**RIFADIN**<sup>®</sup> 
(rifampin capsules USP) 
and 
**RIFADIN IV**<sup>®</sup> 
(rifampin for injection USP) 

To reduce the development of drug-resistant bacteria and maintain the effectiveness of RIFADIN (rifampin capsules USP) and RIFADIN IV (rifampin for injection USP) and other antibacterial drugs, rifampin should be used only to treat or prevent infections that are proven or strongly suspected to be caused by bacteria.

**DESCRIPTION**

RIFADIN (rifampin capsules USP) contains rifampin 600 mg, sodium formate, magnesium stearate, and titanium dioxide. RIFADIN IV (rifampin for injection USP) contains rifampin 600 mg, sodium formaldehyde sulfoxylate 10 mg, and sodium hydroxide to adjust pH.

**INDICATIONS AND USAGE**

RIFADIN (rifampin capsules USP) for oral administration contain 150 mg or 300 mg rifampin per capsule. The 150 mg and 300 mg capsules also contain, as inactive ingredients: corn starch, D&C Red No. 28, FD&C Blue No. 1, FD&C Red No. 40, gelatin, magnesium stearate, and titanium dioxide.

**RIFADIN IV (rifampin for injection USP)** contains rifampin 600 mg, sodium formaldehyde sulfoxylate 10 mg, and sodium hydroxide to adjust pH.

RIFADIN IV is used in the treatment of all forms of tuberculosis.

**Mechanism of Action**

Rifampin inhibits DNA-dependent RNA polymerase activity in susceptible Mycobacterium tuberculosis organisms. Specifically, it interacts with bacterial RNA polymerase but does not inhibit the mammalian enzyme.

**Dosage**

In one study, pediatric patients 6 to 58 months old were given rifampin suspended in simple syrup or as dry powder mixed with applesauce at a dose of 10 mg/kg body weight. Residual concentrations of rifampin 10.7±3.1 and 11.5±5.1 mcg/mL were obtained 1 hour after preprandial ingestion of the drug suspension and the applesauce mixture, respectively. After the administration of either preparation, the t<sub>1/2</sub> of rifampin averaged 2.9 hours. It should be noted that in other studies in pediatric populations, at doses of 10 mg/kg body weight, mean peak serum concentrations of 3.5 mcg/mL to 15 mcg/mL have been reported.

**Microbiology**

**Mechanism of Action**

Rifampin inhibits DNA-dependent RNA polymerase activity in susceptible Mycobacterium tuberculosis organisms. Specifically, it interacts with bacterial RNA polymerase but does not inhibit the mammalian enzyme.

**Resistance**

Organisms resistant to rifampin are likely to be resistant to other rifamycins.

**Stability**

In one study, rifampin was given to healthy adults, the peak serum concentration averages 7 mcg/mL but may vary from 4 to 32 mcg/mL. Absorption of rifampin is reduced by about 30% when the drug is ingested with food.

**Pharmacokinetics**

Rifampin is readily absorbed from the gastrointestinal tract. Peak serum concentrations in healthy adults and pediatric populations vary widely from individual to individual. Following a single 600 mg oral dose of rifampin in healthy adults, the peak serum concentration averages 7 mcg/mL but may vary from 4 to 32 mcg/mL. Absorption of rifampin is reduced by about 30% when the drug is ingested with food. Rifampin is widely distributed throughout the body. It is present in effective concentrations in many organs and body fluids, including cerebrospinal fluid. Rifampin is about 80% protein bound. Most of the unbound fraction is not ionized and, therefore, diffusely freely into tissues.

