

SUMMARY OF PRODUCT CHARACTERISTICS

1. NAME OF THE MEDICINAL PRODUCT

Isoniazid tablets BP 300 mg

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

Isoniazid Tablets BP 300 mg

Each uncoated tablet contains:

Isoniazid BP..... 300 mg

Excipient with known effect

Each tablet contains 30 mg of Lactose Monohydrate

For a full list of excipients see section 6.1.

3. PHARMACEUTICAL FORM

Tablets

White to off- white, circular, beveled edge, uncoated tablets with break line on one surface.

4. CLINICAL PARTICULARS

4.1. Therapeutic indication

Isoniazid tablets BP 300 mg is indicated for the treatment of tuberculosis, caused by *Mycobacterium tuberculosis*.

Consideration should be given to official treatment guidelines for tuberculosis, e.g. those of WHO when initiating treatment.

4.2. Posology and method of administration

Oral use.

ACTIVE TUBERCULOSIS

For the treatment of active tuberculosis, isoniazid must always be used in combination with other antituberculosis drugs.

As component of standard therapy for drug-susceptible tuberculosis.

Daily therapy:

Adults and adolescents:

4-6 mg/kg body weight/day, maximum 300 mg/day

In patients weighing > 45 kg the daily dose is 300 mg, administered as a single dose.

Isoniazid 300 mg is not indicated for daily therapy of patients weighing < 45 kg, as appropriate dose adjustments cannot be made.

Children:

7-15 mg/kg body weight/day, maximum 300 mg/day

In children weighing > 21 kg the daily dose is 300 mg, administered as a single dose.

Isoniazid tablets BP 300 mg is not indicated for daily therapy of children weighing < 21 kg, as appropriate dose adjustments cannot be made. In these cases, another formulation containing lessisoniazid should be used.

As add-on agent to therapy for certain types of drug-resistant tuberculosis

In adults and adolescents:

High dose isoniazid: 16-20 mg/kg body weight/day In patients weighing 30 to 35.9 kg: 600-1000 mg

In patients weighing 36 to 45.9 kg: 1000-1500 mg In patients weighing 46 kg or more: 1500 mg

The duration of therapy is dependent on the diagnostic category, as well as the combination of drugs used together with isoniazid. Official national and/or international guidelines should be consulted.

LATENT TUBERCULOSIS (monotherapy)

Adults and adolescents:

5 mg/kg body weight, maximum 300 mg for 6 or 9 months

Children:

7-15 mg/kg body weight, maximum 300 mg for 6 or 9 months

Isoniazid 300 mg tablets is not suitable for children weighing < 21 kg for this indication, as appropriate dose adjustments cannot be made. In these cases, another formulation containing less isoniazid should be used.

Special populations

Renal impairment:

No dose adjustment in patients with renal impairment is generally recommended. However, patients should be closely monitored for signs of isoniazid toxicity, especially peripheral neuropathy. A dose reduction to two-thirds of the normal daily dose may be considered in slow acetylators with severe renal impairment (ClCr <25 ml/min) or in those with signs of isoniazid toxicity (see sections 4.4 and 5.2).

Hepatic impairment:

Limited data indicate that the pharmacokinetics of isoniazid are altered in patients with hepatic impairment. Therefore, patients with hepatic impairment should be closely observed for signs of isoniazid toxicity (see section 4.4).

Method of administration

Isoniazid tablets BP 300 mg should be swallowed whole with water or another drink.

The tablets should be taken on an empty stomach (at least one hour prior to or two hours after a meal). Patients who vomit within 1 hour of taking the medication should repeat the dose.

If a dose is missed, it should be taken as soon as realized, unless the next regular dose is scheduled within 6 hours. Otherwise, the missed dose should be skipped.

4.3. Contraindications

Isoniazid tablets BP 300 mg are contraindicated in patients with

- hypersensitivity to the active substance or to any of the excipients listed in section 6.1.
- acute liver disease of any etiology
- drug induced hepatic disease
- previous isoniazid-associated hepatic injury or
- previous severe adverse reactions to isoniazid such as drug fever, chills or arthritis.

