**RIFATER®**

(rifampin, isoniazid and pyrazinamide USP)

**Tablets**

**WARNING**

Severe and sometimes fatal hepatic hepatitis associated with isoniazid, a component of RIFATER, may occur and may develop even after many months of treatment. The risk of developing hepatitis is age related. Approximate case rates by age are: 0 per 1,000 for persons under 20 years of age, 3 per 1,000 for persons in the 20 to 34 year age group, 12 per 1,000 for persons in the 35 to 49 year age group, 23 per 1,000 for persons in the 50 to 64 year age group, and 8 per 1,000 for persons over 65 years of age. The risk of hepatitis is increased with daily consumption of alcohol. Precise data to provide a fatality rate for isoniazid-related hepatitis is not available; however, in a U.S. Public Health Service Surveillance Study of 13,838 persons taking isoniazid, there were 8 deaths among 174 cases of hepatitis.

Therefore, patients given RIFATER, which contains isoniazid, should be carefully monitored and interviewed at monthly intervals. Serum transaminase concentration becomes elevated in about 10% to 20% of patients, usually during the first few months of therapy, but it can occur at any time. Usually enzyme levels return to normal despite continuance of the drug, but in some cases progressive liver dysfunction occurs. Patients should be instructed to report immediately any of the prodromal symptoms of hepatitis, such as fatigue, weakness, malaise, anorexia, nausea, or vomiting. If these symptoms appear or if signs suggestive of hepatic damage are detected, RIFATER, 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.

Patients with tuberculosis should be given appropriate treatment with alternative drugs. If isoniazid, a component of RIFATER, must be reinstated, it should be reinstated only after symptoms and laboratory abnormalities have cleared. RIFATER should not be restarted and instead, isoniazid should be restarted in very small and gradually increasing doses and should be withdrawn immediately if there is any indication of recurrent liver involvement. Treatment should be deferred in persons with acute hepatic diseases.

**DESCRIPTION**

RIFATER (rifampin/isoniazid/pyrazinamide USP) tablets are combination tablets containing 120 mg rifampin, 50 mg isoniazid, and 300 mg pyrazinamide for use in antibacterial therapy. The tablets also contain as inactive ingredients: povidone, carboxymethyl cellulose sodium, calcium stearate, sodium lauryl sulfate, sucrose, talc, acacia, titanium dioxide, kaolin, magnesium carbonate, colloidal silicon dioxide, dried aluminum hydroxide gel, ferric oxide, black iron oxide, carnauba wax, white beeswax, collophory, hard paraffin, lecithin, shellac, and propylene glycol. The RIFATER triple therapy combination was developed for dosing convenience.

**Rifampin**

Rifampin is a semisynthetic antibiotic derivative of rifamycin SV. Rifampin is a red-brown crystalline powder very slightly soluble in water at neutral pH, freely soluble in chloroform, soluble in ethyl acetate and methanol. Its molecular weight is 822.95 and its chemical formula is C₅₈H₈₀N₄O₁₂. The chemical name for rifampin is either: 3-[[4-(methyl-1-piperazinyl)imino]methyl]rifamycin or 5,6,9,17,19,21-hexahydroxy-23-methoxy-2,4,12,16,18,20,22-heptamethyl-8-[N-(4-methyl-1-piperazinyl)imino]methyl]-rifamycin.

Its structural formula is:

![Rifampin molecular structure]

**Isoniazid**

Isoniazid is the hydrazide of isonicotinic acid. It is a colorless or white crystalline powder or white crystals. It is odorless and slowly affected by exposure to air and light. It is freely soluble in water, sparingly soluble in alcohol and slightly soluble in chloroform and in ether. Its molecular weight is 137.14 and its chemical formula is C₁₂H₁₁NO₂.

The chemical name for isoniazid is 4-pyridinecarboxylic acid, hydrazide and its structural formula is:

![Isoniazid molecular structure]

**Pyrazinamide**

Pyrazinamide, the pyrazine analogue of nicotinamide, is a white, crystalline powder, stable at room temperature, and sparingly soluble in water. The chemical name for pyrazinamide is pyrazinecarboxamide and its molecular weight is 123.11. Its chemical formula is C₇H₇N₂O₃ and its structural formula is:

![Pyrazinamide molecular structure]

**CLINICAL PHARMACOLOGY**

**General**

A single-dose bioavailability study of five RIFATER tablets (Treatment A, n=23) versus RIFADIN 600 mg, isoniazid 250 mg, and pyrazinamide 1500 mg (Treatment B, n=24) administered concurrently in healthy subjects, there was no difference in extent of absorption, as measured by the area under the plasma concentration versus time curve (AUC), for any three components. However, the mean peak plasma concentration of rifampin was approximately 18% lower following the single-dose administration of RIFATER tablets as compared to RIFADIN administered in combination with pyrazinamide and isoniazid. Mean (±SD) pharmacokinetic parameters are summarized in the following table.

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Cmax (mcg/mL)</th>
<th>Half-life (hr)</th>
<th>Apparent Oral Clearance (L/hr)</th>
<th>Bioavailability (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Isoniazid</td>
<td>3.09</td>
<td>±0.88</td>
<td>3.14</td>
<td>±0.92</td>
</tr>
<tr>
<td>Rifampin</td>
<td>11.04</td>
<td>±3.08</td>
<td>13.61</td>
<td>±3.96</td>
</tr>
<tr>
<td>Pyrazinamide</td>
<td>28.02</td>
<td>±4.52</td>
<td>29.21</td>
<td>±4.35</td>
</tr>
</tbody>
</table>

The effect of food on the pharmacokinetics of RIFATER tablets was not studied.

**Rifampin**

Rifampin is readily absorbed from the gastrointestinal tract. Peak serum levels 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 level 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.

In healthy adults, the biological half-life of rifampin in serum averages 3.3±0.66 hours after a 600 mg oral dose, with increases up to 5.08±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 30–50 mL/min, less than 30 mL/min, and in anuric patients, respectively. Refer to the WARNINGS section for information regarding patients with hepatic insufficiency.

After absorption, rifampin is rapidly eliminated in the biliary 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, and metabolism is reduced by deacetylation, and elimination is facilitated. Up to 30% of a dose is excreted in the urine, with about half as unchanged drug.

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 is diffused freely in tissues.

**Pediatrics**

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. Peak serum concentrations of 10.7±3.7 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 t½ 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.

**Isoniazid**

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The chemical name for isoniazid is 4-pyridinecarboxylic acid, hydrazide and its structural formula is:

![Isoniazid molecular structure]

**Pyrazinamide**

Pyrazinamide, the pyrazine analogue of nicotinamide, is a white, crystalline powder, stable at room temperature, and sparingly soluble in water. The chemical name for pyrazinamide is pyrazinecarboxamide and its molecular weight is 123.11. Its chemical formula is C₇H₇N₂O₃ and its structural formula is:

![Pyrazinamide molecular structure]
Caucasians are “slow inactivators” and the rest are “rapid inactivators”; the majority of Eskimos and Asians are “rapid inactivators.” The rate of acetylation does not significantly alter the effectiveness of isoniazid. However, slow acetylation may lead to higher blood levels of the drug, and, thus, an increase in toxic reactions. Pyridoxine (B6) deficiency is sometimes observed in adults with high doses of isoniazid and is probably due to its competition with pyridoxal phosphate for the enzyme apotryptophanase.