In healthy adults, the mean biological half-life of rifampin in serum averages 3.35±0.66 hours after a 600 mg oral dose, with increases up to 5.0±2.45 hours reported after a 900 mg dose. With repeated administration, the half-life decreases and reaches average values of approximately 2 to 3 hours. The half-life does not differ in patients with renal failure at doses not exceeding 600 mg daily, and consequently, no dosage adjustment is required. The half-life of rifampin at a dose of 720 mg daily has not been established in patients with renal failure. Following a single 900 mg oral dose of rifampin in patients with varying degrees of renal insufficiency, the mean half-life increased from 3.6 hours in healthy adults to 5.0, 7.3, and 11.0 hours in patients with glomerular filtration rates of 30 to 50 mL/min, less than 30 mL/min, and in anuric patients, respectively. Refer to the WARNING section for information regarding patients with hepatic insufficiency.

After absorption, rifampin is rapidly eliminated in the bile, and an enterohepatic circulation ensues. During this process, rifampin undergoes progressive deacetylation so that nearly all the drug in the bile is in this form in about 6 hours. This metabolite has antibacterial activity. Intestinal reabsorption is reduced by deacetylation, and elimination is facilitated. Up to 30% of a dose is excreted in the urine, with about half of this being unchanged drug.

Intravenous Administration

After intravenous administration of a 300 or 600 mg dose of rifampin infused over 30 minutes to healthy male volunteers (n=12), mean peak plasma concentrations were 9.0±3.0 and 17.5±5.0 mcg/mL, respectively. Total body clearances after the 300 and 600 mg IV doses were 0.19±0.06 and 0.14±0.03 L/hr/kg, respectively. Volumes of distribution at steady state were 0.66±0.14 and 0.64±0.11 L/kg for the 300 and 600 mg IV doses, respectively. After intravenous administration of 300 or 600 mg doses, rifampin plasma concentrations in these volunteers remained detectable for 8 and 12 hours, respectively (see Table).
Rifampin is indicated for the treatment of asymptomatic carriers of Neisseria meningitidis to eliminate meningococci from the nasopharynx. Rifampin is not indicated for the treatment of meningococcal infection because of the possibility of the rapid emergence of resistant organisms. (See WARNINGS.)

Rifampin should not be used indiscriminately, and therefore, diagnostic laboratory procedures, including serotyping and susceptibility testing, should be performed for establishment of the carrier state and the correct treatment. So that the usefulness of rifampin in the treatment of asymptomatic meningococcal carriers is preserved, the drug should be used only when the risk of meningococcal infection is high.

To reduce the development of drug-resistant bacteria and maintain the effectiveness of rifampin and other antibacterial drugs, rifampin should be used only to treat or prevent infections that are proven or strongly suspected to be caused by susceptible bacteria. When culture and susceptibility information are available, they should 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.

**CONTRAINDICATIONS**

RIFADIN is contraindicated in patients with a history of hypersensitivity to rifampin or any of the components, or to any of the rifamycins. (See WARNINGS.)

Rifampin is contraindicated in patients who are also receiving ritonavir-boosted saquinavir due to an increased risk of severe hepatocellular toxicity. (See PRECAUTIONS, Drug Interactions.)

Rifampin is contraindicated in patients who are also receiving azatavir, darunavir, fosamprenavir, saquinavir, or tipranavir due to the potential of rifampin to substantially decrease plasma concentrations of these antiviral drugs, which may result in loss of antiviral efficacy and/or development of viral resistance.

**WARNINGS**

Rifampin has been shown to produce liver dysfunction. Fatalities associated with jaundice have occurred in patients with liver disease and in patients taking rifampin with other hepatotoxic agents. Patients with impaired liver function should be given rifampin only in very low doses. In patients with impaired liver function, careful monitoring of liver function, especially SGPT/ALT and SGOT/AST should be carried out prior to therapy and then every 2 to 4 weeks during therapy. If signs of hepatocellular damage occur, rifampin should be withdrawn.

In some patients, porphyria resulting from competition between rifampin and bilirubin for excrelory pathways of the liver at the cell level can occur in the early days of treatment. An isolated report showing a moderate rise in bilirubin and/or transaminase levels is not in itself an indication for interrupting treatment; rather, the decision should be made after a noting trend in the levels, and considering them in conjunction with the patient’s clinical condition.