4.4. Special warnings and precautions for use

Severe and sometimes fatal hepatitis associated with isoniazid therapy has been reported. The majority of cases occur within the first three months of therapy, but hepatotoxicity may also develop after a longer duration of treatment. Therefore, patients should be carefully monitored and interviewed at monthly intervals.

Patients should be instructed to immediately report signs or symptoms consistent with liver damage or other adverse effects.

These include any of the following: unexplained anorexia, nausea, vomiting, dark urine, icterus, rash, persistent paresthesia of the hands and feet, persistent fatigue, weakness of greater than 3 days duration and/or abdominal tenderness, especially of the right upper quadrant.

If these symptoms appear or if signs suggestive of hepatic damage are detected, isoniazid should be discontinued promptly, since continued use of the drug in these cases has been reported to cause a more severe form of liver damage.

Patient groups especially at risk for developing hepatitis include

- age > 35 years
- daily users of alcohol (patients should be strongly advised to restrict intake of alcoholic beverages, see section 4.5)
- patients with active chronic liver disease and
- injection drug users.

In addition to monthly symptom reviews, hepatic enzymes (specifically AST and ALT) should be measured in these patients prior to starting isoniazid therapy and periodically throughout treatment.

Furthermore, the following patients should be carefully monitored:

- patients with concurrent use of any chronically administered medication (see section 4.5)
- existence of peripheral neuropathy or conditions predisposing to neuropathy
- pregnant patients and
- HIV infected patients.

The concentration of liver enzymes is commonly raised during therapy with Isoniazid 300 mg tablets. These effects on liver function are usually mild to moderate, and will most commonly normalize spontaneously within three months, even in the presence of

continued therapy.

If the concentration of liver enzymes exceeds three to five times the upper limit of normal, discontinuation of Isoniazid 300 mg tablets should be strongly considered.

Peripheral neuropathy

Peripheral neuropathy is the most common toxic effect of isoniazid (see section 4.8). The frequency depends on the dose and on predisposing conditions such as malnutrition, impaired renal function, alcoholism or diabetes. Concomitant pyridoxine administration largely reduces the risk of developing neuropathy. Therefore, pyridoxine should be co-administered routinely at doses of 10 mg per day.

Cross-sensitivity

Patients hypersensitive to ethionamide, pyrazinamide, niacin (nicotinic acid), or other chemically related medications may also be hypersensitive to this product.

Isoniazid should be used with caution in patients with pre-existing seizure disorders, a history of psychosis or hepatic impairment.

Diabetes Mellitus

Patients with diabetes should be carefully monitored, since blood glucose control may be affected by isoniazid.

Renal impairment

Patients with renal impairment, particularly those who are slow acetylators (see sections 4.2 and 5.2) may be at increased risk for isoniazid adverse effects such as peripheral neuropathy, and should be monitored accordingly. As in other patients, adequate supplementation with pyridoxine (see above) should be given to avoid neurotoxicity.

4.5. Interactions with other medicinal products and other forms of interaction

Isoniazid acts as an inhibitor of CYP2C19 and CYP3A4. Thus, it may increase exposure to drugs mainly eliminated through either of these pathways. The following list of interactions should not be considered exhaustive, but as representative of the classes of medicinal products where caution should be exercised.

Anticonvulsants

Phenytoin, carbamazepine, valproate: isoniazid decreases the apparent clearance of these drugs, and therefore increases drug exposure. Plasma concentrations of the anticonvulsant should be determined prior to and after initiation of isoniazid therapy; the patient should be monitored closely for signs and symptoms of toxicity and the dose of the anticonvulsant should be adjusted accordingly.

Concomitant intake of phenytoin or carbamazepine may increase the hepatotoxicity of isoniazid.

Sedatives

Benzodiazepines (e.g. diazepam, flurazepam, triazolam, midazolam): isoniazid may decrease the hepatic metabolism of benzodiazepines, leading to increased benzodiazepine plasma concentrations. Patients should be carefully monitored for signs of benzodiazepine toxicity and the dose of the benzodiazepine should be adjusted accordingly.

Phenobarbital: concomitant use with isoniazid may lead to increased hepatotoxicity.

Antipsychotics

Chlorpromazine: concomitant use with isoniazid may impair the metabolism of isoniazid. Patients should be carefully monitored for isoniazid toxicity.

