

DIFLUCAN* **(Fluconazole)**

1. NAME OF THE MEDICINAL PRODUCT

DIFLUCAN* 2 mg/mL solution for infusion

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

Each mL of Diflucan Solution for Intravenous Infusion contains fluconazole 2 mg.

Excipient(s) with known effect:

Each ml contains 9 mg sodium chloride (equivalent to 0.154 mmol sodium) (see section 4.4).

3. PHARMACEUTICAL FORM

Solution for intravenous infusion.

4. CLINICAL PARTICULARS

4.1 Therapeutic Indications

Diflucan is indicated in the following fungal infections (see section 5.1).

Diflucan is indicated in adults for the treatment of:

- Cryptococcal meningitis (see section 4.4).
- Coccidioidomycosis (see section 4.4).
- Invasive candidiasis.
- Mucosal candidiasis including oropharyngeal, oesophageal candidiasis, candiduria and chronic mucocutaneous candidiasis.
- Chronic oral atrophic candidiasis (denture sore mouth) if dental hygiene or topical treatment are insufficient.

Diflucan is indicated in adults for the prophylaxis of:

- Relapse of cryptococcal meningitis in patients with high risk of recurrence.
- Relapse of oropharyngeal or oesophageal candidiasis in patients infected with HIV who are at high risk of experiencing relapse.
- Prophylaxis of candidal infections in patients with prolonged neutropenia (such as patients with haematological malignancies receiving chemotherapy or patients receiving Haematopoietic Stem Cell Transplantation (see section 5.1)).

Diflucan is indicated in term newborn infants, infants, toddlers, children and adolescents aged from 0 to 17 years old:

- Diflucan is used for the treatment of mucosal candidiasis (oropharyngeal, oesophageal), invasive candidiasis, cryptococcal meningitis and the prophylaxis of candidal infections in immunocompromised patients. Diflucan can be used as

maintenance therapy to prevent relapse of cryptococcal meningitis in children with high risk of reoccurrence (see section 4.4).

- Therapy may be instituted before the results of the cultures and other laboratory studies are known; however, once these results become available, anti-infective therapy should be adjusted accordingly.
- Consideration should be given to official guidance on the appropriate use of antifungals.

4.2 Posology and Method of Administration

Posology

The dose should be based on the nature and severity of the fungal infection. Treatment of infections requiring multiple dosing should be continued until clinical parameters or laboratory tests indicate that active fungal infection has subsided. An inadequate period of treatment may lead to recurrence of active infection.

Adults

Indications		Posology	Duration of treatment
Cryptococcosis	- Treatment of cryptococcal meningitis	Loading dose: 400 mg on Day 1 Subsequent dose: 200 mg to 400 mg once daily	Usually at least 6 to 8 weeks. In life-threatening infections the daily dose can be increased to 800 mg
	- Maintenance therapy to prevent relapse of cryptococcal meningitis in patients with high risk of recurrence.	200 mg once daily	Indefinitely at a daily dose of 200 mg
Coccidioidomycosis		200 mg to 400 mg once daily	11 months up to 24 months or longer depending on the patient. 800 mg daily may be considered for some infections and especially for meningeal disease
Invasive candidiasis		Loading dose: 800 mg on Day 1 Subsequent dose: 400 mg once daily	In general, the recommended duration of therapy for candidaemia is for 2 weeks after first negative blood culture result and resolution of signs and symptoms attributable to candidaemia.
Treatment of mucosal candidiasis	- Oropharyngeal candidiasis	Loading dose: 200 mg to 400 mg on Day 1 Subsequent dose:	7 to 21 days (until oropharyngeal candidiasis is in remission).

Indications		Posology	Duration of treatment
		100 mg to 200 mg once daily	Longer periods may be used in patients with severely compromised immune function
	- Oesophageal candidiasis	Loading dose: 200 mg to 400 mg on Day 1 Subsequent dose: 100 mg to 200 mg once daily	14 to 30 days (until oesophageal candidiasis is in remission). Longer periods may be used in patients with severely compromised immune function
	- Candiduria	200 mg to 400 mg once daily	7 to 21 days. Longer periods may be used in patients with severely compromised immune function.
	- Chronic atrophic candidiasis	50 mg once daily	14 days
	- Chronic mucocutaneous candidiasis	50 mg to 100 mg once daily	Up to 28 days. Longer periods depending on both the severity of infection or underlying immune compromise and infection
Prevention of relapse of mucosal candidiasis in patients infected with HIV who are at high risk of experiencing relapse	- Oropharyngeal candidiasis	100 mg to 200 mg once daily or 200 mg 3 times per week.	An indefinite period for patients with chronic immune suppression
	- Oesophageal candidiasis	100 mg to 200 mg once daily or 200 mg 3 times per week.	An indefinite period for patients with chronic immune suppression
Prophylaxis of candidal infections		200 mg to 400 mg once daily	Treatment should start several days before the anticipated onset of neutropenia and continue for 7 days after recovery from neutropenia after the neutrophil count rises above 1,000 cells per mm ³ .

Special Populations

Elderly:

Dosage should be adjusted based on the renal function (see “*Renal impairment*”).

Renal impairment:

Diflucan is predominantly excreted in the urine as unchanged active substance. No adjustments in single dose therapy are necessary. In patients (including paediatric population) with impaired renal function who will receive multiple doses of fluconazole,

an initial dose of 50 mg to 400 mg should be given, based on the recommended daily dose for the indication. After this initial loading dose, the daily dose (according to indication) should be based on the following table:

Creatinine Clearance (mL/min)	Percent of Recommended Dose
>50	100%
≤50 (no haemodialysis)	50%
Haemodialysis	100% after each haemodialysis

Patients on haemodialysis should receive 100% of the recommended dose after each haemodialysis; on non-dialysis days, patients should receive a reduced dose according to their creatinine clearance.

Hepatic impairment:

Limited data are available in patients with hepatic impairment, therefore fluconazole should be administered with caution to patients with liver dysfunction (see sections 4.4 and 4.8).

Paediatric Population

A maximum dose of 400 mg daily should not be exceeded in paediatric population. As with similar infections in adults, the duration of treatment is based on the clinical and mycological response. Diflucan is administered as a single daily dose.

For paediatric patients with impaired renal function, see dosing in “*Renal impairment*”. The pharmacokinetics of fluconazole has not been studied in paediatric population with renal insufficiency (for “Term newborn infants” who often exhibit primarily renal immaturity please see below).