Rifampin has enzyme-inducing properties, including induction of delta amino levulinic acid synthetase. Isolated reports have associated porphyria exacerbation with rifampin administration.

The possibility of rapid emergence of resistant meningococci restricts the use of RIFADIN to short-term treatment of the asymptomatic carrier state. RIFADIN is not to be used for the treatment of meningococcal disease.

Systemic hypersensitivity reactions, including Drug Reaction with Eosinophilia and Systemic Symptoms (DRESS) syndrome, may occur in patients receiving RIFADIN. (See ADVERSE REACTIONS.) Signs and symptoms of hypersensitivity reactions may include fever, rash, urticaria, angioedema, hypotension, acute bronchospasm, conjunctivitis, thrombocytopenia, neutropenia, elevated liver transaminases or flu-like syndrome (weakness, fatigue, fever, chills, aches, itching, sweats, dizziness, shortness of breath, chest pain, cough, syncope, palpitations). These reactions may be severe and DRESS may be fatal. Manifestations of hypersensitivity, such as fever, lymphadenopathy or laboratory abnormalities (including eosinophilia, liver abnormalities) may be present even though rash is not evident. Monitor patients receiving RIFADIN for signs and/or symptoms of hypersensitivity reactions. If these signs or symptoms occur, discontinue RIFADIN and administer supportive measures.

**PRECAUTIONS**

**General**

RIFADIN should be used with caution in patients with a history of diabetes mellitus, as diabetes management may be more difficult. Prescribing rifampin in the absence of a proven or strongly suspected bacterial infection or a prophylactic indication is unlikely to provide benefit to the patient and increases the risk of the development of drug-resistant bacteria.

For the treatment of tuberculosis, rifampin is usually administered on a daily basis. Doses of rifampin greater than 600 mg given once or twice weekly have resulted in a higher incidence of adverse reactions, including the flu-like syndrome (fever, chills and malaise), hematopoietic reactions (leukopenia, thrombocytopenia, or acute hemolytic anemia), cutaneous, gastrointestinal, and hepatic reactions, shortness of breath, shock, anaphylaxis, and renal failure. Recent studies indicate that regimens using twice-weekly doses of rifampin 600 mg plus isoniazid 15 mg/kg are much better tolerated.

Rifampin is not recommended for intermittent therapy; the patient should be cautioned against intentional or accidental interruption of the daily dosage regimen since rare renal hypersensitivity reactions have been reported when therapy was resumed in such cases. Rifampin has enzyme induction properties that can enhance the metabolism of endogenous substrates including adrenal hormones, thyroid hormones, and vitamin D. Rifampin, and other rifamycins, may also increase the metabolism of other drugs that undergo biotransformation through these metabolic pathways. Therefore, patients receiving concomitant therapy with drugs that are eliminated by these metabolic pathways may accelerate elimination of coadministered drugs. To maintain optimum therapeutic blood levels, dosages of drugs metabolized by these enzymes may require adjustment when starting or stopping concomitantly administered rifampin.

Rifampin has been reported to substantially decrease the plasma concentrations of the following antiviral drugs: azatavir, darunavir, fosamprenavir, saquinavir, and tipranavir. These antiviral drugs must not be coadministered with rifampin. (See CONTRAINDICATIONS.)

Rifampin has been reported to accelerate the metabolism of the following drugs: anticonvulsants (e.g., phenytoin), digitoxin, antiarrhythmics (e.g., disopyramide, mexiletine, or procainamide), others (e.g., fluconazol, itracna-zole, ketoconazole), barbiturates, beta-blockers, calcium channel blockers (e.g., diltiazem, nifedipine, verapamil), clonazapam, clorazepate, cyclosporine, diazepam, doxycycline, fluoroquinolones (e.g., ciprofloxacin), haloperidol, oral hypoglycemic agents (sulfonilureas), levothyroxine, methadone, nortriptyline, nortriptyline, quinidine, tacrolimus, theophylline, tricyclic antidepressants (e.g., amitriptyline, nortriptyline) and zidovudine. It may be necessary to adjust the dosages of these drugs if they are given concurrently with rifampin.

