SCHEDULING STATUS S4

PROPRIETARY NAME (AND DOSAGE FORM)

MOXIFLOXACIN DRL (film-coated tablets)

COMPOSITION

MOXIFLOXACIN DRL: Each film-coated tablet contains moxifloxacin hydrochloride equivalent to moxifloxacin 400 mg

Sugar free

MOXIFLOXACIN DRL film-coated tablets contain the following inactive ingredients: colloidal silicon dioxide, croscarmellose sodium, magnesium stearate, microcrystalline cellulose, sodium stearyl fumarate, talc.

The coating material contains hypromellose, iron oxide red, iron oxide yellow, isopropyl alcohol, methylene chloride, polyethylene glycol 400, polysorbate 80 and titanium dioxide.

PHARMACOLOGICAL CLASSIFICATION

A 20.1.1 Broad and medium spectrum antibiotics

PHARMACOLOGICAL ACTION

Moxifloxacin is a fluoroquinolone antibacterial with a broad spectrum of bactericidal action. Moxifloxacin has been shown to be active *in vitro* against most of the following microorganisms listed below. *In vitro* sensitivity may not always have been confirmed in clinical infection (see **INDICATIONS**).

Microbiology

Moxifloxacin has *in vitro* activity against a wide range of gram-positive and gram-negative micro-organisms. The bactericidal action of moxifloxacin results from inhibition of the topoisomerase II (DNA gyrase) and topoisomerase IV required for bacterial DNA replication, transcription, repair and recombination.

There is no known cross-resistance between moxifloxacin and other classes of antimicrobials.

Cross-resistance has been observed between moxifloxacin and other fluoroquinolones against gram-negative

bacteria. Gram-positive bacteria resistant to other fluoroquinolones may, however, still be susceptible to moxifloxacin.

Moxifloxacin has been shown to be active against most strains of the following micro-organisms, both *in vitro* and in clinical infections as described under **INDICATIONS AND DOSAGE AND DIRECTIONS FOR USE**.

Aerobic gram-positive micro-organisms

Staphylococcus aureus (methicillin-susceptible strains only)

Streptococcus pneumoniae (penicillin-susceptible strains)

Aerobic gram-negative micro-organisms

Haemophilus influenzae

Haemophilus parainfluenzae

Klebsiella pneumoniae

Moraxella catarrhalis

Other micro-organisms

Chlamydia pneumoniae

Mycoplasma pneumoniae

The following *in vitro* data are available, but their clinical significance is unknown.

Moxifloxacin exhibits *in vitro* minimum inhibitory concentrations (MICs) of 2 µg/ml or less against most (> 90 %) strains of the following microorganisms, however, the safety and effectiveness of moxifloxacin in treating clinical infections due to these microorganisms have not been established in adequate and well-controlled clinical trials.

Aerobic gram-positive microorganisms

Streptococcus agalactiae

Streptococcus viridans group

Aerobic gram-negative microorganisms

Citrobacter freundii

Enterobacter cloacae

Escherichia coli

Klebsiella oxytoca

Legionella pneumophila

Proteus mirabilis

Anaerobic microorganisms

Fusobacterium species

Peptostreptococcus species

Prevotella species

In vitro sensitivity does not necessarily imply *in vivo* efficacy.

Pharmacokinetics

Following oral administration moxifloxacin is absorbed rapidly and almost completely. The absolute bioavailability amounts to approximately 90 % after oral administration of a 400 mg dose. Pharmacokinetics are linear in the range of 50–1 200 mg single oral dose and up to 600 mg once daily dosing over 10 days. Steady state is reached within 3 days. Following a 400 mg oral dose, peak concentrations of 3,1 mg/l are reached within 0,5-4 h post administration. Peak and trough plasma concentrations at steady state (400 mg once daily) were 3,2 and 0,6 mg/l, respectively.

Moxifloxacin undergoes Phase II biotransformation and is excreted via renal and biliary faecal pathways as unchanged drug as well as in form of a sulfo-compound (M1) and a glucuronide (M2). M1 and M2 are the only metabolites relevant in humans. Both are microbiologically inactive. The recovery from urine (approximately 19 % for unchanged drug, approximately 2,5 % for M1 and approximately 14 % for M2) and faeces (approximately 25 % of unchanged drug, approximately 36 % for M1 and no recovery for M2) totalled to approximately 96,98 % of the dose independent from the route of administration.