Infants, toddlers and children (from 28 days to 11 years old):

Indication	Posology	Recommendations
- Mucosal candidiasis	Initial dose: 6 mg/kg Subsequent dose: 3 mg/kg once daily	Initial dose may be used on the first day to achieve steady-state levels more rapidly
- Invasive candidiasis - Cryptococcal meningitis	Dose: 6 to 12 mg/kg once daily	Depending on the severity of the disease
- Maintenance therapy to prevent relapse of cryptococcal meningitis in children with high risk of recurrence	Dose: 6 mg/kg once daily	Depending on the severity of the disease
- Prophylaxis of <i>Candida</i> in immunocompromised patients	Dose: 3 to 12 mg/kg once daily	Depending on the extent and duration of the induced neutropenia (see Adults posology)

Adolescents (from 12 to 17 years old):

Depending on the weight and pubertal development, the prescriber would need to assess which posology (adults or children) is the most appropriate. Clinical data indicate that children have a higher fluconazole clearance than observed for adults. A dose of 100, 200 and 400 mg in adults corresponds to a 3, 6 and 12 mg/kg dose in children to obtain a comparable systemic exposure.

Term newborn infants (0 to 27 days):
Neonates excrete fluconazole slowly.

There are few pharmacokinetic data to support this posology in term newborn infants (see section 5.2).

Age group	Posology	Recommendations
Term newborn infants (0 to 14 days)	The same mg/kg dose as for infants, toddlers and children should be given every 72 hours	A maximum dose of 12 mg/kg every 72 hours should not be exceeded
Term newborn infants (from 15 to 27 days)	The same mg/kg dose as for infants, toddlers and children should be given every 48 hours	A maximum dose of 12 mg/kg every 48 hours should not be exceeded

Method of Administration

Diflucan may be administered either orally (Capsules and Powder for Oral Suspension) or by intravenous infusion (Solution for Infusion), the route being dependent on the clinical state of the patient. On transferring from the intravenous to the oral route, or *vice versa*, there is no need to change the daily dose.

The physician should prescribe the most appropriate pharmaceutical form and strength according to age, weight and dose. The capsule formulation is not adapted for use in infants and small children. Oral liquid formulations of fluconazole are available that are more suitable in this population.

Intravenous infusion should be administered at a rate not exceeding 10 mL/minute. Diflucan is formulated in sodium chloride 9 mg/mL (0.9%) solution for infusion, each 200 mg (100 mL bottle) containing 15 mmol each of Na⁺ and Cl⁻. Because Diflucan is available as a dilute sodium chloride solution, in patients requiring sodium or fluid restriction, consideration should be given to the rate of fluid administration.

For instruction on dilution of the medicinal product before administration, see section 6.4.

4.3 Contraindications

Hypersensitivity to the active substance, to related azole substances, or to any of the excipients.

Co-administration of terfenadine is contraindicated in patients receiving Diflucan at multiple doses of 400 mg/day or higher based upon results of a multiple dose interaction study. Co-administration of other medicinal products known to prolong the QT interval and which are metabolised via the cytochrome P450 (CYP) 3A4, such as cisapride, astemizole, pimozide, quinidine, and erythromycin are contraindicated in patients receiving fluconazole (see sections 4.4 and 4.5).

4.4 Special Warnings and Precautions for Use

Tinea Capitis

Fluconazole has been studied for treatment of *Tinea capitis* in children. It was shown not to be superior to griseofulvin and the overall success rate was less than 20%. Therefore, Diflucan should not be used for *Tinea capitis*.

Cryptococcosis

The evidence for efficacy of fluconazole in the treatment of cryptococcosis of other sites (e.g., pulmonary and cutaneous cryptococcosis) is limited, which prevents dosing recommendations.

Deep Endemic Mycoses

The evidence for efficacy of fluconazole in the treatment of other forms of endemic mycoses, such as *paracoccidioidomycosis*, *lymphocutaneous sporotrichosis* and *histoplasmosis* is limited, which prevents specific dosing recommendations.

Renal System

Diflucan should be administered with caution to patients with renal dysfunction (see section 4.2).

Adrenal Insufficiency

Ketoconazole is known to cause adrenal insufficiency, and this could also although rarely seen be applicable to fluconazole. Adrenal insufficiency relating to concomitant treatment with prednisone, see section 4.5 'The effect of fluconazole on other medicinal products'.

Hepatobiliary System

Diflucan should be administered with caution to patients with liver dysfunction.

Diflucan has been associated with rare cases of serious hepatic toxicity including fatalities, primarily in patients with serious underlying medical conditions. In cases of fluconazole associated hepatotoxicity, no obvious relationship to total daily dose, duration of therapy, sex or age of patient has been observed. Fluconazole hepatotoxicity has usually been reversible on discontinuation of therapy.

Patients who develop abnormal liver function tests during fluconazole therapy must be monitored closely for the development of more serious hepatic injury.

The patient should be informed of suggestive symptoms of serious hepatic effect (important asthenia, anorexia, persistent nausea, vomiting and jaundice). Treatment of fluconazole should be immediately discontinued and the patient should consult a physician.

Cardiovascular System

Some azoles, including fluconazole, have been associated with prolongation of the QT interval on the electrocardiogram. Fluconazole causes QT prolongation via the inhibition of Rectifier Potassium Channel current (I_{kr}). The QT prolongation caused by other medicinal products (such as amiodarone) may be amplified via the inhibition of cytochrome P450 (CYP) 3A4. During post-marketing surveillance, there have been very rare cases of QT prolongation and *torsade de pointes* in patients taking Diflucan. These reports included seriously ill patients with multiple confounding risk factors,

such as structural heart disease, electrolyte abnormalities and concomitant treatment that may have been contributory. Patients with hypokalaemia and advanced cardiac failure are at an increased risk for the occurrence of life-threatening ventricular arrhythmias and *torsade de pointes*.

Diflucan should be administered with caution to patients with potentially proarrhythmic conditions.

Co-administration of other medicinal products known to prolong the QT interval and which are metabolised via the cytochrome P450 (CYP) 3A4 are contraindicated (see sections 4.3 and 4.5).

Halofantrine

Halofantrine has been shown to prolong QTc interval at the recommended therapeutic dose and is a substrate of CYP3A4. The concomitant use of fluconazole and halofantrine is therefore, not recommended (see section 4.5).

Dermatological Reactions

Patients have rarely developed exfoliative cutaneous reactions, such as Stevens-Johnson syndrome and toxic epidermal necrolysis, during treatment with fluconazole. Drug reaction with eosinophilia and systemic symptoms (DRESS) has been reported. AIDS patients are more prone to the development of severe cutaneous reactions to many medicinal products. If a rash, which is considered attributable to fluconazole, develops in a patient treated for a superficial fungal infection, further therapy with this medicinal product should be discontinued. If patients with invasive/systemic fungal infections develop rashes, they should be monitored closely and fluconazole discontinued if bullous lesions or erythema multiforme develops.

Hypersensitivity

In rare cases, anaphylaxis has been reported (see section 4.3).

Cytochrome P450

Fluconazole is a moderate CYP2C9 and CYP3A4 inhibitor. Fluconazole is also a strong inhibitor of CYP2C19. Diflucan treated patients who are concomitantly treated with medicinal products with a narrow therapeutic window metabolised through CYP2C9, CYP2C19 and CYP3A4 should be monitored (see section 4.5).

