FRONT

VITAC01-var (SIN)

Tacrocord™ Capsules

DESCRIPTION

Tacrocord 0.5 Capsules 0.5mg:
Opaque light yellow color, size "4" hard gelatin capsules imprinted with "C5" "0.5mg" on cap with black ink, containing white to off white granular powder.

Tacrocord 1 Capsules 1mg:
Opaque white color, size "4" hard gelatin capsules imprinted with "C6" "1mg" on cap with black ink, containing white to off white granular powder.

Tacrocord 5 Capsules 5mg:
Opaque grayish red color, size "4" hard gelatin capsules imprinted with "C7" "5mg" on cap with black ink, containing white to off white granular powder.

COMPOSITION

Tacrocord 0.5 Capsules 0.5mg:
Each hard gelatin capsule contains: Tacrolimus 0.5mg
Excipients: Croscarmellose sodium, hypromellose, anhydrous lactose, magnesium stearate, iron oxide yellow, titanium dioxide, gelatin and printing ink (Black Ink: Shellac, Black Iron Oxide and Potassium Hydroxide).

Tacrocord 1 Capsules 1mg:
Each hard gelatin capsule contains: Tacrolimus 1mg
Excipients: Croscarmellose sodium, hypromellose, anhydrous lactose, magnesium stearate, titanium dioxide, gelatin and printing ink (Black Ink: Shellac, Black Iron Oxide and Potassium Hydroxide).

Tacrocord 5 Capsules 5mg:
Each hard gelatin capsule contains: Tacrolimus 5mg
Excipients: Croscarmellose sodium, hypromellose, anhydrous lactose, magnesium stearate, iron oxide red, titanium dioxide, gelatin and printing ink (Black Ink: Shellac, Black Iron Oxide and Potassium Hydroxide).

PHARMACODYNAMICS

Tacrolimus belongs to drug class immunosuppressants and calcineurin inhibitors. At the molecular level, the effects of tacrolimus appear to be mediated by binding to a cytosolic protein (FKBP12) which is responsible for the intracellular accumulation of the compound. The FKBP12-tacrolimus complex specifically and competitively binds to and inhibits calcineurin, leading to a calcium-dependent inhibition of T-cell signal transduction pathways, thereby preventing transcription of a discrete set of lymphokine genes. Tacrolimus is a highly potent immunosuppressive agent and has proven activity in both *in vitro* and *in vivo* experiments. In particular, tacrolimus inhibits the formation of cytotoxic lymphocytes, which are mainly responsible for graft rejection. Tacrolimus suppresses T-cell activation and T-helper-cell dependent B-cell proliferation, as well as the formation of lymphokines (such as interleukins-2, -3, and γ-interferon) and the expression of the interleukin-2 receptor.

PHARMACOKINETICS

Absorption
Tacrolimus has been shown to be able to be absorbed throughout the gastrointestinal tract. Following oral administration, peak concentrations (C_{max}) of tacrolimus in blood are achieved in approximately 1 - 3 hours. Tacrolimus appears to be continuously absorbed over a prolonged period yielding a relatively flat absorption profile. The mean oral bioavailability of tacrolimus is in the range of 20% - 25%. After oral administration (0.30mg/kg/day) to liver transplant patients, steady state concentrations of tacrolimus were achieved within 3 days in most patients.

The rate and extent of absorption of tacrolimus is greatest under fasted conditions. The presence of food decreases both the rate and extent of absorption of tacrolimus, the effect being most pronounced after a high-fat meal. The effect of a high-carbohydrate meal is less pronounced. Bile flow does not influence the absorption of tacrolimus and therefore commencement of tacrolimus therapy with an oral dose or early conversion of liver transplant patients from intravenous to oral therapy is possible. There is strong correlation between the area under the curve (AUC) and the whole blood trough levels at steady state. Thus monitoring of whole blood trough levels provides a good estimate of systemic exposure.

Distribution and Elimination
In the systemic circulation, tacrolimus binds strongly to erythrocytes resulting in an approximate 20:1 distribution ratio of whole blood/plasma concentrations. In plasma, tacrolimus is highly bound (> 98.8%) to plasma proteins, mainly to serum albumin and α-1-acid glycoprotein.

Tacrolimus is extensively distributed in the body. Tacrolimus is a low-clearance substance. Factors such as low haematocrit and protein levels, which result in an increase in the unbound fraction of tacrolimus, or corticosteroid-induced increased metabolism are considered to be responsible for the higher clearance rates observed following transplantation.