Haloperidol: concomitant use with isoniazid may increase plasma levels of haloperidol. Patients should be carefully monitored for haloperidol toxicity and the dose of haloperidol should be adjusted accordingly.

Anticoagulants

Coumarin- or indandione-derivatives (e.g. warfarin and phenindione): concomitant use with isoniazid may inhibit the enzymatic metabolism of the anticoagulants, leading to increased plasma concentrations with an increased risk of bleeding. Therefore, INR should be closely monitored.

Opioids and anaesthetics

Alfentanil: isoniazid may decrease the plasma clearance and prolong the duration of action of alfentanil. The dose of alfentanil may need to be adjusted accordingly.

Enflurane: isoniazid may increase the formation of the potentially nephrotoxic inorganic fluoride metabolite of enflurane when used concomitantly.

Others

Theophylline: Concomitant use with isoniazid may reduce the metabolism of theophylline, thereby increasing its plasma levels. Therefore, theophylline plasma levels should be monitored.

Procainamide: Concomitant use with isoniazid may increase the plasma concentrations of isoniazid. Patients should be carefully monitored for isoniazid toxicity.

Corticosteroids (e.g. prednisolone): In one study, concomitant use with isoniazid decreased isoniazid exposure by 22-30%. Isoniazid dosage adjustments may be required in rapid acetylators.

Acetaminophen, paracetamol: Concurrent use with isoniazid may increase hepatotoxicity. Aluminium hydroxide impairs the absorption of isoniazid. During therapy with Isoniazid 300 mg tablets acid-suppressing drugs or antacids that do not contain aluminium hydroxide should be used. Disulfiram: concurrent use with isoniazid may result in increased incidence of effects on the central nervous system. Reduced dosage or discontinuation of disulfiram may be necessary.

Hepatotoxic medications: concurrent use of isoniazid with other hepatotoxic medications may increase hepatotoxicity and should be avoided.

Neurotoxic medications: concurrent use of isoniazid with other neurotoxic medications may lead to additive neurotoxicity and should be avoided.

Interactions with food and drinks

Alcohol: concurrent daily intake of alcohol may result in an increased incidence of isoniazid induced hepatotoxicity. Patients should be monitored closely for signs of hepatotoxicity and should be strongly advised to restrict intake of alcoholic beverages (see section 4.4).

Cheese and fish (histamine- or tyramine-rich food): concurrent ingestion with isoniazid

may lead to inhibition of mono-/diamine oxidases by isoniazid, interfering with the metabolism of histamine and tyramine. Clinically, this may result in redness or itching of the skin, hot feeling, rapid or pounding heartbeat, sweating, chills or clammy feeling, headache, or lightheadedness.

Interactions with laboratory tests

Isoniazid may cause a false positive response to copper sulfate glucose tests; enzymatic glucose test sare not affected.

4.6. Fertility, pregnancy and Breast-feeding

Fertility

There are no data on the effects of isoniazid on human male or female fertility. In animal studies, male fertility has been impaired by isoniazid (see section 5.3).

Pregnancy

No adverse effects of isoniazid on the fetus have been reported. However, isoniazid is to be used in pregnancy only when the benefits outweigh the potential risks.

Breast-feeding

Isoniazid passes into breast milk. No adverse effects in the baby have been reported. Concentrations in breast milk are so low, that breast-feeding cannot be relied upon for adequate tuberculosis prophylaxis or therapy for nursing infants.

4.7. Effects on ability to drive and use machines

No studies on the effects on the ability to drive and use machines have been performed. Nevertheless, the clinical status of the patient and the adverse reaction profile of this medicine, especially its potential neurotoxicity, should be borne in mind when considering the patient's ability to drive or operate machinery.

4.8. Undesirable effects

The most important adverse effects of isoniazid are peripheral and central neurotoxic effects, and severe and sometimes fatal hepatitis.