Patients using oral or other systemic hormonal contraceptives should be advised to change to nonhormonal methods of birth control during rifampin therapy.

Rifampin has been observed to increase the requirements for anticoagulant drugs of the coumarin type. In patients receiving anticoagulants and rifampin concurrently, it is recommended that the prothrombin time be performed daily as frequently as necessary. Routine laboratory monitoring for toxicity in people with normal baseline measurements is generally not necessary.

**Drug Interactions**

Healthy subjects who received rifampin 600 mg once daily concomitantly with saquinavir 1000 mg/ritonavir 100 mg twice daily (ritonavir-boosted saquinavir) developed severe hepatocellular toxicity. Therefore, concomitant use of these medications is contraindicated. (See CONTRAINDICATIONS.)

**Enzyme Induction**

Rifampin is known to induce certain cytochrome P-450 enzymes. Administration of rifampin with drugs that undergo biotransformation through these metabolic pathways may accelerate elimination of coadministered drugs. To maintain optimum therapeutic blood levels, dosages of drugs metabolized by these enzymes may require adjustment when starting or stopping concomitantly administered rifampin.

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**Other Interactions**

Rifampin has been reported to decrease plasma concentrations of both drugs. Concurrent use of rifampin and enalapril has resulted in decreased concentrations of atovaquone and its active metabolite. When the two drugs were taken concomitantly, decreased concentrations of atovaquone and its active metabolite were observed.

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Drug/Laboratory Interactions

Cross-reactivity and false-positive urine screening tests for opiates have been reported in patients receiving rifampin when using the KIMS (Kinetic Interaction of Macrocyclics in Solution) method (e.g., Abscreen OnLine opiates assay; Roche Diagnostic Systems). Confirmatory tests, such as gas chromatography/mass spectrometry, will distinguish rifampin from morphine.

Therapeutic levels of rifampin have been shown to inhibit standard microbiological assays for serum folate and vitamin B$_{12}$. Thus, alternate assay methods should be considered. Transient abnormalities in liver function tests (e.g., elevation in serum bilirubin, alkaline phosphatase, and serum transaminases) and reduced biliary excretion of contrast media used for visualization of the gallbladder have also been observed. Therefore, these tests should be performed before the morning dose of rifampin.

Carcinogenesis, Mutagenesis, Impairment of Fertility

A few cases of lung cancer have been reported in male (C3Hf/DP) mice dosed for 60 weeks with rifampicin followed by an observation period of 24 weeks. Rifampicin showed no evidence of tumorigenicity in male C3H/DP mice or in similar studies in BALB/c mice, or in two year studies in Wistar rats. There was no evidence of mutagenicity in both prokaryotic (Salmonella typhi, Escherichia coli) and eukaryotic (Saccharomyces cerevisiae) bacteria (transformation, mouse lymphoma, and ICR/Ha Swiss mice). An increase in chromatic breaks was noted when whole blood cell cultures were treated with rifampin. Increased frequency of chromosomal aberrations was observed in vitro in lymphocytes obtained from patients treated with combinations of rifampin, isoniazid, and pyrazamide and combinations of streptomycin, rifampin, isoniazid, and pyrazamide.