The half-life of tacrolimus is long and variable. In healthy subjects, the mean half-life in whole blood is approximately 43 hours. In adult and paediatric liver transplant patients, it averaged 11.7 hours and 12.4 hours, respectively, compared with 15.6 hours in adult kidney transplant recipients. Increased clearance rates contribute to the shorter half-life observed in transplant recipients.

Metabolism and Biotransformation
Tacrolimus is widely metabolised in the liver, primarily by the cytochrome P450-3A4. Tacrolimus is also considerably metabolised in the intestinal wall. There are several metabolites identified. Only one of these has been shown *in vitro* to have immunosuppressive activity similar to that of tacrolimus. The other metabolites have only weak or no immunosuppressive activity. In systemic circulation only one of the inactive metabolites is present at low concentrations. Therefore, metabolites do not contribute to pharmacological activity of tacrolimus.

Excretion
Tacrolimus is almost completely metabolised prior to elimination, bile being the principal route of elimination.

Preclinical Safety Data
Embryotoxicity was observed in animal studies. Tacrolimus subcutaneously administered to male rats at a doses of 2 or 3 mg/kg/day (1.6 to 6.4 times the clinical dose range based on body surface area) resulted in a dose-related decrease in sperm count. Tacrolimus given orally at 1.0 mg/kg (0.8 to 2.2 times the clinical dose range based on body surface area) to male and female rats, prior to and during mating, as well as to dams during gestation and lactation, was associated with embryolethality and adverse effects on female reproduction which were indicated by a higher rate of post-implantation loss and increased numbers of undelivered and nonviable pups. When given at 3.2 mg/kg (2.6 to 6.9 times the clinical dose range based on body surface area), tacrolimus was associated with maternal and paternal toxicity as well as reproductive toxicity including marked adverse effects on estrus cycles, parturition, pup viability, and pup malformations.

INDICATIONS

Primary immunosuppression in liver and kidney allograft recipients and liver and kidney allograft rejection resistant to conventional immunosuppressive agents.

CONTRAINDICATIONS

Tacrocord should not be given to:
- Hypersensitivity to tacrolimus or other macrolides
- Hypersensitivity to any of the excipients of Tacrocord

WARNINGS AND PRECAUTIONS

Patients should be maintained on a single formulation of tacrolimus with the corresponding daily dosing regimen; alterations in formulation or regimen should only take place under the close supervision of a transplant specialist.

During the initial post-transplant period, monitoring of the following parameters should be undertaken on a routine basis: blood pressure, ECG, neurological and visual status, fasting blood glucose levels, electrolytes (particularly potassium), liver and renal function tests, haematology parameters, coagulation values, and plasma protein determinations. If clinically relevant changes are seen, adjustments of the immunosuppressive regimen should be considered.

As the capsule contains lactose, special care should be taken in patients with rare hereditary problems of galactose intolerance, the Lapp lactase deficiency or glucose-galactose malabsorption.

Vaccination
Immunosuppressants may affect the response to vaccination and vaccination during treatment with tacrolimus may be less effective. The use of live attenuated vaccines should be avoided.

Gastrointestinal disorders
Gastrointestinal perforation has been reported in patients treated with tacrolimus. As gastrointestinal perforation is a medically important event that may lead to a life-threatening or serious condition, adequate treatments should be considered immediately after suspected symptoms or signs occur. Since levels of tacrolimus in blood may significantly change during diarrhoea episodes, extra monitoring of tacrolimus concentrations is recommended during episodes of diarrhoea.

Cardiac disorders
Ventricular hypertrophy or hypertrophy of the septum, reported as cardiomyopathies, has been observed on rare occasions. Most cases have been reversible, occurring primarily in children with tacrolimus blood trough concentrations much higher than the recommended maximum levels. Other factors observed to increase the risk of these clinical conditions included pre-existing heart disease, corticosteroid usage, hypertension, renal or hepatic dysfunction, infections, fluid overload, and oedema. Accordingly, high-risk patients, particularly young children and those receiving substantial immunosuppression should be monitored, using such procedures as echocardiography or ECG pre- and post-transplant (e.g. initially at three months and then at 9-12 months). If abnormalities develop, dose reduction of tacrolimus therapy, or change of treatment to another immunosuppressive agent should be considered. Tacrolimus may prolong the QT interval and may cause *Torsades de Pointes*. Caution should be exercised in patients with risk factors for QT prolongation, including patients with a personal or family history of QT prolongation, congestive heart failure, bradyarrhythmias and electrolyte abnormalities. Caution should also be exercised in patients diagnosed or suspected to have Congenital Long QT Syndrome or acquired QT prolongation or patients on concomitant medications known to prolong the QT interval, induce electrolyte abnormalities or known to increase tacrolimus exposure.