The adverse reactions considered at least possibly related to treatment with the components of Isoniazid 300 mg tablets from clinical trial and post-marketing experience are listed below by body system organ class and absolute frequency. Within each frequency grouping, undesirable effects are presented in order of decreasing seriousness. Frequencies are defined as very common ($\geq 1/10$), common ($\geq 1/100$, $< 1/10$), uncommon ($\geq 1/1,000$, $< 1/100$), rare ($\geq 1/10,000$, $< 1/1,000$) or very rare ($< 1/10,000$) including isolated reports, or not known (identified through post-marketing safety surveillance and the frequency cannot be estimated from the available data).

<i>Nervous system disorders</i>
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Very common	Peripheral neuropathy, usually preceded by paraesthesias of the feet and hands. The frequency depends on the dose and on predisposing conditions such as malnutrition, alcoholism or diabetes. It has been reported in 3.5 to 17% of patients treated with isoniazid. Concomitant pyridoxine administration largely reduces this risk (see section 4.4).
Uncommon	seizures, toxic encephalopathy
Not known	dizziness, headache, tremor, vertigo, hyperreflexia
<i>Psychiatric disorders</i>	
Uncommon	memory impairment, toxic psychosis
Not known	confusion, disorientation, hallucination
<i>Gastrointestinal disorders</i>	
Not known	nausea, vomiting, anorexia, dry mouth, flatulence, abdominal pain, constipation.
<i>Hepatobiliary disorders</i>	
Very common	Transient increases of serum transaminases
Uncommon	Hepatitis
<i>Renal and urinary disorders</i>	
Not known	urinary retention, nephrotoxicity including interstitial nephritis
<i>Metabolic and nutrition disorders</i>	

Not known	hyperglycaemia, metabolic acidosis, pellagra
General disorders	
Not known	allergic reactions with skin manifestation (exanthema, erythema, erythema multiforme), pruritus, fever, leucopenia, anaphylaxia, allergic pneumonitis, neutropenia, eosinophilia, Stevens-Johnson syndrome, vasculitis, lymphadenopathy, rheumatic syndrome, lupus-like syndrome
Blood and lymphatic systems disorders	
Not known	anaemia (haemolytic, sideroblastic, or aplastic), thrombocytopenia, leucopenia (allergic), neutropenia with eosinophilia, agranulocytosis
Respiratory, thoracic and mediastinal disorders	
Not known	pneumonitis (allergic)
Musculoskeletal disorders	
Not known	Arthritis
Eye disorders	
Not known	Optic atrophy or neuritis

For recommendations on the management of side effects related to anti-tuberculosis therapy official national and/or international guidelines should be consulted.

Reporting of suspected adverse reactions

Reporting suspected adverse reactions after authorisation of the medicinal product is important. It allows continued monitoring of the benefit/risk balance of the medicinal product. Healthcare professionals are asked to report any suspected adverse reactions to the **TMDA**.

4.9. Overdose

Symptoms

Anorexia, nausea, vomiting, gastrointestinal disturbances, fever, headache, dizziness, slurred speech, hallucinations and/or visual disturbances occur within 30 minutes to 3 hours after ingestion. With marked isoniazid overdoses (≥ 80 mg/kg body weight) respiratory distress and CNS depression, progressing rapidly from stupor to profound coma, along with severe intractable seizures are to be expected. Typical laboratory findings are severe metabolic acidosis, acetonuria, and hyperglycaemia.

Treatment

Emesis, gastric lavage and activated charcoal may be of value if instituted within a few hours of ingestion. Subsequently, pyridoxine (intravenous bolus on a gram per gram basis, equal to the isoniazid dose; if latter dose is unknown an initial dose of 5 g in adults

or 80 mg/kg BW in children should be considered), intravenous diazepam (in case of seizures not responding to pyridoxine) and haemodialysis may be of value. Further treatment should be supportive, with special attention to monitoring/support of ventilation and correction of metabolic acidosis. There is no specific antidote.

5. PHARMACOLOGICAL PROPERTIES

5.1. Pharmacodynamic properties

Pharmacotherapeutic group: Antimycobacterial

ATC Code for isoniazid: J04AC01

Mechanism of action

Isoniazid is highly active against *Mycobacterium tuberculosis*. It is bactericidal *in vitro* and *in vivo* against actively dividing tubercle bacilli. Its primary action is to inhibit the synthesis of long chain mycolic acids, which are unique constituents of mycobacterial cell wall. Resistance to isoniazid occurs rapidly if it is used alone in the treatment of clinical disease due to mycobacteria.