Pyrazinamide

Pyrazinamide is well absorbed from the gastrointestinal tract and attains peak plasma concentrations within 2 hours. Plasma concentrations generally range from 5 to 50 mcg/mL with doses of 20 to 25 mg/kg. It is widely distributed in body tissues and fluids including the liver, lungs, and cerebrospinal fluid (CSF). The CSF concentration is approximately equal to concurrent steady-state plasma concentrations in patients with inflamed meninges. Pyrazinamide is approximately 10% bound to plasma proteins. The plasma half-life of pyrazinamide is 9 to 10 hours in patients with normal renal and hepatic function. The half-life of the drug may be prolonged in patients with impaired renal or hepatic function. Pyrazinamide is hydrolyzed in the liver to its major active metabolite, pyrazinoic acid. Pyrazinoic acid is hydroxylated to the main excretory product, 5-hydroxy-pyrazinoic acid.

Within 24 hours, approximately 70% of an oral dose of pyrazinamide is excreted in urine, mainly by glomerular filtration. About 4% to 14% of the dose is excreted as unchanged drug; the remainder is excreted as metabolites.

Microbiology

Mechanism of Action

Rifampin

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.

Isoniazid

Isoniazid inhibits the biosynthesis of mycolic acids which are major components of the cell wall of Mycobacterium tuberculosis.

Pyrazinamide

The exact mechanism of action by which pyrazinamide inhibits the growth of Mycobacterium tuberculosis organisms is unknown.

Resistance

Organisms resistant to rifampin are likely to be resistant to other rifamycins. β-lactamase production should have no effect on rifampin activity.

In the treatment of tuberculosis, the small number of resistant cells present within large populations of susceptible cells can rapidly become predominant. In addition, the resistance to rifampin has been determined to occur as single-step mutations of the DNA-dependent RNA polymerase. Since resistance can emerge rapidly, appropriate susceptibility tests should be performed in the event of persistent positive cultures.

Activity in vivo and in vitro

Rifampin, isoniazid, and pyrazinamide at therapeutic levels have demonstrated bactericidal activity against both intracellular and extracellular Mycobacterium tuberculosis organisms (see INDICATIONS AND USAGE). Pyrazinamide alone is only active at a slightly acidic pH (pH 5.5) in vitro and in vivo. Isoniazid kills actively growing tubercle bacilli.

Susceptibility Testing

For specific information regarding susceptibility test criteria and associated test methods and quality control standards recognized by FDA for this drug, please see: www.fda.gov/STIC.

CLINICAL TRIALS

A total of 250 patients were enrolled in an open label, prospective, randomized, parallel group, active-controlled trial for the treatment of pulmonary tuberculosis. There were 241 patients evaluable for efficacy, 123 patients received isoniazid, rifampin, and pyrazinamide (see INDICATIONS AND USAGE). Resistance Organisms resistant to rifampin are likely to be resistant to other rifamycins. β-lactamase production should have no effect on rifampin activity.

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INDICATIONS AND USAGE

RIFATER is indicated in the initial phase of the short-course treatment of pulmonary tuberculosis. During this phase, which should last 2 months, RIFATER should be administered on a daily, continuous basis (see DOSAGE AND ADMINISTRATION). Following the initial phase and treatment with RIFATER, treatment should be continued with rifampin and isoniazid for at least 4 months. Treatment should be continued for a longer period of time if the patient is smear or culture positive, if resistant organisms are present, or if the patient is HIV positive.

In the treatment of tuberculosis, the small number of resistant cells present within large populations of susceptible cells can rapidly become the predominant type. Since resistance can emerge rapidly, susceptibility tests should be performed in the event of persistent positive cultures during the course of treatment. Bacteriologic smears or cultures should be obtained before the start of therapy to confirm the susceptibility of the organism to rifampin, isoniazid, and pyrazinamide and they should be repeated throughout therapy to monitor response to the treatment. If test results show resistance to any of the components of RIFATER and the patient is no longer responding to therapy, the drug regimen should be modified.

CONTRAINDICATIONS

RIFATER is contraindicated in patients with a history of hypersensitivity to rifampin, isoniazid, pyrazinamide or any of the components, or to any of the rifamycins.

Rifampin

RIFATER, which contains rifampin, is contraindicated in patients who are also receiving:
• ritonavir-boosted saquinavir due to an increased risk of severe hepatoxicity toxicity.
• atazanavir, 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.
• praziquantel due to 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.
• praziquantel with other hepatotoxic agents.

Other contraindications include patients with severe hepatic damage; severe adverse reactions to isoniazid, a component of RIFATER, such as drug fever, chills, and arthritis; patients with acute liver disease of any etiology; and patients with acute gout.

WARNINGS

RIFATER is a combination of the three drugs, rifampin, isoniazid, and pyrazinamide. Each of these individual drugs has been associated with liver dysfunction. Systemic hypersensitivity reactions were reported with all three components of RIFATER (rifampin, isoniazid, and pyrazinamide). Signs and symptoms of hypersensitivity reactions may include fever, rash, urticaria, angioedema, hypotension, acute bronchospasm, hypoglycemia, nausea, vomiting, headache, chills, fever, sweating, lassitude, malaise, leukopenia, anemia, thrombocytopenia, renal dysfunction, jaundice, and eosinophilia. If these signs or symptoms occur, discontinue RIFATER and administer appropriate therapy.

Other contraindications include patients with acute liver disease of any etiology; and patients with acute gout.

During the continuation phase, both treatment groups received 450 mg of rifampin and 300 mg of isoniazid per day for 4 months if the patient weighed <50 kg or 600 mg of rifampin and 300 mg of isoniazid per day for 4 months if the patient weighed ≥50 kg. Patients were followed for occurrence of relapses for up to 30 months after the end of therapy. There were no significant differences in the negative bacteriological sputum results (available in a subset of patients) between the two treatments at 2 and 6 months during the trial and during the follow-up period. See table below.

Dose of Isoniazid, Rifampin, and Pyrazinamide Administered as Separate Drugs

<table>
<thead>
<tr>
<th>Patient Weight</th>
<th>Isoniazid (mg)</th>
<th>Rifampin (mg)</th>
<th>Pyrazinamide (mg)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;50 kg</td>
<td>300</td>
<td>450</td>
<td>1500</td>
</tr>
<tr>
<td>≥50 kg</td>
<td>300</td>
<td>600</td>
<td>2000</td>
</tr>
</tbody>
</table>

Dose of Isoniazid, Rifampin, and Pyrazinamide Administered as RIFATER

<table>
<thead>
<tr>
<th>Patient Weight</th>
<th>Number of Tablets</th>
<th>Isoniazid (mg)</th>
<th>Rifampin (mg)</th>
<th>Pyrazinamide (mg)</th>
</tr>
</thead>
<tbody>
<tr>
<td>≤44 kg</td>
<td>4</td>
<td>200</td>
<td>480</td>
<td>1200</td>
</tr>
<tr>
<td>45 to 54 kg</td>
<td>5</td>
<td>250</td>
<td>600</td>
<td>1500</td>
</tr>
<tr>
<td>≥55 kg</td>
<td>6</td>
<td>300</td>
<td>720</td>
<td>1800</td>
</tr>
</tbody>
</table>

The median follow-up time for all the RIFATER patients was 736 days with a range of 42 to 1325 days and 745 days with a range of 50 to 1427 days for the patients dosed with separate tablets and capsules.

 astronomical elevations in liver enzymes, isolated jaundice/hyperbilirubinemia, symptomatic self-limited hepatitis to fulminant liver failure and death. Severe hepatic dysfunction is defined by an increase in transaminase levels to >5 times the upper limit of normal or if liver dysfunction is life-threatening. If worsening of symptoms or signs occurs during antituberculosis treatment, appropriate therapy.