Pregnancy

Rifampin has been shown to be teratogenic in rodents. Congenital malformations, primarily spina bifida were increased in the offspring of pregnant rats given rifampin during organogenesis at oral doses of 150 to 250 mg/kg/day (about 1 to 2 times the maximum recommended human dose based on body surface area comparisons). Cleft palate was increased in a dose-dependent fashion in fetuses of pregnant mice treated at oral doses of 50 to 200 mg/kg (about 0.2 to 0.8 times the maximum recommended human dose based on body surface area comparisons). Imperfect osteogenesis and embryotoxicity were also reported in pregnant rabbits given rifampin at oral doses up to 200 mg/kg/day (about 3 times the maximum recommended human dose based on body surface area comparisons). There are no adequate and well-controlled studies of RIFADIN in pregnant women. Rifampin has been reported to cross the placental barrier and appear in cord blood.

Rifampin should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers

Because of the potential for tumorigenesis shown for rifampin in animal studies, a decision should be made whether to discontinue nursing or discontinue the drug, taking into account the importance of the drug to the mother.

Pediatric Use

See CLINICAL PHARMACOLOGY--Pediatrics; see also DOSAGE AND ADMINISTRATION.

Geriatric Use

Clinical studies of RIFADIN did not include sufficient numbers of subjects aged 65 and over to determine whether they respond differently from younger subjects. Other reported clinical experience has not identified differences in responses between the elderly and younger patients. Caution should therefore be observed in using rifampin in elderly patients. (See WARNINGS.)

ADVERSE REACTIONS

Gastrointestinal

Heartburn, eructation, diarrhea, nausea, vomiting, flatulence, cramps, and constipation have been noted in some patients. Although Clostridium difficile has been shown in vitro to be sensitive to rifampin, pseudomembranous colitis has been reported with the use of rifampin (and other broad spectrum antibiotics). Therefore, it is important to consider this diagnosis in patients who develop diarrhea in association with antibiotic use. Tooth discoloration (which may be permanent) may occur.

Hepatic

Transient abnormalities in liver function tests (e.g., elevations in serum bilirubin, alkaline phosphatase, and serum transaminases) have been observed. Rarely, hepatitis or a shock-like syndrome with hepatic involvement and abnormal liver function tests has been reported.

Hematologic

Thrombocytopenia has occurred primarily with high dose intermittent therapy, but has also been observed after resumption of interrupted treatment. It rarely occurs during well-supervised daily therapy. This effect is reversible if the drug is discontinued as soon as purpura occurs. Cerebral hemorrhage and fatalities have been reported when rifampin administration has been continued or resumed after the appearance of purpura.

Rare reports of thrombocytopenia and purpura have been observed. Leukopenia, hemolytic anemia, and decreased hemoglobin have been observed. Agranulocytosis has been reported very rarely.

Central Nervous System

Headache, fever, drowsiness, fatigue, ataxia, dizziness, inability to concentrate, mental confusion, behavioral changes, muscular weakness, pains in extremities, and generalized numbness have been observed.

Psychoses have been rarely reported.

Rare reports of myopathy have also been observed.

Ocular

Visual disturbances have been observed.

Endocrine

Menstrual disturbances have been observed.

Rare reports of adrenal insufficiency in patients with compromised adrenal function have been observed.

Renal

Elevations in BUN and serum uric acid have been reported. Rarely, hemolysis, hemoglobinuria, hematuria, interstitial nephritis, acute tubular necrosis, renal insufficiency, and renal failure have been noted. These are generally considered to be hypersensitivity reactions. They usually occur during intermittent therapy or when treatment is resumed following intentional or accidental interruption of a daily dosage regimen, and are reversible when rifampin is discontinued and appropriate therapy instituted.

Gastrointestinal

Cutaneous reactions are mild and self-limiting and do not appear to be hypersensitivity reactions. Typically, they consist of flushing and itching with or without a rash. More serious cutaneous reactions which may be due to hypersensitivity occur but are uncommon.

Hypersensitivity Reactions

Occasionally, pruritus, urticaria, rash, pempigoid reaction, erythema multiforme including Stevens-Johnson syndrome, toxic epidermal necrolysis, Drug Reaction with Eosinophilia and Systemic Symptoms syndrome (see WARNINGS), vasculitis, esophagitis, sore throat, and conjunctivitis have been observed.