5.2. Pharmacokinetic properties

Absorption

After oral administration isoniazid is rapidly absorbed with a bioavailability of $\geq 80\%$, and peak serum concentrations reached after 1-2 hours. The rate and extent of absorption are reduced when isoniazid is administered with food. Isoniazid undergoes appreciable presystemic (first pass) metabolism in the wall of small intestine and liver.

As per data reported in published literature, following single dose isoniazid 300 mg administration in healthy volunteers, the mean (\pm SD) isoniazid C_{max} value was 8323 ng/ml (\pm 3637), and the corresponding value for AUC was 38063 ng.hours/ml (\pm 10516). The mean (\pm SD) isoniazid t_{max} value was 0.92 (\pm 0.76) hours.

Distribution

Isoniazid is distributed in the body with an apparent volume of distribution volume of 0.57 to 0.76 l/kg. Protein binding is very low (0-10%).

Metabolism

Isoniazid undergoes extensive metabolism that takes place in the mucosal cells of the small intestine and in the liver. First isoniazid is inactivated through acetylation. Subsequently acetyl-isoniazid is further hydrolysed. Isoniazid acetylation is dependent on the genetically determined metabolic rate of the individual patients, who are termed either fast or slow acetylators (this is due to a genetic polymorphism in the metabolising enzyme N-acetyl transferase). Different ethnic groups contain differing proportions of acetylator phenotypes. Acetylator status is the main determinant of isoniazid exposure at a given dose. At recommended doses, exposure in fast acetylators is about half that seen in slow acetylators.

Excretion

Up to 95% of ingested isoniazid is excreted in the urine within 24 hours, primarily as

inactive metabolites. Less than 10% of the dose is excreted in the faeces. The main excretion products in their urine are N-acetylisoniazid and isonicotinic acid.

Special populations

Renal impairment:

The documentation of the pharmacokinetics of isoniazid and its metabolites in patients with renal impairment is incomplete. However, the half-life of isoniazid is prolonged and exposure is increased, in slow acetylators. The exposure to the (inactive) metabolites of isoniazid is likely to be increased in both fast and slow acetylators.

5.3 Preclinical safety data

Non-clinical data reveal no special hazard for humans at recommended doses based on conventional studies of safety pharmacology, repeated -dose toxicity, genotoxicity, carcinogenic potential, toxicity to reproduction. In male rats spermatogenesis impairment and abnormalities in testicular histopathology was seen.

6. PHARMACEUTICAL PARTICULARS

6.1. List of excipients

Microcrystalline Cellulose (Avicel PH101), Povidone (K-30), Copovidone (kollidon VA 64 fine), Polyethylene Glycol 6000, Crospovidone (Polyplasdone XL 10), Colloidal Silicon Dioxide (Aerosil 200) and Stearic acid.

6.2. Incompatibilities

Not applicable

6.3. Shelf life

24 months

6.4. Special precautions for storage

Do not store above 30°C. Protected from light and moisture.

6.5. Nature and contents of container

Pack I: Amber PVC/PVDC Blister Pack

Description: 10 Tablets shall be packed per blister using Amber PVC/PVdC 90GSM foil as a base material and 0.025mm thick hard tampered heat seal lacquer coated printed Aluminium foil as a lidding material.

Pack II: Aluminium Blister Pack

Description: 10 Tablets shall be packed per Blister using 25 micron printed aluminium foil as a lidding material and Plain Cold Forming Alu-Alu foil as a base material.

6.6. Instructions for use and handling and disposal

Any unused product or waste material should be disposed of in accordance with

local requirements.

7. MARKETING AUTHORISATION HOLDER

Lupin Ltd Kalpataru Inspire
3rd Floor, Off Western Express Highway Santacruz
(East)
Mumbai 400055
INDIA

8. MARKETING AUTHORISATION NUMBER (S)

TAN 20 HM 0238

9. DATE OF FIRST AUTHORISATION/RENEWAL OF AUTHORISATION

9th July, 2020

10. DATE OF REVISION OF THE TEXT