RIFATER (rifampin, isoniazid, and pyrazinamide). If symptoms or signs of severe cutaneous adverse reactions develop, discontinue RIFATER and institute appropriate therapy.

Postmarketing cases of paradoxical drug reaction (recurrence or appearance of new symptoms, physical and radiological signs in a patient who had previously shown improvement with appropriate antituberculosis treatment, in the absence of disease relapse, poor treatment compliance, drug resistance, side effects of treatment, or secondary infection/diagnosis) have been reported with all three components of RIFATER (rifampin, isoniazid, and pyrazinamide) (see ADVERSE REACTIONS). Paradoxical drug reactions are often transient and should not be misinterpreted as failure to respond to treatment. If worsening of symptoms or signs occurs during antituberculosis treatment, consider paradoxical drug reaction in the differential diagnosis, monitor, or treat accordingly.

Rifampin

Hepatotoxicity of hepatocellular, cholestatic, and mixed patterns has been reported in patients treated with rifampin, a component of RIFATER. Severity ranged from asymptomatic elevations in liver enzymes, isolated jaundice/hyperbilirubinemia, symptomatic self-limited hepatitis to fulminant liver failure and death. Severe hepatic dysfunction is defined by an increase in transaminase levels to >5 times the upper limit of normal or if liver dysfunction is life-threatening. If worsening of symptoms or signs occurs during antituberculosis treatment, appropriate therapy.

Monitor for symptoms and clinical/ laboratory signs of liver injury, especially if treatment is prolonged or given with other hepatotoxic drugs. Patients with impaired liver function should be given RIFATER only in cases of necessity and then under strict medical
supervision. In these patients, careful monitoring of liver function should be done prior to therapy and then every 2 to 4 weeks during therapy. If signs of hepatic damage occur or worsen, discontinue RIFATER.

Rifampin, a component of RIFATER, has enzyme-inducing properties, including induction of delta amino levulinic acid synthetase. Isolated reports have associated porphyria exacerabation with rifampin, a component of RIFATER.

Cases of severe cutaneous adverse reactions (SCAR) such as Stevens-Johnson syndrome or toxic epidermal necrolysis (TEN), acute generalized exanthematous pustulose (AGEP, and drug reaction with eosinophilia and systemic symptoms (DRESS)) syndrome have been reported with rifampin. If symptoms or signs of severe cutaneous adverse reactions develop, discontinue RIFATER immediately and institute appropriate therapy.

Rifampin, a component of RIFATER, may cause vitamin K–dependent coagulation disorders and bleeding (see ADVERSE REACTIONS). Monitor coagulation tests during RIFATER treatment (prothrombin time and other coagulation tests) in patients at risk of vitamin K deficiency (such as those with chronic liver disease, poor nutritional status, on prolonged antibacterial drugs or anticoagulants). Consider discontinuation of RIFATER if abnormal prothrombin time is noted or bleeding occurs. Supplemental vitamin K administration should be considered when appropriate.

Postmarketing reports suggest that concomitant administration of high doses of cefazolin and rifampin, a component of RIFATER, may prolong the prothrombin time, leading to severe vitamin K–dependent coagulation disorders that may be life-threatening or fatal. Avoid concomitant use of cefazolin and RIFATER in patients at increased risk for bleeding. If no alternative treatment options are available, closely monitor prothrombin time and other coagulation tests, and administer vitamin K as indicated.

Pulmonary toxicity manifested as interstitial lung disease (including, but not limited to, pneumonitis, hypersensitivity pneumonitis, eosinophilic pneumonia, pulmonary infiltrates, and organizing pneumonia) has been reported with treatment with rifampin, a component of RIFATER. Pulmonary toxicity could be fatal. If symptoms or signs of severe pulmonary toxicity (respiratory distress, hypoxia, and acute respiratory distress syndrome) develop, discontinue RIFATER immediately and initiate appropriate treatment.

Genital rash or pruritus and/or miliaria lesions immediately. Discontinue RIFATER, if these reactions occur.

Cases of thrombotic microangiopathy (TMA), including thrombotic thrombocytopenic purpura and hemolytic uremia syndrome, some fatal, have been reported with rifampin. Discontinue RIFATER if symptoms and laboratory findings consistent with TMA occur. The findings of unexplained thrombocytopenia and anemia should prompt further evaluation and consideration of the diagnosis of TMA.

Pyrazinamide

Since RIFATER contains pyrazinamide, patients started on RIFATER should have baseline serum uric acid and liver function determinations. Patients with preexisting liver disease or those patients at increased risk for drug related hepatitis (e.g., alcohol abusers) should be followed closely.

Because it contains pyrazinamide, RIFATER should be discontinued and not be resumed if signs of hepatoceleular damage or hyperuricemia accompanied by an acute gouty arthritis appear. If hyperuricemia accompanied by an acute gouty arthritis occurs without liver dysfunction, the patient should be transferred to a regimen not containing pyrazinamid.

PRECAUTIONS

General

RIFATER should be used with caution in patients with a history of diabetes mellitus, as diabetes management may be more difficult.

Rifampin

For treatment of tuberculosis, rifampin, a component of RIFATER, is usually administered on a daily basis. Doses of rifampin (600 mg) given once or twice weekly have resulted in therapeutic drug levels in some regimens. A dosage of 900 mg (daily or twice weekly) is effective in some patients in whom once or twice weekly doses of rifampin are less effective than daily dosing. Doses of 900 mg (daily or twice weekly) are usually well tolerated by adults but are likely to be associated with more gastrointestinal toxicity than daily doses. RIFATER, a combination of rifampin and isoniazid, 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, when given as a single daily dose, may cause symptoms or signs of severe cutaneous adverse reactions. Cases of Stevens-Johnson syndrome and toxic epidermal necrolysis (TEN) have been reported. RIFATER, a combination of rifampin and isoniazid, is also associated with the risk of developing drug reactions. The patient should be instructed to notify their physician immediately if they experience any of the following: rash with fever or blisters, with or without peeling skin, itching, or swollen lymph nodes, loss of appetite, malaise, nausea, vomiting, abdominal pain, darkened urine, yellowish discoloration of the skin and eyes, light-colored bowel movements, fever, hepatitis, fatigue, myalgias, cough, shortness of breath, chest pain, wheezing, and pain or swelling of the joints.

Patients should be advised to seek medical advice immediately if their symptoms of tuberculosis, including, but not limited to, cough, fever, tiredness, shortness of breath, malaise, headache, pain, night sweats, swollen glands, loss of appetite, weight loss, or weakness, worse (see ADVERSE REACTIONS).

Advise patients to abstain from alcohol, hepatotoxic medications or herbal products while taking RIFATER.

Concomitance with the full course of therapy must be emphasized, and the importance of not missing any doses must be stressed.

Laboratory Tests

Adults treated for tuberculosis with RIFATER should have baseline measurements of hepatic enzymes, bilirubin, serum creatinine, a complete blood count (CBC) and platelet count, and uric acid. Routine laboratory monitoring for toxicity in people with normal baseline measurements is generally not necessary.