Lymphoproliferative disorders and malignancies
Patients treated with tacrolimus have been reported to develop Epstein-Barr virus (EBV)-associated lymphoproliferative disorders. Patients switched to tacrolimus therapy should not receive anti-lymphocyte treatment concomitantly. Very young (< 2 years), EBV-VCA-negative children have been reported to have an increased risk of developing lymphoproliferative disorders. Therefore, in this patient group, EBV-VCA serology should be ascertained before starting treatment with tacrolimus. During treatment, careful monitoring with EBV-PCR is recommended. Positive EBV-PCR may persist for months and is per se not indicative of lymphoproliferative disease or lymphoma.

As with other immunosuppressive agents, owing to the potential risk of malignant skin changes, exposure to sunlight and UV light should be limited by wearing protective clothing and using a sunscreen with a high protection factor. As with other potent immunosuppressive compounds, the risk of secondary cancer is unknown.

Posterior reversible encephalopathy syndrome (PRES)
Patients treated with tacrolimus have been reported to develop posterior reversible encephalopathy syndrome (PRES). If patients taking tacrolimus present with symptoms indicating PRES such as headache, altered mental status, seizures, and visual disturbances, a radiological procedure (e.g. MRI) should be performed. If PRES is diagnosed, adequate blood pressure control and immediate discontinuation of systemic tacrolimus is advised. Most patients completely recover after appropriate measures are taken.

Infections including opportunistic infections
Patients treated with immunosuppressant, including tacrolimus are at increased risk of opportunistic infections (bacterial, fungal, viral and protozoal). Among these conditions are BK virus associated nephropathy and JC virus associated progressive multifocal leukoencephalopathy (PML). These infections are often related to a high total immunosuppressive burden and may lead to serious or fatal conditions that physicians should consider in patients with deteriorating renal function or neurological symptoms.

Pure Red Cell Aplasia
Cases of pure red cell aplasia (PRCA) have been reported in patients treated with tacrolimus. All patients reported risk factors for PRCA such as parvovirus B19 infection, underlying disease or concomitant medications associated with PRCA.

FERTILITY, PREGNANCY AND LACTATION

Pregnancy
Human data show that tacrolimus is able to cross the placenta and infants exposed to tacrolimus in utero may be at a risk of prematurity, birth defects/congenital anomalies, low birth weight, and fetal distress. The use of tacrolimus during pregnancy has been associated with preterm delivery, neonatal hyperkalemia and renal dysfunction. Tacrolimus may increase hyperglycemia in pregnant women with diabetes (including gestational diabetes). Monitor maternal blood glucose levels regularly. Tacrolimus may exacerbate hypertension in pregnant women and increase pre-eclampsia. Monitor and control blood pressure. Females and males of reproductive potential should consider the use of appropriate contraception prior to starting treatment of tacrolimus. Due to the need of treatment, tacrolimus can be considered in pregnant women when there is no safer alternative and when the perceived benefit justifies the potential risk to the foetus. In rats and rabbits, tacrolimus caused embryofoetal toxicity at doses which demonstrated maternal toxicity.

Breast-feeding
Human data demonstrate that tacrolimus is excreted into breast milk. The effects of tacrolimus on the breastfed infant, or on milk production have not been assessed. As detrimental effects on the new born cannot be excluded, women should not breast feed whilst receiving Tacrolimus.

Fertility
A negative effect of tacrolimus on male fertility in the form of reduced sperm counts and motility was observed in rats (see section preclinical safety data).

EFFECTS ON ABILITY TO DRIVE AND USE MACHINE

Tacrolimus may cause visual and neurological disturbances. This effect may be enhanced if tacrolimus is administered in association with alcohol.