Terfenadine

The co-administration of fluconazole at doses lower than 400 mg/day with terfenadine should be carefully monitored (see sections 4.3 and 4.5).

Candidiasis

Studies have shown an increasing prevalence of infections with *Candida* species other than *C. albicans*. These are often inherently resistant (e.g., *C. krusei* and *C. auris*) or show reduced susceptibility to fluconazole (*C. glabrata*). Such infections may require alternative antifungal therapy secondary to treatment failure. Therefore, prescribers are advised to take into account the prevalence of resistance in various *Candida* species to fluconazole.

Excipients

This medicinal product contains 88.5 mg sodium per 25 mL, equivalent to 4.4% of the WHO recommended maximum daily intake of 2 g sodium for an adult.

The maximum daily dose of this product is equivalent to 71% of the WHO recommended maximum daily intake for sodium.

Diflucan 2 mg/mL solution for infusion is considered high in sodium. This should be particularly taken into account when it is administered to patients on a low salt diet.

4.5 Interaction with Other Medicinal Products and Other Forms of Interaction

Concomitant Use of the Following Other Medicinal Products is Contraindicated:

Cisapride: There have been reports of cardiac events including *torsade de pointes* in patients to whom fluconazole and cisapride were co-administered. A controlled study found that concomitant fluconazole 200 mg once daily and cisapride 20 mg four times a day yielded a significant increase in cisapride plasma levels and prolongation of QTc interval. Concomitant treatment with fluconazole and cisapride is contraindicated (see section 4.3).

Terfenadine: Because of the occurrence of serious cardiac dysrhythmias secondary to prolongation of the QTc interval in patients receiving azole antifungals in conjunction with terfenadine, interaction studies have been performed. One study at a 200 mg daily dose of fluconazole failed to demonstrate a prolongation in QTc interval. Another study at a 400 mg and 800 mg daily dose of fluconazole demonstrated that fluconazole taken in doses of 400 mg/day or greater significantly increases plasma levels of terfenadine when taken concomitantly. The combined use of fluconazole at doses of 400 mg or greater with terfenadine is contraindicated (see section 4.3). The co-administration of fluconazole at doses lower than 400 mg/day with terfenadine should be carefully monitored.

Astemizole: Concomitant administration of fluconazole with astemizole may decrease the clearance of astemizole. Resulting increased plasma concentrations of astemizole can lead to QT prolongation and rare occurrences of *torsade de pointes*. Co-administration of fluconazole and astemizole is contraindicated (see section 4.3).

Pimozide: Although not studied *in vitro* or *in vivo*, concomitant administration of fluconazole with pimozide may result in inhibition of pimozide metabolism. Increased pimozide plasma concentrations can lead to QT prolongation and rare occurrences of *torsade de pointes*. Co-administration of fluconazole and pimozide is contraindicated (see section 4.3).

Quinidine: Although not studied *in vitro* or *in vivo*, concomitant administration of fluconazole with quinidine may result in inhibition of quinidine metabolism. Use of quinidine has been associated with QT prolongation and rare occurrences of *torsade de pointes*. Co-administration of fluconazole and quinidine is contraindicated (see section 4.3).

Erythromycin: Concomitant use of fluconazole and erythromycin has the potential to increase the risk of cardiotoxicity (prolonged QT interval, *torsade de pointes*) and consequently sudden heart death. Co-administration of fluconazole and erythromycin

is contraindicated (see section 4.3).

Concomitant Use of the Following Other Medicinal Products cannot be Recommended:

Halofantrine: Fluconazole can increase halofantrine plasma concentration due to an inhibitory effect on CYP3A4.

Concomitant use of fluconazole and halofantrine has the potential to increase the risk of cardiotoxicity (prolonged QT interval, *torsade de pointes*) and consequently sudden heart death. This combination should be avoided (see section 4.4).

Concomitant Use that Should be Used with Caution:

Amiodarone: Concomitant administration of fluconazole with amiodarone may increase QT prolongation. Caution must be exercised if the concomitant use of fluconazole and amiodarone is necessary, notably with high dose fluconazole (800 mg).

Concomitant Use of the Following Other Medicinal Products Leads to Precautions and Dose Adjustments:

The effect of other medicinal products on fluconazole

Rifampicin: Concomitant administration of fluconazole and rifampicin resulted in a 25% decrease in the AUC and a 20% shorter half-life of fluconazole. In patients receiving concomitant rifampicin, an increase of the fluconazole dose should be considered.

Interaction studies have shown that when oral fluconazole is co-administered with food, cimetidine, antacids or following total body irradiation for bone marrow transplantation, no clinically significant impairment of fluconazole absorption occurs.

Hydrochlorothiazide: In a pharmacokinetic interaction study, co-administration of multiple-dose hydrochlorothiazide to healthy volunteers receiving fluconazole increased plasma concentration of fluconazole by 40%. An effect of this magnitude should not necessitate a change in the fluconazole dose regimen in subjects receiving concomitant diuretics.

The effect of fluconazole on other medicinal products

Fluconazole is a moderate inhibitor of cytochrome P450 (CYP) isoenzymes 2C9 and 3A4. Fluconazole is also a strong inhibitor of the isozyme CYP2C19. In addition to the observed/documentated interactions mentioned below, there is a risk of increased plasma concentration of other compounds metabolised by CYP2C9, CYP2C19 and CYP3A4 co-administered with fluconazole. Therefore, caution should be exercised when using these combinations and the patients should be carefully monitored. The enzyme inhibiting effect of fluconazole persists 4-5 days after discontinuation of fluconazole treatment due to the long half-life of fluconazole (see section 4.3).

Abrocitinib: Fluconazole (inhibitor of CYP2C19, 2C9, 3A4) increased exposure of abrocitinib active moiety by 155%. If co-administered with fluconazole, adjust the dose of abrocitinib as instructed in the abrocitinib prescribing information.

Alfentanil: During concomitant treatment with fluconazole (400 mg) and intravenous alfentanil (20 µg/kg) in healthy volunteers, the alfentanil AUC₁₀ increased 2-fold,

probably through inhibition of CYP3A4. Dose adjustment of alfentanil may be necessary.

Amitriptyline, Nortriptyline: Fluconazole increases the effect of amitriptyline and nortriptyline. 5-nortriptyline and/or S-amitriptyline may be measured at initiation of the combination therapy and after one week. Dose of amitriptyline/nortriptyline should be adjusted, if necessary.

Amphotericin B: Concurrent administration of fluconazole and amphotericin B in infected normal and immunosuppressed mice showed the following results: a small additive antifungal effect in systemic infection with *Candida albicans*, no interaction in intracranial infection with *Cryptococcus neoformans*, and antagonism of the two medicinal products in systemic infection with *Aspergillus fumigatus*. The clinical significance of results obtained in these studies is unknown.