Drug Interactions of the Individual Components of RIFATER

There were no drug-drug interaction trials conducted with RIFATER. Information regarding potential drug interactions with the individual components of RIFATER are provided below. These recommendations include quantitative clinical effects based on drug interaction trials, qualitative effects noted in the primary literature, or predicted interactions due to the expected magnitude of interaction and potential for serious adverse events or loss of efficacy. (See CONTRAINDICATIONS.)

Rifampin and Isoniazid

Cytochrome P450 enzyme interaction

Rifampin is known to induce and isoniazid is known to inhibit certain cytochrome P450 enzymes. The impact of the competing effects of rifampin and isoniazid on the metabolism of drugs that undergo biotransformation through the affected pathways is unknown. Therefore, caution should be used when prescribing RIFATER with drugs metabolized by cytochrome P450. To maintain optimum therapeutic drug concentrations, dosages of drugs metabolized by these enzymes may require adjustment when starting or stopping RIFATER.

Rifampin

Pharmacodynamic Interactions

Healthy volunteers given rifampin, 600 mg once daily concomitantly with saquinavir 1000 mg/ritonavir 100 mg twice daily (ritonavir-boosted saquinavir) developed severe hepatocellular toxicity. Concomitant use of ritonavir-boosted saquinavir and RIFATER is contraindicated. (See CONTRAINDICATIONS.)

Rifampin, given concurrently with other hepatotoxic medications such as halothane or isoniazid, the potential for hepatotoxicity is increased. Avoid concomitant use of RIFATER with halothane. Monitor patients receiving RIFATER for hepatotoxicity. (See the boxed WARNING.)

Effect of Rifampin on Other Drugs

Induction of Drug Metabolizing Enzymes and Transporter Systems

Drug metabolizing enzymes and transporters affected by rifampin include cytochromes P450 (CYP) 1A2, 2B6, 2C8, 2C9, 2C19, and 3A4, UDP-glucuronosyltransferases (UGT), sulfotransferases, and P-glycoproteins (P-gp) and multidrug resistance-associated protein 2 (MRP2). Most drugs are substrates for one or more of these enzyme or transporter pathways and these pathways may be induced by rifampin simultaneously. Therefore, rifampin may increase the metabolism and decrease the half-life of certain substrates. Drugs that increase the activity of a coadministered pro-drug (where metabolic activation is required), and has the potential to perpetuate clinically important drug-drug interactions against many drugs and across many drug classes (Table 1).

Table 1 summarizes the effect of rifampin on other drugs or drug classes. Adjust dosages

3. Patients with current chronic liver disease or severe renal dysfunction.

Pyrazinamide

Pyrazinamide, a component of RIFATER, inhibits renal excretion of urate, frequently resulting in hyperuricemia which is usually asymptomatic. If hyperuricemia is accompanied by acute gouty arthritis, RIFATER should be discontinued.
of concomitant drugs based on approved drug labeling and if applicable, therapeutic drug monitoring, unless otherwise specified.

<table>
<thead>
<tr>
<th>Drug or Drug Class and Prevention or Management</th>
<th>Clinical Effect</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Antiretrovirals</strong></td>
<td></td>
</tr>
<tr>
<td>Prevention or Management: Concomitant use is contraindicated (see CONTRAINDICATIONS)</td>
<td></td>
</tr>
<tr>
<td>Alazanavir</td>
<td>Decrease AUC by 72%</td>
</tr>
<tr>
<td>Darunavir†</td>
<td>Substantial decrease in exposure, which may result in loss of therapeutic effect and development of resistance.</td>
</tr>
<tr>
<td>Tiranavir</td>
<td>Decrease AUC by 82%</td>
</tr>
<tr>
<td>Fosamprenavir†</td>
<td>Decrease AUC by 70%</td>
</tr>
<tr>
<td>Saquinavir</td>
<td>Coadministration may result in severe hepatocellular toxicity.</td>
</tr>
<tr>
<td><strong>Antiretrovirals</strong></td>
<td></td>
</tr>
<tr>
<td>Prevention or Management: Avoid concomitant use</td>
<td></td>
</tr>
<tr>
<td>Zidovudine</td>
<td>Decrease AUC by 47%</td>
</tr>
<tr>
<td>Indinavir</td>
<td>Decrease AUC by 92%</td>
</tr>
<tr>
<td>Efavirenz</td>
<td>Decrease AUC by 26%</td>
</tr>
<tr>
<td><strong>Hepatitis C Antiviral</strong></td>
<td></td>
</tr>
<tr>
<td>Prevention or Management: Avoid concomitant use</td>
<td></td>
</tr>
<tr>
<td>Daclatasvir</td>
<td>Decrease AUC by 79%</td>
</tr>
<tr>
<td>Simeprevir</td>
<td>Decrease AUC by 48%</td>
</tr>
<tr>
<td>Sofosbuvir†</td>
<td>Decrease AUC by 72%</td>
</tr>
<tr>
<td>Telaprevir</td>
<td>Decrease AUC by 92%</td>
</tr>
<tr>
<td><strong>Systemic Hormonal Contraceptives</strong></td>
<td></td>
</tr>
<tr>
<td>Prevention or Management: Advise patients to change to non-hormonal methods of birth control during treatment with RIFATER, which contains rifampin</td>
<td></td>
</tr>
<tr>
<td>Estrogens</td>
<td>Increase exposure</td>
</tr>
<tr>
<td>Progestins</td>
<td>Increase exposure</td>
</tr>
<tr>
<td><strong>Anticonvulsants</strong></td>
<td></td>
</tr>
<tr>
<td>Phenytoin§</td>
<td>Decrease exposure§</td>
</tr>
<tr>
<td><strong>Antiarrhythmics</strong></td>
<td></td>
</tr>
<tr>
<td>Disopyramide</td>
<td>Decrease exposure</td>
</tr>
<tr>
<td>Mexiletine</td>
<td>Decrease exposure</td>
</tr>
<tr>
<td>Quinidine</td>
<td>Decrease exposure</td>
</tr>
<tr>
<td>Propafenone</td>
<td>Decrease AUC by 50%–67%</td>
</tr>
<tr>
<td>Tocainide</td>
<td>Decrease exposure</td>
</tr>
<tr>
<td><strong>Antiestrogens</strong></td>
<td></td>
</tr>
<tr>
<td>Tamoxifen</td>
<td>Decrease AUC by 86%</td>
</tr>
<tr>
<td>Toremifene</td>
<td>Decrease steady state concentrations of toremifene in serum</td>
</tr>
<tr>
<td><strong>Antithrombotic Agents</strong></td>
<td></td>
</tr>
<tr>
<td>Clopidogrel Prevention or Management: Concomitant use of clopidogrel and rifampin should be discouraged</td>
<td>Increase active metabolite exposure and risk of bleeding</td>
</tr>
<tr>
<td>Ticagrelor Prevention or Management: Avoid use</td>
<td>Decrease exposure</td>
</tr>
<tr>
<td><strong>Antipsychotics</strong></td>
<td></td>
</tr>
<tr>
<td>Haloperidol</td>
<td>Decrease plasma concentrations by 70%</td>
</tr>
<tr>
<td><strong>Oral Anticoagulants</strong></td>
<td></td>
</tr>
<tr>
<td>Prevention or Management: Perform prothrombin time daily or as frequently as necessary to establish and maintain the required dose of anticoagulant</td>
<td>Decrease exposure</td>
</tr>
<tr>
<td>Warfarin</td>
<td>Decrease exposure</td>
</tr>
<tr>
<td><strong>Antifungals</strong></td>
<td></td>
</tr>
</tbody>
</table>