DRUG INTERACTIONS

Metabolic interactions
Systemically available tacrolimus is metabolised by hepatic CYP3A4. There is also evidence of gastrointestinal metabolism by CYP3A4 in the intestinal wall. Concomitant use of medicinal products or herbal remedies known to inhibit or induce CYP3A4 may affect the metabolism of tacrolimus and thereby increase or decrease tacrolimus blood levels. It is therefore strongly recommended to closely monitor tacrolimus blood levels, as well as, QT prolongation (with ECG), renal function and other side effects, whenever substances which have the potential to alter CYP3A4 metabolism are used concomitantly and to interrupt or adjust the tacrolimus dose as appropriate in order to maintain similar tacrolimus exposure.

Inhibitors of metabolism
Clinically the following substances have been shown to increase tacrolimus blood levels
Strong interactions have been observed with antifungal agents such as ketoconazole, fluconazole, itraconazole and voriconazole, the macrolide antibiotic erythromycin, HIV protease inhibitors (e.g. ritonavir, nelfinavir, saquinavir) or HCV protease inhibitors (e.g. telaprevir, boceprevir, and the combination of ombitasvir and paritaprevir with ritonavir, when used with and without dasabuvir), or the CMV antiviral letermovir. Concomitant use of these substances may require decreased tacrolimus doses in nearly all patients.

Weaker interactions have been observed with clotrimazole, clarithromycin, josamycin, nifedipine, nicardipine, diltiazem, verapamil, amiodarone, danazol, ethinylestradiol, omeprazole, nefazodone and (Chinese) herbal remedies containing extracts of *Schisandra sphenanthera*.

In vitro the following substances have been shown to be potential inhibitors of tacrolimus metabolism: bromocriptine, cortisone, dapsone, ergotamine, gestodene, lidocaine, mephenytoin, miconazole, midazolam, nilvadipine, norethisterone, quinidine, tamoxifen, troleandomycin.

Grapefruit juice has been reported to increase the blood level of tacrolimus and should therefore be avoided.

Lansoprazole and ciclosporin may potentially inhibit CYP3A4-mediated metabolism of tacrolimus and thereby increase tacrolimus whole blood concentrations.

Other interactions potentially leading to increased tacrolimus blood levels
Tacrolimus is extensively bound to plasma proteins. Possible interactions with other medicinal products known to have high affinity for plasma proteins should be considered (e.g., NSAIDs, oral anticoagulants, or oral antidiabetics).

Other potential interactions that may increase systemic exposure of tacrolimus include the prokinetic agent metoclopramide, cimetidine and magnesium-aluminium-hydroxide.

Inducers of metabolism
Clinically the following substances have been shown to decrease tacrolimus blood levels
Strong interactions have been observed with rifampicin, phenytoin or St. John's Wort (*Hypericum perforatum*) which may require increased tacrolimus doses in almost all patients. Clinically significant interactions have also been observed with phenobarbital. Maintenance doses of corticosteroids have been shown to reduce tacrolimus blood levels.

High dose prednisolone or methylprednisolone administered for the treatment of acute rejection have the potential to increase or decrease tacrolimus blood levels.

Carbamazepine, metamizole and isoniazid have the potential to decrease tacrolimus concentrations.

Effect of tacrolimus on the metabolism of other medicinal products
Tacrolimus is a known CYP3A4 inhibitor; thus concomitant use of tacrolimus with medicinal products known to be metabolised by CYP3A4 may affect the metabolism of such medicinal products.

The half-life of ciclosporin is prolonged when tacrolimus is given concomitantly. In addition, synergistic/additive nephrotoxic effects can occur. For these reasons, the combined administration of ciclosporin and tacrolimus is not recommended and care should be taken when administering tacrolimus to patients who have previously received ciclosporin.

Tacrolimus has been shown to increase the blood level of phenytoin.

As tacrolimus may reduce the clearance of steroid-based contraceptives leading to increased hormone exposure, particular care should be exercised when deciding upon contraceptive measures.

Limited knowledge of interactions between tacrolimus and statins is available. Available data suggests that the pharmacokinetics of statins are largely unaltered by the co-administration of tacrolimus.

Animal data have shown that tacrolimus could potentially decrease the clearance and increase the half-life of pentobarbital and phenazone.

Other interactions which have led to clinically detrimental effects
Concurrent use of tacrolimus with medicinal products known to have nephrotoxic or neurotoxic effects may increase these effects (e.g., aminoglycosides, gyrase inhibitors, vancomycin, sulfamethoxazole + trimethoprim, NSAIDs, ganciclovir or aciclovir).

Enhanced nephrotoxicity has been observed following the administration of amphotericin B and ibuprofen in conjunction with tacrolimus.