Anticoagulants: In post-marketing experience, as with other azole antifungals, bleeding events (bruising, epistaxis, gastrointestinal bleeding, haematuria, and melena) have been reported, in association with increases in prothrombin time in patients receiving fluconazole concurrently with warfarin. During concomitant treatment with fluconazole and warfarin, the prothrombin time was prolonged up to 2-fold, probably due to an inhibition of the warfarin metabolism through CYP2C9. In patients receiving coumarin-type or indanedione anticoagulants concurrently with fluconazole, the prothrombin time should be carefully monitored. Dose adjustment of the anticoagulant may be necessary.

Benzodiazepines (short-acting), i.e., midazolam, triazolam: Following oral administration of midazolam, fluconazole resulted in substantial increases in midazolam concentrations and psychomotor effects.

Concomitant intake of fluconazole 200 mg and midazolam 7.5 mg orally increased the midazolam AUC and half-life 3.7-fold and 2.2-fold, respectively. Fluconazole 200 mg daily given concurrently with triazolam 0.25 mg orally increased the triazolam AUC and half-life 4.4-fold and 2.3-fold, respectively. Potentiated and prolonged effects of triazolam have been observed at concomitant treatment with fluconazole. If concomitant benzodiazepine therapy is necessary in patients being treated with fluconazole, consideration should be given to decreasing the benzodiazepine dose, and the patients should be appropriately monitored.

Carbamazepine: Fluconazole inhibits the metabolism of carbamazepine and an increase in serum carbamazepine of 30% has been observed. There is a risk of developing carbamazepine toxicity. Dose adjustment of carbamazepine may be necessary depending on concentration measurements/effect.

Calcium Channel Blockers: Certain calcium channel antagonists (nifedipine, isradipine, amlodipine, verapamil and felodipine) are metabolised by CYP3A4. Fluconazole has the potential to increase the systemic exposure of the calcium channel antagonists. Frequent monitoring for adverse events is recommended.

Celecoxib: During concomitant treatment with fluconazole (200 mg daily) and celecoxib (200 mg), the celecoxib C_{max} and AUC increased by 68% and 134%,

respectively. Half of the celecoxib dose may be necessary when combined with fluconazole.

Cyclophosphamide: Combination therapy with cyclophosphamide and fluconazole results in an increase in serum bilirubin and serum creatinine. The combination may be used while taking increased consideration to the risk of increased serum bilirubin and serum creatinine.

Fentanyl: One fatal case of fentanyl intoxication due to possible fentanyl fluconazole interaction was reported. Furthermore, it was shown in healthy volunteers that fluconazole delayed the elimination of fentanyl significantly. Elevated fentanyl concentration may lead to respiratory depression. Patients should be monitored closely for the potential risk of respiratory depression. Dosage adjustment of fentanyl may be necessary.

HMG-CoA Reductase Inhibitors: The risk of myopathy and rhabdomyolysis increases (dose-dependent) when fluconazole is co-administered with HMG-CoA reductase inhibitors metabolised through CYP3A4, such as atorvastatin and simvastatin, or through CYP2C9, such as fluvastatin (decreased hepatic metabolism of the statin). If concomitant therapy is necessary, the patient should be observed for symptoms of myopathy and rhabdomyolysis and creatine kinase should be monitored. HMG-CoA reductase inhibitors should be discontinued if a marked increase in creatine kinase is observed or myopathy/rhabdomyolysis is diagnosed or suspected. Lower doses of HMG-CoA reductase inhibitors may be necessary as instructed in the statins prescribing information.

Ibrutinib: Moderate inhibitors of CYP3A4 such as fluconazole increase plasma ibrutinib concentrations and may increase risk of toxicity. If the combination cannot be avoided, reduce the dose of ibrutinib to 280 mg once daily (two capsules) for the duration of the inhibitor use and provide close clinical monitoring.

Ivacaftor (alone or combined with drugs in the same therapeutic class): Co-administration with ivacaftor, a cystic fibrosis transmembrane conductance regulator (CFTR) potentiator, increased ivacaftor exposure by 3-fold and hydroxymethyl-ivacaftor (M1) exposure by 1.9-fold. A reduction of the ivacaftor (alone or combined) dose is necessary as instructed in the ivacaftor (alone or combined) prescribing information.

Olaparib: Moderate inhibitors of CYP3A4 such as fluconazole increase olaparib plasma concentrations; concomitant use is not recommended. If the combination cannot be avoided, limit the dose of olaparib to 200 mg twice daily.

Immunosuppressors (i.e., cyclosporin, everolimus, sirolimus and tacrolimus):

Cyclosporin: Fluconazole significantly increases the concentration and AUC of cyclosporin. During concomitant treatment with fluconazole 200 mg daily and cyclosporin (2.7 mg/kg/day), there was a 1.8-fold increase in cyclosporin AUC. This combination may be used by reducing the dose of cyclosporin depending on cyclosporin concentration.

Everolimus: Although not studied *in vivo* or *in vitro*, fluconazole may increase serum

concentrations of everolimus through inhibition of CYP3A4.

Sirolimus: Fluconazole increases plasma concentrations of sirolimus presumably by inhibiting the metabolism of sirolimus via CYP3A4 and P-glycoprotein. This combination may be used with a dose adjustment of sirolimus depending on the effect/concentration measurements.

Tacrolimus: Fluconazole may increase the serum concentrations of orally administered tacrolimus up to 5 times due to inhibition of tacrolimus metabolism through CYP3A4 in the intestines. No significant pharmacokinetic changes have been observed when tacrolimus is given intravenously. Increased tacrolimus levels have been associated with nephrotoxicity. Dose of orally administered tacrolimus should be decreased depending on tacrolimus concentration.

Losartan: Fluconazole inhibits the metabolism of losartan to its active metabolite (E-3174) which is responsible for most of the angiotensin II-receptor antagonism which occurs during treatment with losartan. Patients should have their blood pressure monitored continuously.

Lurasidone: Moderate inhibitors of CYP3A4 such as fluconazole may increase lurasidone plasma concentrations. If concomitant use cannot be avoided, reduce the dose of lurasidone as instructed in the lurasidone prescribing information.

Methadone: Fluconazole may enhance the serum concentration of methadone. Dose adjustment of methadone may be necessary.

Non-steroidal Anti-inflammatory Drugs: The C_{max} and AUC of flurbiprofen were increased by 23% and 81%, respectively, when co-administered with fluconazole compared to administration of flurbiprofen alone. Similarly, the C_{max} and AUC of the pharmacologically active isomer [S-(+)-ibuprofen] were increased by 15% and 82%, respectively, when fluconazole was co-administered with racemic ibuprofen (400 mg) compared to administration of racemic ibuprofen alone.