**Table 1: Drug Interactions with Rifampin that Affect Concomitant Drug Concentrations (continued)**

<table>
<thead>
<tr>
<th>Drug or Drug Class and Prevention or Management</th>
<th>Clinical Effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fluconazole</td>
<td>Decrease AUC by 23%</td>
</tr>
<tr>
<td>Itraconazole</td>
<td>Decrease exposure</td>
</tr>
<tr>
<td>Prevention or Management: Not recommended 2 weeks before and during itraconazole treatment</td>
<td></td>
</tr>
<tr>
<td>Ketoconazole</td>
<td>Decrease exposure</td>
</tr>
<tr>
<td><strong>Beta-blockers</strong></td>
<td></td>
</tr>
<tr>
<td>Metoprolol</td>
<td>Decrease exposure</td>
</tr>
<tr>
<td>Propranolol</td>
<td>Decrease exposure</td>
</tr>
<tr>
<td><strong>Benzodiazepines</strong></td>
<td></td>
</tr>
<tr>
<td>Diazepam-§</td>
<td>Decrease exposure</td>
</tr>
<tr>
<td><strong>Benzodiazepine-related drugs</strong></td>
<td></td>
</tr>
<tr>
<td>Zopiclone</td>
<td>Decrease AUC by 82%</td>
</tr>
<tr>
<td>Zolpidem</td>
<td>Decrease AUC by 73%</td>
</tr>
<tr>
<td><strong>Calcium Channel Blockers</strong>§</td>
<td></td>
</tr>
<tr>
<td>Diltiazem</td>
<td>Decrease exposure</td>
</tr>
<tr>
<td><strong>Antipsychotics</strong></td>
<td></td>
</tr>
<tr>
<td>Haloperidol§</td>
<td>Decrease exposure</td>
</tr>
<tr>
<td><strong>Cardiac Glycosides</strong></td>
<td></td>
</tr>
<tr>
<td>Digoxin Prevention or Management: Measure serum digoxin concentrations before initiating RIFATER, which contains rifampin. Continue monitoring and increase digoxin dose by approximately 20%–40% as necessary.</td>
<td>Decrease exposure</td>
</tr>
<tr>
<td>Digitoxin</td>
<td>Decrease exposure</td>
</tr>
<tr>
<td><strong>Fluoroquinolones</strong></td>
<td></td>
</tr>
<tr>
<td>Pefloxacin§</td>
<td>Decrease exposure</td>
</tr>
<tr>
<td>Moxifloxacin§†</td>
<td>Decrease exposure</td>
</tr>
<tr>
<td><strong>Oral Hypoglycemic Agents (e.g., sulfonylureas)</strong></td>
<td></td>
</tr>
<tr>
<td>Glyburide</td>
<td>Decrease exposure</td>
</tr>
<tr>
<td>Coadministration of glyburide with RIFATER may worsen glucose control of glyburide.</td>
<td></td>
</tr>
<tr>
<td>Glipizide</td>
<td>Decrease exposure</td>
</tr>
<tr>
<td><strong>Immunosuppressive Agents</strong></td>
<td></td>
</tr>
<tr>
<td>Cyclosporine</td>
<td>Decrease exposure</td>
</tr>
<tr>
<td>Tacrolimus Prevention or Management: Monitoring of whole blood concentrations and appropriate dosage adjustments of tacrolimus are recommended when RIFATER, which contains rifampin, and tacrolimus are used concomitantly.</td>
<td>Decrease AUC by 56%</td>
</tr>
<tr>
<td><strong>Narcotic Analgesics</strong></td>
<td></td>
</tr>
<tr>
<td>Oxycodone</td>
<td>Decrease AUC by 86%</td>
</tr>
<tr>
<td>Morphine</td>
<td>Decrease exposure</td>
</tr>
<tr>
<td><strong>Selective 5-HT3 Receptor Antagonists</strong></td>
<td></td>
</tr>
<tr>
<td>Ondansetron</td>
<td>Decrease exposure</td>
</tr>
<tr>
<td><strong>Statins Metabolized by CYP3A4</strong></td>
<td></td>
</tr>
<tr>
<td>Simvastatin</td>
<td>Decrease exposure</td>
</tr>
<tr>
<td>Thiazolidinediones</td>
<td>Decrease exposure</td>
</tr>
<tr>
<td>Rosiglitazone</td>
<td>Decrease AUC by 66%</td>
</tr>
<tr>
<td><strong>Tricyclic Antidepressants</strong></td>
<td></td>
</tr>
</tbody>
</table>
Concomitant use with probenecid and cotrimoxazole increases the concentration of antacids.

Concomitant use with antacids may reduce the absorption of rifampin which may reduce the effect of Other Drugs on Rifampin.

Table 1: Drug Interactions with Rifampin that Affect Concomitant Drug Concentrations (continued)

<table>
<thead>
<tr>
<th>Drug or Drug Class and Prevention or Management</th>
<th>Clinical Effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nortriptyline&lt;sup&gt;a&lt;/sup&gt;</td>
<td>Decrease exposure</td>
</tr>
<tr>
<td>Other Drugs</td>
<td></td>
</tr>
<tr>
<td>Enalapril</td>
<td>Decrease active metabolite exposure</td>
</tr>
<tr>
<td>Chloramphenicol&lt;sup&gt;b&lt;/sup&gt;</td>
<td>Decrease exposure</td>
</tr>
<tr>
<td>Clarithromycin</td>
<td>Decrease exposure</td>
</tr>
</tbody>
</table>

Dapsone

Rifampin has been shown to increase the clearance of dapsone and, accordingly, decrease dapsone exposure. Rifampin has also been shown to increase the production of the hydroxylamine metabolite of dapsone which could increase the risk of methemoglobinemia.

Doxycycline<sup>b</sup>

Decrease exposure

Irinotecan<sup>a</sup> Prevention or Management: Avoid the use of RIFATER (which contains rifampin, a strong CYP3A4 inducer) if possible. Substitute non-enzyme inducing therapies at least 2 weeks prior to initiation of irinotecan therapy.

Decrease irinotecan and active metabolite exposure

Levothyroxine

Decrease exposure

<table>
<thead>
<tr>
<th>Drug</th>
<th>Parent</th>
<th>Active metabolite (E3174)</th>
<th>Decrease AUC by 30%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Losartan</td>
<td></td>
<td>Active metabolite</td>
<td></td>
</tr>
<tr>
<td>Methadone</td>
<td></td>
<td></td>
<td>Decrease AUC by 40%</td>
</tr>
</tbody>
</table>

Praziquantel

Prevention or Management: Concomitant use is contraindicated (see CONTRAINDICATIONS).

Decrease plasma praziquantel concentrations to undetectable levels

Quinine

Prevention or Management: Avoid concomitant use

Decrease AUC by 75%–85%

Tetrahydrocannabinol

Decrease AUC by 86%

Theophylline

Decrease exposure by 20% to 40%

AUC = area under the time-concentration curve

<sup>a</sup>Administered with rifampin 600 mg daily, unless otherwise specified

<sup>b</sup>Rifampin dosage used concomitantly with the drug(s) is not specified in the proposed package insert.