As tacrolimus treatment may be associated with hyperkalaemia, or may increase pre-existing hyperkalaemia, high potassium intake, or potassium-sparing diuretics (e.g., amiloride, triamterene, or spironolactone) should be avoided.

Immunosuppressant may affect the response to vaccination and vaccination during treatment with tacrolimus may be less effective. The use of live attenuated vaccines should be avoided.

BACK

MAIN SIDE/ ADVERSE EFFECTS

Adverse drug reactions are listed below in descending order by frequency of occurrence: very common (≥1/10); common (≥1/100, <1/10); uncommon (≥1/1,000, <1/100); rare (≥1/10,000, <1/1,000); very rare (<1/10,000); not known (cannot be estimated from the available data).

Description of selected adverse reactions
Pain in extremity has been described in a number of published case reports as part of Calcineurin-Inhibitor Induced Pain Syndrome (CIPS). This typically presents as a bilateral and symmetrical, severe, ascending pain in the lower extremities and may be associated with supratherapeutic levels of tacrolimus. The syndrome may respond to tacrolimus dose reduction. In some cases, it was necessary to switch to alternative immunosuppression.

Infections and infestations
As is well known for other potent immunosuppressive agents, patients receiving tacrolimus are frequently at increased risk for infections (viral, bacterial, fungal, protozoal). The course of pre-existing infections may be aggravated. Both generalised and localised infections can occur.

Cases of BK virus associated nephropathy, as well as cases of JC virus associated progressive multifocal leukoencephalopathy (PML), have been reported in patients treated with immunosuppressants, including tacrolimus.

Neoplasms benign, malignant and unspecified (incl. cysts and polyps)
Patients receiving immunosuppressive therapy are at increased risk of developing malignancies. Benign as well as malignant neoplasms including EBV-associated lymphoproliferative disorders and skin malignancies have been reported in association with tacrolimus treatment.

