium and tazobactam sodium. Both ingredients work together to kill the bacteria and reduce the infection.

**What are the ingredients in JAMP-PIP/TAZ?**

Medicinal ingredients: Piperacillin Sodium and Tazobactam Sodium.

Non-medicinal ingredients: None.

**JAMP-PIP/TAZ comes in the following dosage forms:**



Lyophilized powder for injection available glass vials as:

- 4.5 g (4 g piperacillinsodium / 0.5 g tazobactam sodium)

**Do not use JAMP-PIP/TAZ if:**

- you are allergic to any ingredient in the drug
- you are allergic to any of the penicillins, cephalosporins or beta-lactamase inhibitors

**To help avoid side effects and ensure proper use, talk to your healthcare professional before you take JAMP-PIP/TAZ. Talk about any health conditions or problems you may have, including if you:**

- are allergic to JAMP-PIP/TAZ, penicillin, cephalosporins or beta-lactamase inhibitors
- have cystic fibrosis
- have a history of diarrhea or bowel problems due to an antibiotic
- have kidney, liver or gallbladder problems
- have bleeding problems
- are pregnant, planning to become pregnant or are breastfeeding. Piperacillin is excreted at low levels in human milk
- are over 65 years and have kidney, liver or heart problems
- are on a low sodium diet. This product contains sodium
- have low blood potassium levels
- are receiving cytotoxic therapy or methotrexate (for the treatment of cancer)
- are taking diuretics (drugs that increase urine production)
- are taking blood thinners (e.g. heparin) or any medicines that may affect blood clot formation
- are being treated for gonorrhea

**Other Warnings:**

Stop taking this product and contact your doctor right away if the following occurs:

- severe or lasting diarrhea (watery or bloody) with or without fever, stomach pain, or tenderness.

You may have Clostridium difficile colitis (bowel inflammation)

**Tell your healthcare professional about all the medicines you take, including any drugs, vitamins, minerals, natural supplements or alternative medicines.**

**The following may interact with JAMP-PIP/TAZ:**

- Aminoglycosides (a type of antibiotic, e.g. tobramycin)
- Probenecid (a drug used to treat gout)
- Drugs used to thin blood (e.g. Heparin)
- Vecuronium (a muscle relaxant)
- Methotrexate (a drug used to treat cancer)

### **How to take JAMP-PIP/TAZ:**

JAMP-PIP/TAZ **will be given to you intravenously by your doctor.**

### **Usual dose:**

Your doctor will give you the most appropriate dose based on the severity and type of your bacterial infection. If you have kidney problems or are taking medications that may interact with JAMP-PIP/TAZ, your doctor will adjust the dose.

The usual dose of JAMP-PIP/TAZ for adults is 3 g / 0.375 g, given every six hours, for a total dose of 12 g / 1.5 g per day.

For intra-abdominal infections, the dose of JAMP-PIP/TAZ for adults is 4 g / 0.5 g, given every eight hours, for a total dose of 12 g / 1.5 g per day.

For hospital-acquired pneumonia, the dose of JAMP-PIP/TAZ for adults is 4 g / 0.5 g, plus an aminoglycoside (type of antibiotic) every six hours, for a total dose of 16 g / 2 g per day.

### **Overdose:**

Symptoms of overdose include:

- nausea, vomiting, diarrhea
- neuromuscular excitability (increased sensitivity of muscles and nerves)
- convulsions (involuntary contractions of the muscles)

If you think you have taken too much JAMP-PIP/TAZ, contact your healthcare professional, hospital emergency department or regional Poison Control Centre immediately, even if there are no symptoms.

### **Missed Dose:**

Talk to your doctor if you suspect a missed dose.

### **What are possible side effects from using JAMP-PIP/TAZ?**

These are not all the possible side effects you may feel when taking JAMP-PIP/TAZ. If you experience any side effects not listed here, contact your healthcare professional.

Side effects may include:

- nausea or indigestion
- vomiting
- diarrhea or constipation
- rash, itchy or red skin
- allergic reaction such as hives
- a new infection caused by bacteria that are resistant to JAMP-PIP/TAZ (superinfection)
- difficulty sleeping
- headache, dizziness or lightheadedness
- anxiety, sweating, agitation
- shortness of breath
- chest pain
- abdominal pain or swelling
- fever
- pain

These are not all the possible side effects you may feel when taking JAMP-PIP/TAZ. If you experience any side effects not listed here, contact your healthcare professional. Please also see Warnings and Precautions.

<b>SERIOUS SIDE EFFECTS AND WHAT TO DO ABOUT THEM</b>				
<b>Symptom / effect</b>		<b>Talk to your healthcare professional</b>		<b>Stop taking drug and get immediate medical help</b>
		<b>Only if severe</b>	<b>In all cases</b>	
<b>COMMON</b>	Chest pain		✓	
	Diarrhea			✓
<b>LESS COMMON</b>	Confusion		✓	
	Convulsions		✓	
	Hallucinations		✓	
	Jaundice (yellowing of skin or eyes)		✓	

<b>SERIOUS SIDE EFFECTS AND WHAT TO DO ABOUT THEM</b>				
<b>Symptom / effect</b>		<b>Talk to your healthcare professional</b>		<b>Stop taking drug and get immediate medical help</b>
		<b>Only if severe</b>	<b>In all cases</b>	
<b>RARE</b>	Allergic reactions such as: Chest tightness, dizziness, faintness, hives, itching, shortness of breath, severe skin rash, peeling or blistering skin, swollen face, lips, mouth or tongue, troubled breathing, wheezing		✓	

If you have a troublesome symptom or side effect that is not listed here or becomes bad enough to interfere with your daily activities, talk to your healthcare professional.

### **Reporting Side Effects**

You can report any suspected side effects associated with the use of health products to Health Canada by:

- Visiting the Web page on [Adverse Reaction Reporting](https://www.canada.ca/en/health-canada/services/drugs-health-products/medeffect-canada/adverse-reaction-reporting.html) (<https://www.canada.ca/en/health-canada/services/drugs-health-products/medeffect-canada/adverse-reaction-reporting.html>) for information on how to report online, by mail or by fax; or
- Calling toll-free at 1-866-234-2345

*NOTE: Contact your health professional if you need information about how to manage your side effects. The Canada Vigilance Program does not provide medical advice.*

### **Storage:**

JAMP-PIP/TAZ vials should be stored at controlled room temperature between 15°C and 30°C.

For single dose vial discard unused portions.

Keep out of reach and sight of children.

**If you want more information about JAMP-PIP/TAZ:**

- Talk to your healthcare professional
- Find the full Product Monograph that is prepared for healthcare professionals and includes this Patient Medication Information by visiting the Health Canada website (<https://health-products.canada.ca/dpd-bdpp/index-eng.jsp>); or by calling 1-866-399-9091.

This leaflet was prepared by  
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