Anaphylaxis has been reported rarely.

Miscellaneous

Edema of the face and extremities has been reported. Other reactions which have occurred with intermittent dosing regimens include "flu syndrome" (such as episodes of fever, chills, headache, dizziness, and bone pain), shortness of breath, wheezing, decrease in blood pressure and shock. The "flu syndrome" may also appear if rifampin is taken irregularly by the patient or if daily administration is resumed after a drug free interval.

OVERDOSE

Signs and Symptoms

Nausea, vomiting, abdominal pain, pruritus, headache, and increasing lethargy will occur in a short time after ingestion; unconsciousness may occur when there is severe hepatic disease. Transient increases in liver enzymes and/or bilirubin may occur. Brownish-red or orange discoloration of the skin, urine, sweat, saliva, tears, and feces will occur, and its intensity is proportional to the amount ingested.

Liver enlargement, stellate with tenderness, can develop within a few hours after severe overdosage; bilirubin levels may increase and jaundice may develop rapidly. Hepatic involvement may be more marked in patients with prior impairment of hepatic function. Other physical findings remain essentially normal. A direct effect upon the hematopoietic system is unlikely.

In the event of an overdose, the patient should be removed from further exposure to rifampin and given symptomatic and supportive treatment.

Facial or periocular edema has also been reported in pediatric patients. Hypotension, sinus tachycardia, ventricular arrhythmias, seizures and cardiac arrest were reported in some fatal cases.

Acute Toxicity

The minimum acute lethal or toxic dose is not well established. However, nonfatal acute overdoses in adults have been reported with doses ranging from 9 to 20 gm rifampin. Fatal acute overdoses in adults have been reported with doses ranging from 14 to 50 gm. Alcohol or a history of alcohol abuse was involved in some of the fatal and nonfatal reports. Nonfatal overdoses in pediatric patients ages 1 to 4 years old of 100 mg/kg for one to two doses has been reported.

Treatment

Intensive support measures should be instituted and individual symptoms treated as they arise. The airway should be secured and adequate respiratory exchange established. Since nausea and vomiting are likely to be present, gastric lavage within the first 2 to 3 hours of ingestion is probably the best form of emesis. Following evacuation of the gastric contents, the instillation of activated charcoal slurry into the stomach may help absorb any remaining drug from the gastrointestinal tract. Antiserum medication may be required to control severe nausea and vomiting.

Active diuresis (with measured intake and output) will help promote excretion of the drug. For severe cases, extracorporeal hemodialysis may be required. If this is not available, peritoneal dialysis can be used along with forced diuresis.

DOSAGE AND ADMINISTRATION

Rifampin can be administered by the oral route or by IV infusion (see INDICATIONS AND USAGE). IV doses are the same as those for oral.

See CLINICAL PHARMACOLOGY for dosing information in patients with renal failure.

Tuberculosis

Adults: 600 mg/day, in a single daily administration, not to exceed 600 mg/day, oral or IV Pediatric Patients: 10–20 mg/kg, not to exceed 600 mg/day, oral or IV

It is recommended that oral rifampin be administered once daily, either 1 hour before or 2 hours after a meal with a full glass of water.

Rifampin is indicated in the treatment of all forms of tuberculosis. A three-drug regimen consisting of rifampin, isoniazid, and pyrazinamide (e.g., RIFATER$^\circledR$) is recommended in the initial phase of short-course therapy which is usually continued for 2 months. The Advisory Council for the Elimination of Tuberculosis, the American Thoracic Society, and the Centers for Disease Control and Prevention recommend that either streptomycin or ethambutol be added as a fourth drug in a regimen containing isoniazid (INH), rifampin and pyrazinamide for initial treatment of tuberculosis unless the likelihood of INH resistance is very low. The need for a fourth drug should be reassessed when the results of drug sensitivity tests are known. If community rates of INH resistance are currently less than 4%, an initial treatment regimen with less than four drugs may be considered.