Blood and lymphatic system disorders	
Common	anaemia, leukopenia, thrombocytopenia, leukocytosis, red blood cell analyses abnormal
Uncommon	coagulopathies, coagulation and bleeding analyses abnormal, pancytopenia, neutropenia
Rare	thrombotic thrombocytopenic purpura, hypoprothrombinaemia, thrombotic microangiopathy
Not known	pure red cell aplasia, agranulocytosis, haemolytic anaemia
Immune system disorders Allergic and anaphylactoid reactions have been observed in patients receiving tacrolimus.	
Endocrine disorders	
Rare	hirsutism
Metabolism and nutrition disorders	
Very common	hyperglycaemic conditions, diabetes mellitus, hyperkalaemia
Common	hypomagnesaemia, hypophosphataemia, hypokalaemia, hypocalcaemia, hyponatraemia, fluid overload, hyperuricaemia, appetite decreased, metabolic acidoses, hyperlipidaemia, hypercholesterolaemia, hypertriglyceridaemia, other electrolyte abnormalities
Uncommon	dehydration, hypoproteinaemia, hyperphosphataemia, hypoglycaemia
Psychiatric disorders	
Very common	insomnia
Common	anxiety symptoms, confusion and disorientation, depression, depressed mood, mood disorders and disturbances, nightmare, hallucination, mental disorders
Uncommon	psychotic disorder
Nervous system disorders	
Very common	tremor, headache
Common	seizures, disturbances in consciousness, paraesthesias and dysaesthesias, peripheral neuropathies, dizziness, writing impaired, nervous system disorders
Uncommon	coma, central nervous system haemorrhages and cerebrovascular accidents, paralysis and paresis, encephalopathy, speech and language abnormalities, amnesia
Rare	hypertonia
Very Rare	myasthenia
Eye disorders	
Common	vision blurred, photophobia, eye disorders
Uncommon	cataract
Rare	blindness
Not Known	optic neuropathy
Ear and labyrinth disorders	
Common	tinnitus
Uncommon	hypoacusis
Rare	deafness neurosensory
Very Rare	hearing impaired
Cardiac disorders	
Common	ischaemic coronary artery disorders, tachycardia
Uncommon	ventricular arrhythmias and cardiac arrest, heart failures, cardiomyopathies, ventricular hypertrophy, supraventricular arrhythmias, palpitations
Rare	pericardial effusion
Very Rare	*Torsades de Pointes*
Vascular disorders	
Very Common	hypertension
Common	haemorrhage, thrombembolic and ischaemic events, peripheral vascular disorders, vascular hypotensive disorders
Uncommon	infarction, venous thrombosis deep limb, shock
Respiratory, thoracic and mediastinal disorders	
Common	dyspnoea, parenchymal lung disorders, pleural effusion, pharyngitis, cough, nasal congestion and inflammations
Uncommon	respiratory failures, respiratory tract disorders, asthma
Rare	acute respiratory distress syndrome
Gastrointestinal disorders	
Very Common	diarrhoea, nausea
Common	gastrointestinal inflammatory conditions, gastrointestinal ulceration and perforation, gastrointestinal haemorrhages, stomatitis and ulceration, ascites, vomiting, gastrointestinal and abdominal pains, dyspeptic signs and symptoms, constipation, flatulence, bloating and distension, loose stools, gastrointestinal signs and symptoms
Uncommon	ileus paralytic, acute and chronic pancreatitis, gastrooesophageal reflux disease, impaired gastric emptying
Rare	subileus, pancreatic pseudocyst
Hepatobiliary disorders	
Common	cholestasis and jaundice, hepatocellular damage and hepatitis, cholangitis
Rare	hepatitic artery thrombosis, venoocclusive liver disease
Very Rare	hepatic failure, bile duct stenosis
Skin and subcutaneous tissue disorders	
Common	pruritus, rash, alopecias, acne, sweating increased
Uncommon	dermatitis, photosensitivity
Rare	toxic epidermal necrolysis (Lyell's syndrome)
Very Rare	Stevens Johnson syndrome
Musculoskeletal and connective tissue disorders	
Common	arthralgia, muscle spasms, pain in extremity, back pain
Uncommon	joint disorders
Rare	mobility decreased
Renal and urinary disorders	
Very Common	renal impairment
Common	renal failure, renal failure acute, oliguria, renal tubular necrosis, nephropathy toxic, urinary abnormalities, bladder and urethral symptoms
Uncommon	anuria, haemolytic uraemic syndrome
Very Rare	nephropathy, cystitis haemorrhagic
Reproductive system and breast disorders	
Uncommon	dysmenorrhoea and uterine bleeding
General disorders and administration site conditions	
Common	asthenic conditions, febrile disorders, oedema, pain and discomfort, body temperature perception disturbed
Uncommon	multi-organ failure, influenza like illness, temperature intolerance, chest pressure sensation, feeling jittery, feeling abnormal,
Rare	thirst, fall, chest tightness, ulcer
Very Rare	fat tissue increased
Not Known	febrile neutropenia
Investigations	
Common	hepatic enzymes and function abnormalities, blood alkaline phosphatase increased, weight increased
Uncommon	amylase increased, ECG investigations abnormal, heart rate and pulse investigations abnormal, weight decreased, blood lactate dehydrogenase increased
Very Rare	echocardiogram abnormal, electrocardiogram QT prolonged
Injury, poisoning and procedural complications	
Common	primary graft dysfunction

OVERDOSE AND TREATMENT

Experience with overdosage is limited. Several cases of accidental overdosage have been reported; symptoms have included tremor, headache, nausea and vomiting, infections, urticaria, lethargy, increased blood urea nitrogen and elevated serum creatinine concentrations, and increase in alanine aminotransferase levels.

No specific antidote to tacrolimus therapy is available. If overdosage occurs, general supportive measures and symptomatic treatment should be conducted. Based on its high molecular weight, poor aqueous solubility, and extensive erythrocyte and plasma protein binding, it is anticipated that tacrolimus will not be dialysable. In isolated patients with very high plasma levels, haemofiltration or -diafiltration have been effective in reducing toxic concentrations. In cases of oral intoxication, gastric lavage and/or the use of adsorbents (such as activated charcoal) may be helpful, if used shortly after intake.

DOSAGE AND ADMINISTRATION

Only physicians experienced in immunosuppressive therapy and the management of organ transplant patients should prescribe Tacrolimus.

Patients receiving the drug should be managed in facilities equipped and staffed with adequate laboratory and supportive medical resourced. The physician responsible for maintenance therapy should have complete information requisite for the follow up of the patient.

The dosage recommendations given below for oral and intravenous administration are intended to act as a guideline. Tacrolimus doses should be adjusted according to individual patient requirements.

Dosing should commence orally, if necessary via an intranasal gastric tube. If the clinical condition of the patient does not allow oral therapy, initial intravenous dosing may be necessary.