<sup>c</sup>Administered with rifampin 300 mg daily

<sup>d</sup>Administered with rifampin 450 mg daily

<sup>e</sup>Administered with rifampin 1200 mg daily

<sup>f</sup>Rifampin 1200 mg administered as a single oral dose 8 hours before administering a single oral dose of nifedipine 10 mg

<sup>g</sup>Numerous cases in the literature describe a decrease in glucocorticoid effect when used concomitantly with rifampin. The literature contains reports of acute adrenal crisis or adrenal insufficiency induced by the combination of rifampin-isoniazid-ethambutol or rifampin-isoniazid in patients with Addison's disease.

<sup>h</sup>Administered with rifampin 900 mg daily

<sup>i</sup>A tuberculosis treatment regimen including rifampin (600 mg/day), isoniazid (300 mg/day), pyrazinamide (500 mg 3x per day), and pyridoxine (25 mg) was associated with higher than expected doses of nortriptyline to be required to obtain a therapeutic drug level. Following the discontinuation of rifampin, the patient became drowsy and the serum nortriptyline levels rose precipitously (3-fold) into the toxic range.

<sup>j</sup>Concomitant use with rifampin in 2 children

<sup>k</sup>Administered with rifampin (10 mg/kg daily)

<sup>l</sup>Administered with an antibiotic regimen including rifampin (450 mg/day), isoniazid (300 mg/day), and streptomycin (0.5 g/day) IM

**Effect of Other Drugs on Rifampin**

Concomitant use with antacids may reduce the absorption of rifampin which may reduce the efficacy of RIFATER. Administer RIFATER at least 1 hour before the ingestion of antacids.

Concomitant use with probenecid and cotrimoxazole increases the concentration of rifampin which may increase the risk of RIFATER toxicities. Monitor for adverse reactions associated with RIFATER during coadministration.

**Other Interactions**

**Atovaquone**

Concomitant use of RIFATER with atovaquone decreases concentrations of atovaquone and increase concentrations of rifampin which may increase the risk of RIFATER toxicities. Coadministration of RIFATER with atovaquone is not recommended.

**Isoniazid**

**Pharmacodynamic Interactions**

Concomitant use with daily ingestion of alcohol may be associated with a higher incidence of isoniazid hepatiitis. Concomitant use of isoniazid with rifampin may increase the hepatotoxicity of both drugs. Monitor patients using RIFATER for hepatitis.

Concomitant use may exaggerate the CNS effects of meperidine (drowsiness), cycloserine (dizziness, drowsiness), and disulfiram (acute behavioral and coordination changes).

Concomitant use with levedopa may produce symptoms of excess catecholamine stimulation (agitation, flushing, palpitations) or lack of levedopa effect.

Concomitant use with oral hypoglycemics may produce hyperglycemia and lead to loss of glucose control.

Concomitant use with enflurane may produce high concentrations of hydrazine that facilitate defluorination of enflurane due to fast acetylation of isoniazid. Monitor renal function.

**Pharmacokinetic Interactions**

**Effect of Isoniazid on Other Drugs**

Inhibition of drug metabolizing enzymes

Isoniazid, a component of RIFATER, is known to inhibit certain cytochrome P-450 enzymes (e.g., CYP1A2, CYP2C9, CYP2C19, CYP3A4). Concomitant use may decrease elimination of drugs metabolized by these enzymes which may increase the risk of toxicities of these drugs. Adjust dosages of drugs metabolized by these enzymes based on approved drug labeling and if applicable, therapeutic drug monitoring.

Isoniazid has been reported to inhibit the metabolism of the following drugs: anticonvulsants (e.g., carbamazepine, phenytoin, primidone, valproic acid), benzodiazepines (e.g., diazepam), haloperidol, theophylline, and warfarin. Therefore, isoniazid may increase the risk of toxicities of these drugs. However, as RIFATER contains both isoniazid (inhibitor) and rifampin (inducer), the effect on the metabolism of the above listed drugs when used concomitantly with RIFATER is unknown. A potential for increased toxicity cannot be excluded. Monitor closely for adverse reactions.

**Other Interactions**

**Antacid**

Concomitant use with antacid may reduce the absorption of isoniazid which may reduce RIFATER efficacy. Administer RIFATER at least 1 hour before use of antacids.

**Corticosteroids**

Concomitant use with corticosteroids (e.g., prednisolone) may decrease the serum concentration of isoniazid by increasing acetylation rate and/or renal clearance which may reduce RIFATER efficacy.

**Para-aminosalicylic acid**

Concomitant use with para-aminosalicylic acid may increase the plasma concentration and elimination half-life of isoniazid by competition of acetylating enzymes which may increase the risk of RIFATER toxicities.

**Drug/Laboratory Test Interactions**

**Rifampin**

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

Therapeutic levels of rifampin, a component of RIFATER, have been shown to inhibit standard microbiological assays for serum folate and vitamin B<sub>12</sub>. Therefore, alternative assay methods should be considered. Transient abnormalities in liver function tests (e.g., elevation in serum bilirubin, alkaline phosphatase and serum transaminases), and reduced bilirubin 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 RIFATER.

Rifampin and isoniazid, components of RIFATER, have been reported to alter vitamin D metabolism. In some cases, reduced levels of circulating 25-hydroxy vitamin D and 1,25-dihydroxy vitamin D have been accompanied by reduced serum calcium and phosphate, and elevated parathyroid hormone.

**Pyrazinamide**

Pyrazinamide, a component of RIFATER, has been reported to interfere with ACETEST® and KETOSTIX® urine tests to produce a pink-brown color.

**Carcinogenesis, Mutagenesis, Impairment of Fertility**

There were no nonclinical studies conducted with RIFATER.

Increased frequency of chromosomal aberrations was observed in vitro in lymphocytes obtained from patients treated with combinations of rifampin, isoniazid, and pyrazinamide and combinations of streptomycin, rifampin, isoniazid, and pyrazinamide.

Information regarding potential carcinogenic and mutagenic effects with the individual components of RIFATER are provided below.

**Rifampin**

A few cases of accelerated growth of lung carcinoma have been reported in man, but a causal relationship with the drug has not been established. Hepatomas were increased in female B6C3F1/DPI mice dosed for 60 weeks with rifampin followed by an observation period of 46 weeks, at 20 to 120 mg/kg (equivalent to 0.1 to 0.5 times the maximum dosage used clinically, based on body surface area comparisons). There was 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 (Saccharomyces cerevisiae, Escherichia coli) and eukaryotic (Drosophila melanogaster, Salmonella typhi, Drosophila melanogaster, or ICR/Ha Swiss mice). An increase in chromatid 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 pyrazinamide and combinations of streptomycin, rifampin, isoniazid, and pyrazinamide.
Isoniazid
Isoniazid has been reported to induce pulmonary tumors in a number of strains of mice.

Pyrazinamide
Pyrazinamide was not carcinogenic in lifetime bioassays in rats (at doses up to 500 mg/kg, about three times the recommended human dose, based on body surface area comparisons) or mice (at doses up to 2000 mg/kg, about five times the recommended human dose, based on body surface area comparisons).

Pyrazinamide was not mutagenic in the Ames bacterial test but induced chromosomal aberrations in human lymphocyte cell cultures.

Pregnancy – Teratogenic Effects
Although animal reproduction studies have not been conducted with RIFATER, teratogenic effects (including cleft palate and spina bifida) have been observed in rodents treated with rifampin at doses 0.2 to 2 times the maximum recommended human dose, based on body surface area comparisons. There are no adequate and well-controlled studies of RIFATER in pregnant women. RIFATER should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Rifampin
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 daily human dose based on body surface area comparisons). Although there are no adequate and well-controlled studies in pregnant women, rifampin has been reported to cross the placental barrier and appear in cord blood.