Moxifloxacin is eliminated from plasma and saliva with a mean terminal half-life of approximately 12 hours. The mean apparent total body clearance following a 400 mg dose ranges from 179 to 246 ml/min. Renal clearance amounted to about 24-53 ml/min suggesting partial tubular reabsorption of the drug from the kidneys. Approximately 19 % of the dose is excreted unchanged into the urine and approximately 25 % in the faeces. Approximately 2,5 % is recovered as M1 in the urine and 36 % in the faeces respectively. About 14 % is recovered as M2 in the urine.

INDICATIONS

MOXIFLOXACIN DRL is indicated for the treatment of severe and/or complicated infections caused by moxifloxacin sensitive bacteria where other antimicrobials, approved for a similar indication and to which the causative bacteria are sensitive, were considered not to be an appropriate treatment option, have failed, are contraindicated or not tolerated.

MOXIFLOXACIN DRL is not indicated/approved for the initiation of treatment (first line treatment) of infections described as mild/moderate/acute and uncomplicated, caused by bacteria sensitive to moxifloxacin, unless treatment with other appropriate antimicrobials, approved for a similar indication and to which the causative bacteria are sensitive, have failed, are contraindicated or not tolerated.

MOXIFLOXACIN DRL is indicated for the treatment of adults (> 18 years of age) with mild to moderately severe infections caused by susceptible strains of the designated microorganisms in the conditions listed below, where these infections are compliant with the indication context:

- Acute bacterial sinusitis caused by *Streptococcus pneumoniae, Haemophilus influenzae,* or *Moraxella catarrhalis.*
- Acute exacerbations of chronic obstructive pulmonary disease (COPD) including chronic bronchitis (AECB) caused by *Streptococcus pneumoniae, Haemophilus influenzae, Haemophilus parainfluenzae, Klebsiella pneumoniae, Staphylococcus aureus* or *Moraxella catarrhalis.*
- Community acquired pneumonia (of mild to moderate severity) caused by *Streptococcus pneumoniae, Haemophilus influenzae, Mycoplasma pneumoniae, Chlamydia pneumoniae* or *Moraxella catarrhalis.*
- Severe and/or complicated skin and soft tissue infections caused by *Stapylococcus aureus*, *Streptococcus pyogenes*.
- Uncomplicated pelvic inflammatory disease, not caused *by Neisseria gonorrhoea.*

Appropriate culture and susceptibility tests should be performed before treatment in order to isolate and identify organisms causing infection and to determine their susceptibility to **MOXIFLOXACIN DRL**. Therapy with

MOXIFLOXACIN DRL may be initiated in severe and/or complicated infections before results of these tests are known; once results become available, appropriate therapy should be continued.

CONTRAINDICATIONS

- Known hypersensitivity to any component of the tablets or other quinolones;
- Due to the lack of clinical data the use of **MOXIFLOXACIN DRL** is not recommended in patients with moderate or severe hepatic insufficiency;
- Quinolones are known to distribute well into breast milk of lactating women. The use of **MOXIFLOXACIN DRL** in pregnancy and nursing mothers is contra-indicated;
- Concomitant administration of **MOXIFLOXACIN DRL** with ACE inhibitors/Angiotensin receptor blockers in patients with moderate to severe renal impairment and the elderly;
- A history of tendon, muscle, joint, nerve, central nervous system or psychiatric disorders especially those related to previous quinolone/fluoroquinolone use where alternative appropriate antibiotic choices are available;
- A history of convulsions, epilepsy or difficult to control epilepsy disorders;
- Concomitant use with medicines that prolong the QT interval;
- Congenital or documented acquired QT prolongation;
- Clinically relevant heart failure with reduced left-ventricular ejection fraction;
- Electrolyte disturbances, particularly in uncorrected hypokalaemia;
- Clinically relevant bradycardia;
- Previous history of symptomatic dysrhythmias.
- Aortic aneurysm and/or dissection or in patients with risk factors or conditions predisposing for aortic aneurysm and/or dissection where alternative antibiotic choices are available.
- Use of fluoroquinolones is contraindicated in patients with confirmed mitral valve and/or aortic valve regurgitation unless no safer appropriate alternative antibiotic is available, has failed or is not well tolerated.

MOXIFLOXACIN DRL is contraindicated in children under 18 years and in growing adolescents (except where no other suitable antimicrobial agent can be used). Experimental

evidence indicates that species variable reversible lesions of the cartilage of weight bearing joints has been seen in immature members of certain animal species.

WARNINGS AND SPECIAL PRECAUTIONS

THE SAFETY AND EFFECTIVENESS OF MOXIFLOXACIN DRLIN PAEDIATRIC PATIENTS, ADOLESCENTS (LESS THAN 18 YEARS OF AGE), PREGNANT WOMEN AND LACTATING WOMEN HAVE NOT BEEN ESTABLISHED.