Although not specifically studied, fluconazole has the potential to increase the systemic exposure of other NSAIDs that are metabolised by CYP2C9 (e.g., naproxen, lornoxicam, meloxicam, diclofenac). Frequent monitoring for adverse events and toxicity related to NSAIDs is recommended. Adjustment of dose of NSAIDs may be needed.

Phenytoin: Fluconazole inhibits the hepatic metabolism of phenytoin. Concomitant repeated administration of 200 mg fluconazole and 250 mg phenytoin intravenously, caused an increase of the phenytoin AUC₂₄ by 75% and C_{min} by 128%. With co-administration, serum phenytoin concentration levels should be monitored in order to avoid phenytoin toxicity.

Prednisone: There was a case report that a liver-transplanted patient treated with prednisone developed acute adrenal cortex insufficiency when a three-month therapy with fluconazole was discontinued. The discontinuation of fluconazole presumably caused an enhanced CYP3A4 activity which led to increased metabolism of prednisone. Patients on long-term treatment with fluconazole and prednisone should be carefully

monitored for adrenal cortex insufficiency when fluconazole is discontinued.

Rifabutin: Fluconazole increases serum concentrations of rifabutin, leading to increase in the AUC of rifabutin up to 80%. There have been reports of uveitis in patients to whom fluconazole and rifabutin were co-administered. In combination therapy, symptoms of rifabutin toxicity should be taken into consideration.

Saquinavir: Fluconazole increases the AUC and C_{max} of saquinavir with approximately 50% and 55% respectively, due to inhibition of saquinavir's hepatic metabolism by CYP3A4 and inhibition of P-glycoprotein. Interaction with saquinavir/ritonavir has not been studied and might be more marked. Dose adjustment of saquinavir may be necessary.

Sulfonylureas: Fluconazole has been shown to prolong the serum half-life of concomitantly administered oral sulfonylureas (e.g., chlorpropamide, glibenclamide, glipizide, tolbutamide) in healthy volunteers. Frequent monitoring of blood glucose and appropriate reduction of sulfonylurea dose is recommended during co-administration.

Theophylline: In a placebo-controlled interaction study, the administration of fluconazole 200 mg for 14 days resulted in an 18% decrease in the mean plasma clearance rate of theophylline. Patients who are receiving high dose theophylline or who are otherwise at increased risk for theophylline toxicity should be observed for signs of theophylline toxicity while receiving fluconazole. Therapy should be modified if signs of toxicity develop.

Tofacitinib: Exposure of tofacitinib is increased when tofacitinib is co-administered with medications that result in both moderate inhibition of CYP3A4 and strong inhibition of CYP2C19 (e.g., fluconazole). Therefore, it is recommended to reduce tofacitinib dose to 5 mg once daily when it is combined with these drugs.

Tolvaptan: Exposure to tolvaptan is significantly increased (200% in AUC; 80% in C_{max}) when tolvaptan, a CYP3A4 substrate, is co-administered with fluconazole, a moderate CYP3A4 inhibitor, with risk of significant increase in adverse reactions particularly significant diuresis, dehydration and acute renal failure. In case of concomitant use, the tolvaptan dose should be reduced as instructed in the tolvaptan prescribing information and the patient should be frequently monitored for any adverse reactions associated with tolvaptan.

Vinca Alkaloids: Although not studied, fluconazole may increase the plasma levels of the vinca alkaloids (e.g., vincristine and vinblastine) and lead to neurotoxicity, which is possibly due to an inhibitory effect on CYP3A4.

Vitamin A: Based on a case-report in one patient receiving combination therapy with all-trans-retinoid acid (an acid form of vitamin A) and fluconazole, CNS related undesirable effects have developed in the form of pseudotumour cerebri, which disappeared after discontinuation of fluconazole treatment. This combination may be used but the incidence of CNS related undesirable effects should be borne in mind.

Voriconazole (CYP2C9, CYP2C19 and CYP3A4 inhibitor): Co-administration of oral voriconazole (400 mg Q12h for 1 day, then 200 mg Q12h for 2.5 days) and oral

fluconazole (400 mg on Day 1, then 200 mg Q24h for 4 days) to 8 healthy male subjects resulted in an increase in C_{max} , and AUC_{τ} of voriconazole by an average of 57% (90% CI: 20%, 107%) and 79% (90% CI: 40%, 128%), respectively. The reduced dose and/or frequency of voriconazole and fluconazole that would eliminate this effect have not been established. Monitoring for voriconazole associated adverse events is recommended if voriconazole is used sequentially after fluconazole.

Zidovudine: Fluconazole increases C_{max} and AUC of zidovudine by 84% and 74%, respectively, due to an approximately 45% decrease in oral zidovudine clearance. The half-life of zidovudine was likewise prolonged by approximately 128% following combination therapy with fluconazole. Patients receiving this combination should be monitored for the development of zidovudine-related adverse reactions. Dose reduction of zidovudine may be considered.

Azithromycin: An open-label, randomised, three-way crossover study in 18 healthy subjects assessed the effect of a single 1200 mg oral dose of azithromycin on the pharmacokinetics of a single 800 mg oral dose of fluconazole as well as the effects of fluconazole on the pharmacokinetics of azithromycin. There was no significant pharmacokinetic interaction between fluconazole and azithromycin.

Oral Contraceptives: Two pharmacokinetic studies with a combined oral contraceptive have been performed using multiple doses of fluconazole. There were no relevant effects on hormone level in the 50 mg fluconazole study, while at 200 mg daily, the AUCs of ethinyl estradiol and levonorgestrel were increased 40% and 24%, respectively. Thus, multiple dose use of fluconazole at these doses is unlikely to have an effect on the efficacy of the combined oral contraceptive.

4.6 Fertility, Pregnancy and Lactation

Women of childbearing potential

Before initiating treatment, the patient should be informed of the potential risk to the foetus.

After single dose treatment, a washout period of 1 week (corresponding to 5-6 half-lives) is recommended before becoming pregnant (see section 5.2).

For longer courses of treatment, contraception may be considered, as appropriate, in women of childbearing potential throughout the treatment period and for 1 week after the final dose.

Pregnancy

Observational studies suggest an increased risk of spontaneous abortion in women treated with fluconazole during the first trimester and/or second trimester compared to women not treated with fluconazole or treated with topical azoles during the same period.

Data from several thousand pregnant women treated with a cumulative dose of ≤ 150 mg of fluconazole, administered in the first trimester, show no increase in the overall risk of malformations in the foetus. In one large observational cohort study, first trimester exposure to oral fluconazole was associated with a small increased risk of

musculoskeletal malformations, corresponding to approximately 1 additional case per 1000 women treated with cumulative doses \leq 450 mg compared with women treated with topical azoles and to approximately 4 additional cases per 1000 women treated with cumulative doses over 450 mg. The adjusted relative risk was 1.29 (95% CI 1.05 to 1.58) for 150 mg oral fluconazole and 1.98 (95% CI 1.23 to 3.17) for doses over 450 mg fluconazole.