Primary Immunosuppression Dose Levels
Adults
Liver and kidney transplantation: Oral tacrolimus therapy should commence at 0.10 – 0.20 mg/kg/day for liver transplantation and at 0.15 – 0.30 mg/kg/day for kidney transplantation administered as two divided doses. Administration should start approximately 6 hours after the completion of liver transplant surgery and within 24 hours after completion of kidney transplant surgery. If clinical condition of the patient does not allow oral dosing, then intravenous tacrolimus therapy should be initiated as a continuous 24 hours infusion at 0.01 to 0.05 mg/kg for liver transplant and 0.05 to 0.10 mg/kg for kidney transplant.

Primary Immunosuppression Dose Levels
Paediatric Patients
Paediatric patients generally require doses 1.5 to 2 times higher than the recommended adult doses to achieve the same blood levels. Liver and kidney transplantation: An initial dose of 0.3 mg/kg/day for liver and kidney transplantation should be administered in two divided doses. If the dose cannot be given orally, an initial intravenous dose of 0.05 mg/kg/day for the liver transplantation or 0.1 mg/kg/day for kidney transplantation should be administered as a continuous 24 hours infusion.

Maintenance Therapy Dose Levels
It is necessary to continue immunosuppression with oral Tacrolimus to maintain graft survival. Dose can frequently be reduced during maintenance therapy. Dosing should be primarily based on clinical assessments of rejection and tolerability of the patient. If progression of disease occurs (e.g. signs of acute rejection) alteration of the immunosuppressive regimen should be considered. Increase the amount of corticosteroids, introduction of short courses of mono/polyclonal antibodies and increase in the dose of Tacrolimus have been used to manage rejection episodes. If signs of toxicity (e.g. pronounced adverse event) are noted, the dose of Tacrolimus should be reduced. When Tacrolimus is administered in combination with a corticosteroid these may often be reduced and in rare cases the treatment has continued as monotherapy.

Therapy Dose Levels for Liver and Kidney Allograft Rejection Resistant to Conventional
Immunosuppressive Regimens
In patients experiencing rejections episodes which are unresponsive to conventional immunosuppressive therapy, Tacrolimus treatment should begin with the initial dose recommended for primary immunosuppression in that particular allograft. Tacrolimus should be initiated after considering cyclosporin blood concentrations and the clinical condition of the patient. In practice, Tacrolimus therapy has been initiated 12-24 hours after discontinuation of cyclosporin. Monitoring of cyclosporin blood levels should be continued following conversion as the clearance of cyclosporin may be affected.

Duration of dosing
For oral dosing the capsules normally have to be taken continuously to suppress graft rejection and no limit for therapy duration can be given. Patients should be converted from intravenous to oral medication as soon as individual circumstances permit. Intravenous therapy should not be continued for more than 7 days.

Mode of Intake
Capsules should generally be administered on an empty stomach or at least 1 hour before or 2 to 3 hours after a meal, to achieve maximal absorption (See Pharmacokinetic properties).

Monitoring of Whole Blood Concentrations
Drug level monitoring is recommended during the early post-transplantation period, following dose adjustment of Tacrolimus therapy after switching from another immunosuppressive regimen or following co-administration of drugs which are likely to lead to a drug interaction. Trough blood levels of Tacrolimus should also be monitored periodically during maintenance therapy. The frequency of blood level monitoring should be based on clinical needs. As tacrolimus has a long half-life, it can take several days for adjustments in Tacrolimus dosing to be reflected in changes in blood levels.

Patient with Liver Impairment
A dose reduction is necessary.

Patient with Renal Impairment
Careful monitoring of renal function including serial creatinine estimations, calculations of creatinine clearance and monitoring urine output is recommended.

Elderly Patients
There is no evidence currently available to indicate that dosing should be adjusted in older people.

Note: The information given here is limited. For further information, consult your doctor or pharmacist.

Storage : Store below 30°C. Protect from light and moisture.

Presentation/ Packing : Blister pack of 6x10's / Aluminium (alu-alu).

Manufactured for / Product Registration Holder (Malaysia) / Product Owner : HOVID Berhad
121, Jalan Tunku Abdul Rahman
(Jalan Kuala Kangsar),
30010 Ipoh, Perak, Malaysia.

Manufactured by : Concord Biotech Limited
297-298/2p, Siyawada, Valthera,
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