Following the initial phase, treatment should be continued with rifampin and isoniazid (e.g., RIFAMATE$^\circledR$) for at least 4 months. Treatment should be continued for longer if the patient is still spuatum or culture positive, if resistant organisms are present, or if the patient is HIV positive.

Preparation of Solution for IV Infusion

Reconstitute the lyophilized powder by transferring 10 mL of sterile water for injection to a vial containing 600 mg of rifampin for injection. Swirl vial gently to completely dissolve the antibiotic. The reconstituted solution contains 60 mg rifampin per mL and is stable at room temperature for up to 30 hours. Prior to administration, withdraw from the reconstituted solution a volume equivalent to the amount of rifampin calculated to be administered and add to 500 mL of infusion medium. Mix well and infuse at a rate allowing
for complete infusion within 3 hours. Alternatively, the amount of rifampin calculated to be 
administered may be added to 100 mL of infusion medium and infused in 30 minutes. 
Dilutions in dextrose 5% for injection (DSW) are stable at room temperature for up to 8 
hours and should be prepared and used within this time. Precipitation of rifampin from the 
infusion solution may occur beyond this time. Dilutions in normal saline are stable at room 
temperature for up to 6 hours and should be prepared and used within this time. Other 
infusion solutions are not recommended.

Incompatibilities

Physical incompatibility (precipitate) was observed with undiluted (5 mg/mL) and diluted 
(1 mg/mL in normal saline) diltiazem hydrochloride and rifampin (8 mg/mL in normal saline) 
during simulated Y-site administration.

Meningococcal Carriers

Adults: For adults, it is recommended that 600 mg rifampin be administered twice daily 
for two days.

Pediatric Patients: Pediatric patients 1 month of age or older: 10 mg/kg (not to exceed 600 
mg per dose) every 12 hours for two days.

Pediatric patients under 1 month of age: 5 mg/kg every 12 hours for two days.

Preparation of Extemporaneous Oral Suspension

For pediatric and adult patients in whom capsule swallowing is difficult or where lower 
doses are needed, a liquid suspension may be prepared as follows:

1. Empty the contents of four RIFADIN 300 mg capsules or eight RIFADIN 150 mg 
capsules onto a piece of weighing paper.
2. If necessary, gently crush the capsule contents with a spatula to produce a fine 
powder.
3. Transfer the rifampin powder blend to a 4-ounce amber glass or plastic (high density 
   polyethylene [HDPE], polypropylene, or polycarbonate) prescription bottle.
4. Rinse the paper and spatula with 20 mL of one of the above-mentioned syrups, and 
   add the rinse to the bottle. Shake vigorously.
5. Add 100 mL of syrup to the bottle and shake vigorously.

This compounding procedure results in a 1% w/v suspension containing 10 mg rifampin/ 
ml. Stability studies indicate that the suspension is stable when stored at room temperature (25±3°C) 
or in a refrigerator (2–8°C) for four weeks. This extemporaneously prepared suspension must be shaken well prior to administration.

HOW SUPPLIED

150 mg maroon and scarlet capsules imprinted “RIFADIN 150.”

Bottles of 30 (NDC 0068-0510-30)

300 mg maroon and scarlet capsules imprinted “RIFADIN 300.”

Bottles of 60 (NDC 0068-0508-60)

Storage: Store at 25°C (77°F); excursions permitted to 15–30°C (59–86°F) [see USP 
Controlled Room Temperature]. Keep tightly closed. Store in a dry place. Avoid excessive 
heat.

RIFADIN IV (rifampin for injection USP) is available in sterile glass vials containing 600 
mg rifampin (NDC 0068-0597-01).

Storage: Store at 25°C (77°F); excursions permitted to 15–30°C (59–86°F) [see USP 
Controlled Room Temperature]. Avoid excessive heat (temperatures above 40°C or 
104°F). Protect from light.

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