Available epidemiological studies on cardiac malformations with use of fluconazole during pregnancy provide inconsistent results. However, a meta-analysis of 5 observational studies including several thousand pregnant women exposed to fluconazole during the first trimester finds a 1.8-2-fold increased risk of cardiac malformations when compared to no fluconazole use and/or topical azoles use.

Case reports describe a pattern of birth defects among infants whose mothers received high-dose (400 to 800 mg/day) fluconazole during pregnancy for 3 months or more, in the treatment of coccidioidomycosis. The birth defects seen in these infants include brachycephaly, ears dysplasia, giant anterior fontanelles, femoral bowing and radio-humeral synostosis. A causal relationship between fluconazole use and these birth defects is uncertain.

A few published case reports describe a rare pattern of distinct congenital anomalies in infants exposed in-utero to high-dose maternal fluconazole (400-800 mg/day) during most or all of the first trimester. These reported anomalies are similar to those seen in animal studies. If this drug is used during pregnancy, or if the patient becomes pregnant while taking the drug, the patient should be informed of the potential hazard to the foetus.

Fluconazole in standard doses and short-term treatments should not be used in pregnancy unless clearly necessary.

Fluconazole in high dose and/or in prolonged regimens should not be used during pregnancy except for potentially life-threatening infections.

Breast-feeding

Fluconazole passes into breast milk to reach concentrations similar to those in plasma (see section 5.2). Breast-feeding may be maintained after a single dose of 150 mg fluconazole. Breast-feeding is not recommended after repeated use or after high dose fluconazole. The developmental and health benefits of breast-feeding should be considered along with the mother's clinical need for Diflucan and any potential adverse effects on the breast-fed child from Diflucan or from the underlying maternal condition.

Fertility

Fluconazole did not affect the fertility of male or female rats (see section 5.3).

4.7 Effects on Ability to Drive and Use Machines

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

Patients should be warned about the potential for dizziness or seizures (see section 4.8)

while taking Diflucan and should be advised not to drive or operate machines if any of these symptoms occur.

4.8 Undesirable Effects

Summary of safety profile:

Drug reaction with eosinophilia and systemic symptoms (DRESS) has been reported in association with fluconazole treatment (see section 4.4).

The most frequently ($\geq 1/100$ to $< 1/10$) reported adverse reactions are headache, abdominal pain, diarrhoea, nausea, vomiting, alanine aminotransferase increased, aspartate aminotransferase increased, blood alkaline phosphatase increased and rash.

The following adverse reactions have been observed and reported during treatment with Diflucan with the following frequencies: Very common ($\geq 1/10$); common ($\geq 1/100$ to $< 1/10$); uncommon ($\geq 1/1,000$ to $< 1/100$); rare ($\geq 1/10,000$ to $< 1/1,000$); very rare ($< 1/10,000$), not known (cannot be estimated from the available data).

System Organ Class	Common	Uncommon	Rare	Not Known
Blood and the lymphatic system disorders		Anaemia	Agranulocytosis, leucopenia, thrombocytopenia, neutropenia	
Immune system disorders			Anaphylaxis	
Metabolism and nutrition disorders		Decreased appetite	Hypercholesterolaemia, hypertriglyceridaemia, hypokalaemia	
Psychiatric disorders		Somnolence, insomnia		
Nervous system disorders	Headache	Seizures, paraesthesia, dizziness, taste perversion	Tremor	
Ear and labyrinth disorders		Vertigo		
Cardiac disorders			<i>Torsade de pointes</i> (see section 4.4), QT prolongation (see section 4.4)	
Gastrointestinal disorders	Abdominal pain, vomiting, diarrhoea, nausea	Constipation, dyspepsia, flatulence, dry mouth		
Hepatobiliary disorders	Alanine aminotransferase increased (see section 4.4), aspartate aminotransferase increased (see section 4.4), blood alkaline phosphatase	Cholestasis (see section 4.4), jaundice (see section 4.4), bilirubin increased (see section 4.4)	Hepatic failure (see section 4.4), hepatocellular necrosis (see section 4.4), hepatitis (see section 4.4), hepatocellular damage (see section 4.4)	

System Organ Class	Common	Uncommon	Rare	Not Known
	increased (see section 4.4)			
Skin and subcutaneous tissue disorders	Rash (see section 4.4)	Drug eruption* (see section 4.4), urticaria (see section 4.4), pruritus, increased sweating	Toxic epidermal necrolysis (see section 4.4), Stevens-Johnson syndrome (see section 4.4), acute generalised exanthematous-pustulosis (see section 4.4), dermatitis exfoliative, angio-oedema, face oedema, alopecia	Drug reaction with eosinophilia and systemic symptoms (DRESS)
Musculoskeletal and connective tissue disorders		Myalgia		
General disorders and administration site conditions		Fatigue, malaise, asthenia, fever		

* Including Fixed Drug Eruption

Paediatric Population

The pattern and incidence of adverse reactions and laboratory abnormalities recorded during paediatric clinical trials are comparable to those seen in adults.

Reporting of Suspected Adverse Reactions

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

4.9 Overdose

There have been reports of overdose with Diflucan. Hallucination and paranoid behaviour have been concomitantly reported.

In the event of overdose, symptomatic treatment (with supportive measures and gastric lavage if necessary) may be adequate.

Fluconazole is largely excreted in the urine; forced volume diuresis would probably increase the elimination rate. A three-hour haemodialysis session decreases plasma levels by approximately 50%.

5. PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic Properties

Pharmacotherapeutic group: Antimycotics for systemic use, triazole derivatives, ATC code: J02AC01.

Mechanism of Action

Fluconazole is a triazole antifungal agent. Its primary mode of action is the inhibition

of fungal cytochrome P-450-mediated 14- α -lanosterol demethylation, an essential step in fungal ergosterol biosynthesis. The accumulation of 14- α -methyl sterols correlates with the subsequent loss of ergosterol in the fungal cell membrane and may be responsible for the antifungal activity of fluconazole. Fluconazole has been shown to be more selective for fungal cytochrome P-450 enzymes than for various mammalian cytochrome P-450 enzyme systems.

Fluconazole 50 mg daily given up to 28 days has been shown not to effect testosterone plasma concentrations in males or steroid concentration in females of child-bearing age. Fluconazole 200 mg to 400 mg daily has no clinically significant effect on endogenous steroid levels or on ACTH stimulated response in healthy male volunteers. Interaction studies with antipyrine indicate that single or multiple doses of fluconazole 50 mg do not affect its metabolism.

Susceptibility *in vitro*

In vitro, fluconazole displays antifungal activity against clinically common *Candida* species (including *C. albicans*, *C. parapsilosis*, *C. tropicalis*). *C. glabrata* shows reduced susceptibility to fluconazole while *C. krusei* and *C. auris* are resistant to fluconazole. The MICs and epidemiological cut-off value (ECOFF) of fluconazole for *C. guilliermondii* are higher than for *C. albicans*.