Isoniazid
It has been reported that in both rats and rabbits, isoniazid may exert an embryocidal effect when administered orally during pregnancy, although no isoniazid-related congenital anomalies have been found in reproduction studies in mammalian species (mice, rats, and rabbits).

Pyrazinamide
Animal reproductive studies have not been conducted with pyrazinamide. It is also not known whether pyrazinamide can cause fetal harm when administered to a pregnant woman.

Pregnancy – Non-Teratogenic Effects
Rifampin
When administered during the last few weeks of pregnancy, rifampin, a component of RIFATER, can cause postnatal hemorrhages in the mother and infant. Treatment with vitamin K may be indicated for postnatal hemorrhage in patients treated with RIFATER.

Nursing Mothers
Since rifampin, isoniazid, and pyrazinamide are known to pass into maternal breast milk, it would be expected that there would be transplacental transfer of these drugs to the infant. The possible transplacental transfer of these drugs should be considered when making therapeutic decisions concerning the nursing mother.

Pediatric Use
Safety and effectiveness of RIFATER in pediatric patients under the age of 15 have not been established. (See CLINICAL PHARMACOLOGY, General; See also DOSAGE AND ADMINISTRATION.)

Geriatric Use
Clinical studies of RIFATER 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 RIFATER in elderly patients. (See WARNINGS.)

ADVERSE REACTIONS
Adverse Experiences during the Clinical Trial
Adverse event data reported for the RIFATER and the separate drug treatment groups during the first 2 months of the trial are shown in the table below.

<table>
<thead>
<tr>
<th>Adverse Events</th>
<th>Number of Patients with Adverse Events</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Adverse Events by Body Systems During First 2 Months of Trial</strong></td>
<td><strong>RIFATER</strong></td>
</tr>
<tr>
<td>Cutaneous (rash, erythema, erthema, exfoliative dermatitis, Lyell syndrome, urticaria, localized skin rash, diffuse skin rash, pruritus, generalized hypersensitivity)</td>
<td>8 (7%)</td>
</tr>
<tr>
<td>Gastrointestinal (nausea, vomiting, digestive pain, diarrhea)</td>
<td>8 (7%)</td>
</tr>
<tr>
<td>Musculoskeletal (arthralgia, long bones pain, phlebitis, localized joint pain, diffuse joint pain, edema of the legs)</td>
<td>5 (4%)</td>
</tr>
<tr>
<td>Hearing and Vestibular (tinnitus, vertigo, vertigo with loss of equilibrium)</td>
<td>3 (2%)</td>
</tr>
<tr>
<td>Liver and Biliary (hepatitis with conjunctival jaundice, hepatitis with deep jaundice)</td>
<td>0 (0%)</td>
</tr>
</tbody>
</table>

Number of Patients | RIFATER n=122† | Separate n=123† |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Central and Peripheral Nervous System (swelling, headache, insomnia, diffuse parasthesia of the legs, anxiety, diabetic coma)</td>
<td>5 (4%)</td>
<td>4 (3%)</td>
</tr>
<tr>
<td>Total Body (spiking fever, persistent fever)</td>
<td>2 (2%)</td>
<td>4 (3%)</td>
</tr>
<tr>
<td>Cardiorespiratory (lightness in chest, coughing, diffuse chest pain, hemoptysis, angina, palpitation, total pneumothorax)</td>
<td>8 (7%)</td>
<td>3 (2%)</td>
</tr>
<tr>
<td>Total number of patients with one or more adverse events</td>
<td>29</td>
<td>43</td>
</tr>
</tbody>
</table>

†A given patient may have experienced ≥1 adverse event.
††Total of 250 patients (124 RIFATER; 126 separate) were originally enrolled in the study. Five patients (2 RIFATER, 3 separate) were excluded due to admission errors.
‡Isoniazid, rifampin, and pyrazinamide dosed as separate tablets and capsules.

Adverse Events Reported During the Clinical Study (continued)

Adverse Events by Body Systems During First 2 Months of Trial

<table>
<thead>
<tr>
<th>Adverse Events by Body Systems During First 2 Months of Trial</th>
<th>RIFATER n=122†</th>
<th>Separate n=123†</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central and Peripheral Nervous System (swelling, headache, insomnia, diffuse parasthesia of the legs, anxiety, diabetic coma)</td>
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<td>Total Body (spiking fever, persistent fever)</td>
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</tr>
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</table>

†A given patient may have experienced ≥1 adverse event.
††Total of 250 patients (124 RIFATER; 126 separate) were originally enrolled in the study. Five patients (2 RIFATER, 3 separate) were excluded due to admission errors.
‡Isoniazid, rifampin, and pyrazinamide dosed as separate tablets and capsules.

No serious adverse events were reported in the patients receiving RIFATER tablets. Three serious adverse events were reported in the patients given isoniazid, rifampin, and pyrazinamide as separate tablets and capsules. The three serious adverse events were two general hypersensitivity reactions and one jaundice reaction.

There were no significant differences between the two treatment groups in standard liver function, renal function, and hematological laboratory test values measured at baseline and after 5 weeks of therapy. As would be expected for these drugs, there were alterations in liver enzymes (SGOT, SGPT) and serum uric acid levels. The adverse events reported during therapy with RIFATER are consistent with those described below for the individual components.

Adverse Reactions Reported for Individual Components of RIFATER

The following adverse reactions associated with the use of RIFATER were identified in clinical studies or post-marketing reports. Because some of these reactions were reported voluntarily from a population of uncertain size, it is not always possible to reliably estimate their frequency or establish a causal relationship to drug exposure.

Rifampin
Gastrointestinal
Heartburn, epigastric distress, anorexia, nausea, vomiting, jaundice, flatulence, cramps, and diarrhea 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
Hepatotoxicity including transient abnormalities in liver function tests (e.g., elevations in serum bilirubin, alkaline phosphatase, serum transaminases, gamma-glutamyl transferase), hepatitis, shock-like syndrome with hepatic involvement and abnormal liver function tests, and cholestasis have been reported (see WARNINGS).

Hematologic
Cases of thrombotic microangiopathy, including thrombotic thrombocytopenic purpura and hemolytic-uremic syndrome, have been reported (see WARNINGS). Thrombocytopenia has occurred primarily with high dose intermittent therapy but has also been noted 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 disseminated intravascular coagulation have been observed.

Leukopenia, hemolytic anemia, decreased hemoglobin, bleeding, and vitamin K–dependent coagulation disorders (abnormal prolongation of prothrombin time or low vitamin K–dependent coagulation factors) have been observed.

Agranulocytosis has been reported 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 acute 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.

Dermatologic
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, pemphigoid reaction, erythema multiforme, acute generalized exanthematous pustulosis, Stevens-Johnson syndrome, toxic epidermal necrolysis, drug reaction with eosinophilia and systemic symptoms syndrome (see WARNINGS), vasculitis, eosinophilia, sore mouth, sore tongue, and conjunctivitis have been observed.

Anaphylaxis has been reported rarely.

Respiratory, Thoracic and Mediastinal Disorders

Pulmonary toxicity (including, but not limited to, interstitial lung disease, pneumonitis, hypersensitivity pneumonitis, eosinophilic pneumonia, pulmonary infiltrates, organizing pneumonia, pulmonary failure, pulmonary fibrosis, and acute respiratory distress syndrome) has been observed (see WARNINGS).