Fluconazole also exhibits activity *in vitro* against *Cryptococcus neoformans* and *Cryptococcus gattii* as well as the endemic moulds *Blastomyces dermatitidis*, *Coccidioides immitis*, *Histoplasma capsulatum* and *Paracoccidioides brasiliensis*.

Pharmacokinetic/Pharmacodynamic Relationship

In animal studies, there is a correlation between minimum inhibitory concentration (MIC) values and efficacy against experimental mycoses due to *Candida* spp. In clinical studies, there is an almost 1:1 linear relationship between the AUC and the dose of fluconazole. There is also a direct though imperfect relationship between the AUC or dose and a successful clinical response of oral *candidiasis* and to a lesser extent candidaemia to treatment. Similarly cure is less likely for infections caused by strains with a higher fluconazole MIC.

Mechanisms of Resistance

Candida spp. have developed a number of resistance mechanisms to azole antifungal agents. Fungal strains which have developed one or more of these resistance mechanisms are known to exhibit high MICs to fluconazole which impacts adversely efficacy *in vivo* and clinically.

In usually susceptible species of *Candida*, the most commonly encountered mechanism of resistance development involves the target enzymes of the azoles, which are responsible for the biosynthesis of ergosterol. Resistance may be caused by mutation, increased production of an enzyme, drug efflux mechanisms, or the development of compensatory pathways.

There have been reports of superinfection with *Candida* species other than *C. albicans*, which often have inherently reduced susceptibility (*C. glabrata*) or resistance to fluconazole (e.g., *C. krusei*, *C. auris*). Such infections may require alternative antifungal therapy. The resistance mechanisms have not been completely elucidated in

some intrinsically resistant (*C. krusei*) or emerging (*C. auris*) species of *Candida*.

EUCAST Breakpoints

Based on analyses of pharmacokinetic/pharmacodynamic (PK/PD) data, susceptibility *in vitro* and clinical response EUCAST-AFST (European Committee on Antimicrobial Susceptibility Testing-Subcommittee on Antifungal Susceptibility Testing) has determined breakpoints for fluconazole for *Candida* species (EUCAST Fluconazole rationale document (2020)-version 3); European Committee on Antimicrobial Susceptibility Testing, Antifungal Agents, Breakpoint tables for interpretation of MICs, Version 10.0, valid from 2020-02-04). These have been divided into non-species related breakpoints, which have been determined mainly on the basis of PK/PD data and are independent of MIC distributions of specific species, and species related breakpoints for those species most frequently associated with human infection. These breakpoints are given in the table below:

Antifungal	Species-related breakpoints (S≤/R>) in mg/L						Non-species related breakpoints ^A S≤/R> in mg/L
	<i>Candida albicans</i>	<i>Candida dubliniensis</i>	<i>Candida glabrata</i>	<i>Candida krusei</i>	<i>Candida parapsilosis</i>	<i>Candida tropicalis</i>	
Fluconazole	2/4	2/4	0.001*/16	--	2/4	2/4	2/4

S = Susceptible, R = Resistant.

A = Non-species related breakpoints have been determined mainly on the basis of PK/PD data and are independent of MIC distributions of specific species. They are for use only for organisms that do not have specific breakpoints.

-- = Susceptibility testing not recommended as the species is a poor target for therapy with the medicinal product.

* = The entire *C. glabrata* is in the I category. MICs against *C. glabrata* should be interpreted as resistant when above 16 mg/L. Susceptible category (≤0.001 mg/L) is simply to avoid misclassification of "I" strains as "S" strains. I - Susceptible, increased exposure: A microorganism is categorised as Susceptible, increased exposure when there is a high likelihood of therapeutic success because exposure to the agent is increased by adjusting the dosing regimen or by its concentration at the site of infection.

5.2 Pharmacokinetic Properties

The pharmacokinetic properties of fluconazole are similar following administration by the intravenous or oral route.

Absorption

After oral administration, fluconazole is well absorbed, and plasma levels (and systemic bioavailability) are over 90% of the levels achieved after intravenous administration. Oral absorption is not affected by concomitant food intake. Peak plasma concentrations in the fasting state occur between 0.5 and 1.5 hours post-dose. Plasma concentrations are proportional to dose. Ninety percent steady-state levels are reached by Day 4-5 with multiple once daily dosing. Administration of a loading dose (on Day 1) of twice the usual daily dose enables plasma levels to approximate to 90% steady-state levels by Day 2.

Distribution

The apparent volume of distribution approximates to total body water. Plasma protein

binding is low (11%-12%).

Fluconazole achieves good penetration in all body fluids studied. The levels of fluconazole in saliva and sputum are similar to plasma levels. In patients with fungal meningitis, fluconazole levels in the CSF are approximately 80% the corresponding plasma levels.

High skin concentration of fluconazole, above serum concentrations, are achieved in the stratum corneum, epidermis-dermis and eccrine sweat. Fluconazole accumulates in the stratum corneum. At a dose of 50 mg once daily, the concentration of fluconazole after 12 days was 73 µg/g and 7 days after cessation of treatment the concentration was still 5.8 µg/g. At the 150 mg once-a-week dose, the concentration of fluconazole in stratum corneum on Day 7 was 23.4 µg/g and 7 days after the second dose was still 7.1 µg/g.

Concentration of fluconazole in nails after 4 months of 150 mg once-a-week dosing was 4.05 µg/g in healthy and 1.8 µg/g in diseased nails; and, fluconazole was still measurable in nail samples 6 months after the end of therapy.

Biotransformation

Fluconazole is metabolised only to a minor extent. Of a radioactive dose, only 11% is excreted in a changed form in the urine. Fluconazole is a moderate inhibitor of the isozymes CYP2C9 and CYP3A4 (see section 4.5). Fluconazole is also a strong inhibitor of the isozyme CYP2C19.

Elimination

Plasma elimination half-life for fluconazole is approximately 30 hours. The major route of excretion is renal, with approximately 80% of the administered dose appearing in the urine as unchanged medicinal product. Fluconazole clearance is proportional to creatinine clearance. There is no evidence of circulating metabolites.

The long plasma elimination half-life provides the basis for single dose therapy for vaginal candidiasis, once daily and once weekly dosing for other indications.

Pharmacokinetics in Renal Impairment

In patients with severe renal insufficiency, (GFR<20 mL/min) half-life increased from 30 to 98 hours. Consequently, reduction of the dose is needed. Fluconazole is removed by haemodialysis and to a lesser extent by peritoneal dialysis. After 3 hours of haemodialysis session, around 50% of fluconazole is eliminated from blood.