Miscellaneous

Paradoxical drug reaction has been reported (see WARNINGS). 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.

Isoniazid

The most frequent reactions are those affecting the nervous system and the liver. (See the boxed WARNING.)

Nervous System

Peripheral neuropathy is the most common toxic effect. It is dose-related, occurs most often in the malnourished and in those predisposed to neuritis (e.g., alcoholics and diabetics), and is usually preceded by paresthesia of the feet and hands. The incidence is higher in “slow inactivators.”

Other neurotoxic effects, which are uncommon with conventional doses, are convulsions, toxic encephalopathy, optic neuritis and atrophy, memory impairment, and toxic psychosis.

Gastrointestinal

Pancreatitis, nausea, vomiting, and epigastric distress.

Hepatic

Elevated serum transaminases (SGOT, SGPT), bilirubinemia, bilirubinuria, jaundice, and occasionally severe and sometimes fatal hepatitis. The common prodromal symptoms are anorexia, nausea, vomiting, fatigue, malaise, and weakness. Mild and transient elevation of serum transaminase levels occurs in 10 to 20% of persons taking isoniazid. The abnormality usually occurs in the first 4 to 6 months of treatment but can occur at any time during therapy. In most instances, enzyme levels return to normal with no necessity to discontinue medication. In occasional instances, progressive liver damage occurs, with accompanying symptoms. In these cases, the drug should be discontinued immediately.

The frequency of progressive liver damage increases with age. It is rare in persons under 20 but occurs in up to 2.3% of those over 50 years of age.

Hematologic

Cases of thrombotic microangiopathy including thrombotic thrombocytopenic purpura and hemolytic uremic syndrome, have been reported (see WARNINGS). Agranulocytosis, anemia (including aplastic, hemolytic, and sideroblastic anemia), thrombocytopenia, and eosinophilia have been reported.

Metabolic and Endocrine

Pyridoxine deficiency, pellagra, hyperglycemia, metabolic acidosis, and gynecomastia.

Miscellaneous

Paradoxical drug reaction has been reported (see WARNINGS). Rhematoid syndrome and systemic lupus erythematosus-like syndrome have been reported.

Isoniazid

The principal adverse effect is a hepatic reaction (see WARNINGS). Hepatotoxicity appears to be dose related and may appear at any time during therapy. Isoniazid can cause hyperuricemia and gout (see PRECAUTIONS).

Gastrointestinal

GI disturbances including nausea, vomiting, and anorexia have also been reported. Hematologic and Lymphatic

Thrombocytopenia and sideroblastic anemia with erythroid hyperplasia, vacuolation of erythrocytes, and increased serum concentration have occurred rarely with this drug. Adverse effects on blood clotting mechanisms have also been rarely reported.

Miscellaneous

Mild arthralgia and myalgia have been reported frequently. Hypersensitivity reactions including Drug Reaction with Eosinophilia and Systemic Symptoms syndrome (see WARNINGS), rashes, urticaria, pruritus, and erythema have been reported. Paradoxical drug reaction has been reported (see WARNINGS). Angioedema has been reported rarely. Fever, ache, photosensitivity, porphyria, dysuria, and interstitial nephritis have been reported rarely.

OVERDOSE

There is no human experience with RIFATER overdose. Human experience with individual components (rifampin, isoniazid, pyrazinamide) of RIFATER are described below.

Acute Toxicity

Rifampin

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 12 gm rifampin. Fatal acute overdoses in adults have been reported with doses ranging from 10 to 60 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 have been reported.

Isoniazid

Untreated or inadequately treated cases of gross isoniazid overdose can be fatal, but good response has been reported in most patients treated within the first few hours after drug ingestion. Ingested acutely, as little as 1.5 g isoniazid may cause toxicity in adults. Doses of 35 to 40 mg/kg have resulted in seizures. Ingestion of 80 to 150 mg/kg isoniazid has been associated with severe toxicity and, if untreated, significant mortality.

Pyrazinamide

Overdose experience with pyrazinamide is limited.

Signs and Symptoms

The following signs and symptoms have been seen with each individual component of RIFATER in an overdose situation.

Rifampin

Nausea, vomiting, abdominal pain, pruritus, headache, and increasing lethargy will usually occur within a short time after rifampin overdose; 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, possibly with jaundice, can be expected within a few hours. After severe overdose, 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, electrolyte levels, or a renal or hepatic disorder is usually involved.

Isoniazid

Signs and symptoms of isoniazid overdose develop within 30 minutes to 3 hours. Nausea, vomiting, dizziness, slurring of speech, blurring of vision, and visual hallucinations (including bright colors and strange designs) are among the early manifestations. With marked overdosage, respiratory distress and CNS depression, progressing rapidly from stupor to profound coma, are to be expected along with severe, intractable seizures. Severe metabolic acidosis, acetonuria, and hyperglycemia are typical laboratory findings.

Pyrazinamide

In one overdose case of pyrazinamide abnormal liver function tests were reported. These spontaneously reverted to normal when the drug was stopped.

Treatment

The airway should be secured and adequate respiratory exchange should be established in cases of overdose with RIFATER. Only then should gastric emptying (lavage-aspiration) be attempted; this may be difficult because of seizures.

Obtain blood samples for immediate determination of gases, electrolytes, BUN, glucose, etc.; type and cross-match blood in preparation for possible hemodialysis.

Gastric lavage within the first 2 to 3 hours after ingestion is advised, but it should not be attempted unless convulsions or consciousness are not present. If gastric lavage is done, administer diazepam or short-acting barbiturates, and IV pyridoxine (usually 1 mg/g isoniazid ingested). Following evacuation of gastric contents, the instillation of activated charcoal slurry into the stomach may help absorb any remaining drug from the gastrointestinal tract.

Antiemetic medication may be required to control severe nausea and vomiting.

RAPID CONTROL OF METABOLIC ACIDOSIS IS FUNDAMENTAL TO MANAGEMENT.

Give IV sodium bicarbonate at once and repeat as needed, adjusting subsequent dosage on the basis of laboratory findings (e.g., serum sodium, pH, etc.). Forced diuresis must be started early and should be continued for some hours after clinical improvement to hasten renal clearance of drug and help prevent relapse; monitor fluid intake and output.

Bile drainage may be indicated in presence of serious impairment of hepatic function lasting more than 24–48 hours. Under these circumstances and for severe cases, extracorporeal hemodialysis may be required; if this is not available, peritoneal dialysis can be used along with forced diuresis.

Along with measures based on initial and repeated determination of blood gases and other laboratory tests as needed, utilize meticulous respiratory and other intensive care to protect against hypoxia, hypotension, aspiration pneumonitis, etc.

Untreated or inadequately treated cases of gross isoniazid overdose can terminate fatally, but good response has been reported in most patients brought under adequate treatment within the first few hours after drug ingestion.

DOSAGE AND ADMINISTRATION

RIFATER 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 or rifampin resistance is very low. The need for a fourth drug is determined by the presence or absence of INH or rifampin resistance in the patient's sputum culture, the drug susceptibility of the organism, and the clinical response to the initial drug therapy.
Pediatric Patients
The ratio of the drugs in RIFATER may not be appropriate in pediatric patients under the age of 15 (e.g., higher mg/kg doses of isoniazid are usually given in pediatric patients than adults).

HOW SUPPLIED
Storage
Store at 25°C (77°F); excursions permitted to 15–30°C (59–86°F) [see USP Controlled Room Temperature]. Protect from excessive humidity.
Rx only

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