Pharmacokinetics during Lactation

A pharmacokinetic study in 10 lactating women, who had temporarily or permanently stopped breast-feeding their infants, evaluated fluconazole concentrations in plasma and breast milk for 48 hours following a single 150 mg dose of Diflucan. Fluconazole was detected in breast milk at an average concentration of approximately 98% of those in maternal plasma. The mean peak breast milk concentration was 2.61 mg/L at 5.2 hours post-dose. The estimated daily infant dose of fluconazole from breast milk (assuming mean milk consumption of 150 mL/kg/day) based on the mean peak milk concentration is 0.39 mg/kg/day, which is approximately 40% of the recommended neonatal dose (<2 weeks of age) or 13% of the recommended infant dose for mucosal

candidiasis.

Pharmacokinetics in Children

Pharmacokinetic data were assessed for 113 paediatric patients from 5 studies; 2 single-dose studies, 2 multiple-dose studies, and a study in premature neonates. Data from one study were not interpretable due to changes in formulation pathway through the study. Additional data were available from a compassionate use study.

After administration of 2-8 mg/kg fluconazole to children between the ages of 9 months to 15 years, an AUC of about 38 µg·h/mL was found per 1 mg/kg dose units. The average fluconazole plasma elimination half-life varied between 15 and 18 hours and the distribution volume was approximately 880 mL/kg after multiple doses. A higher fluconazole plasma elimination half-life of approximately 24 hours was found after a single dose. This is comparable with the fluconazole plasma elimination half-life after a single administration of 3 mg/kg i.v. to children of 11 days-11 months old. The distribution volume in this age group was about 950 mL/kg.

Experience with fluconazole in neonates is limited to pharmacokinetic studies in premature newborns. The mean age at first dose was 24 hours (range 9-36 hours) and mean birth weight was 0.9 kg (range 0.75-1.10 kg) for 12 pre-term neonates of average gestation around 28 weeks. Seven patients completed the protocol; a maximum of five 6 mg/kg intravenous infusions of fluconazole were administered every 72 hours.

The mean half-life (hour) was 74 (range 44-185) on Day 1, which decreased, with time, to a mean of 53 (range 30-131) on Day 7 and 47 (range 27-68) on Day 13. The area under the curve (µg.h/mL) was 271 (range 173-385) on Day 1 and increased with a mean of 490 (range 292-734) on Day 7 and decreased with a mean of 360 (range 167-566) on Day 13. The volume of distribution (mL/kg) was 1,183 (range 1,070-1,470) on Day 1 and increased, with time, to a mean of 1,184 (range 510-2,130) on Day 7 and 1,328 (range 1,040-1,680) on Day 13.

Pharmacokinetics in Elderly

A pharmacokinetic study was conducted in 22 subjects, 65 years of age or older receiving a single 50 mg oral dose of fluconazole. Ten of these patients were concomitantly receiving diuretics. The C_{max} was 1.54 µg/mL and occurred at 1.3 hours post-dose. The mean AUC was 76.4 ± 20.3 µg.h/mL, and the mean terminal half-life was 46.2 hours. These pharmacokinetic parameter values are higher than analogous values reported for normal young male volunteers. Co-administration of diuretics did not significantly alter AUC or C_{max}. In addition, creatinine clearance (74 mL/min), the percent of medicinal product recovered unchanged in urine (0-24 h, 22%) and the fluconazole renal clearance estimates (0.124 mL/min/kg) for the elderly were generally lower than those of younger volunteers. Thus, the alteration of fluconazole disposition in the elderly appears to be related to reduced renal function characteristics of this group.

5.3 Preclinical Safety Data

Effects in non-clinical studies were observed only at exposures considered sufficiently in excess of the human exposure indicating little relevance to clinical use.

Carcinogenesis

Fluconazole showed no evidence of carcinogenic potential in mice and rats treated orally for 24 months at doses of 2.5, 5 or 10 mg/kg/day (approximately 2-7 times the recommended human dose). Male rats treated with 5 and 10 mg/kg/day had an increased incidence of hepatocellular adenomas.

Mutagenesis

Fluconazole, with or without metabolic activation, was negative in tests for mutagenicity in 4 strains of *Salmonella typhimurium*, and in the mouse lymphoma L5178Y system. Cytogenetic studies *in vivo* (murine bone marrow cells, following oral administration of fluconazole) and *in vitro* (human lymphocytes exposed to fluconazole at 1,000 µg/mL) showed no evidence of chromosomal mutations.

Reproductive Toxicity

Fluconazole did not affect the fertility of male or female rats treated orally with daily doses of 5, 10 or 20 mg/kg or with parenteral doses of 5, 25 or 75 mg/kg.

There were no foetal effects at 5 or 10 mg/kg; increases in foetal anatomical variants (supernumerary ribs, renal pelvis dilation) and delays in ossification were observed at 25 and 50 mg/kg and higher doses. At doses ranging from 80 mg/kg to 320 mg/kg embryoletality in rats was increased and foetal abnormalities included wavy ribs, cleft palate, and abnormal cranio-facial ossification.

The onset of parturition was slightly delayed at 20 mg/kg orally and dystocia and prolongation of parturition were observed in a few dams at 20 mg/kg and 40 mg/kg intravenously. The disturbances in parturition were reflected by a slight increase in the number of still-born pups and decrease of neonatal survival at these dose levels.

These effects on parturition are consistent with the species specific oestrogen-lowering property produced by high doses of fluconazole. Such a hormone change has not been observed in women treated with fluconazole (see section 5.1).

6. PHARMACEUTICAL PARTICULARS

6.1 Incompatibilities

This medicinal product must not be mixed with other medicinal products except those mentioned in section 6.4.

6.2 Shelf Life

Please refer to carton for expiry date.

Once opened the product should be used immediately. Any unused infusion should be discarded.

From a microbiological point of view, the dilutions should be used immediately. If not used immediately, in-use storage times and conditions prior to use are the responsibility of the user and would normally not be longer than 24 hours at 2°C to 8°C, unless dilution has taken place in controlled and validated aseptic conditions.

6.3 Special Precautions for Storage

Please refer to carton for storage condition.

Glass vials: Do not freeze.

6.4 Instructions for Use/Handling

Fluconazole intravenous infusion is compatible with the following administration fluids:

- a) Dextrose 5% and 20%
- b) Ringer's solution
- c) Hartmann's solution
- d) Potassium chloride in dextrose
- e) Sodium bicarbonate 4.2% and 5%
- f) Aminosyn 3.5%
- g) Sodium chloride 9 mg/mL (0.9%)
- h) Dialaflex (interperitoneal dialysis solution 6.36%)

Fluconazole may be infused through an existing line with one of the above listed fluids. Although no specific incompatibilities have been noted, mixing with any other medicinal products prior to infusion is not recommended.

The solution for infusion is for single use only.

The dilution is to be made under aseptic conditions. The solution is to be inspected visually for particulate matter and discolouration prior to administration. The solution should only be used if the solution is clear and free from particles.

Any unused medicinal product or waste material should be disposed of in accordance with local requirements.

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