MOXIFLOXACIN DRL should be used with caution as many patients may experience adverse reactions that may be disabling, long-lasting and potentially irreversible.

Prolongation of QTc interval and potentially QTc-prolongation-related clinical conditions:

MOXIFLOXACIN DRL HAS BEEN SHOWN TO PROLONG THE QT INTERVAL OF THE ELECTROCARDIOGRAM IN SOME PATIENTS. DRL MOXIFLOXACIN SHOULD BE AVOIDED IN PATIENTS WITH KNOWN PROLONGATION OF THE QT INTERVAL, PATIENTS WITH UNCORRECTED HYPOKALAEMIA AND PATIENTS RECEIVING CLASS IA (e.g. QUINIDINE, PROCAINAMIDE) OR CLASS III (e.g. AMIODARONE, SOTALOL) ANTIARRHYTHMIC AGENTS, DUE TO THE LACK OF CLINICAL EXPERIENCE WITH MOXIFLOXACIN DRL IN THESE PATIENT POPULATIONS.

Pharmacokinetic studies between moxifloxacin and other medicines that prolong the QT interval such as cisapride, erythromycin, antipsychotics and tricyclic antidepressants have not been performed.

An additive effect of **MOXIFLOXACIN DRL** and these medicines cannot be excluded; therefore **MOXIFLOXACIN DRL** should be used with caution when given concurrently with these medicines.

The effect of **MOXIFLOXACIN DRL** on patients with congenital prolongation of the QT interval has not been studied; however it is expected that these individuals may be more susceptible to drug-induced QT prolongation. Because of limited clinical experience, **MOXIFLOXACIN DRL** should be used with caution in patients with ongoing proarrhythmic conditions, such as clinically significant bradycardia, acute myocardial ischemia.

The magnitude of QT prolongation may increase with increasing concentrations of **MOXIFLOXACIN DRL** therefore, the recommended dose should not be exceeded. QT prolongation may lead to an increased risk for ventricular arrhythmias including torsade de pointes. The mean ±SD effect of moxifloxacin 400 mg on the QTc interval was 6 ± 26 ms.

Aortic aneurysm and dissection

Epidemiologic studies report an increased risk of aortic aneurysm and dissection after intake of fluoroquinolones, particularly in the older population.

Therefore, **MOXIFLOXACIN DRL**, should only be used after careful benefit-risk assessment and after consideration of other therapeutic options in patients with positive family history of aneurysm disease, or in patients diagnosed with pre-existing aortic aneurysm and/or dissection, or in presence of other risk factors or conditions predisposing for aortic aneurysm and dissection (e.g. Marfan syndrome, vascular Ehlers-Danlos syndrome, Takayasu arteritis, giant cell arteritis, Behcet's disease, hypertension, known atherosclerosis).

In case of sudden abdominal, chest or back pain, patients should be advised to immediately consult a physician in an emergency department.

Therefore, **MOXIFLOXACIN DRL**, should only be prescribed to patients with a pre-existing dilated aorta, aortic aneurysm/dissection, or the presence of other risk factors predisposing to aortic aneurysm/dissection, where other antimicrobials have been considered not to be an appropriate treatment option, have failed, are contraindicated or cannot be tolerated.

Cartilage and joints effects

The oral administration of moxifloxacin caused lameness in immature dogs. Histopathological examination of the weight-bearing joints of these dogs revealed permanent lesions of the cartilage. Related quinolone-class medicines also produce erosions of cartilage of weight bearing joints and other signs of arthropathy in immature animals of various species.

Central Nervous System

Convulsions have been reported in patients receiving quinolones such as **MOXIFLOXACIN DRL**. Quinolones may also cause central nervous system (CNS) events including: peripheral neuropathy, dizziness, confusion, tremors, psychosis, anxiety, insomnia, hallucinations, depression and rarely, suicidal thoughts or acts, impairment of vision, hearing, smell and taste)

These reactions may occur following the first dose. If these reactions occur in patients receiving moxifloxacin,

MOXIFLOXACIN DRL should be discontinued and appropriate measures instituted. **MOXIFLOXACIN DRL** should be used with caution in patients with known or suspected CNS disorders (e.g. severe cerebral arteriosclerosis, epilepsy) or in the presence of other risk factors that may predispose to seizures or lower the seizure threshold (See **SIDE EFFECTS**).

Quinolones such as **MOXIFLOXACIN DRL** may cause central nervous system (CNS) events, including: nervousness, agitation, insomnia, anxiety, nightmares or paranoia.

Hypersensitivity

Serious and occasionally fatal hypersensitivity (anaphylactic) reactions, some following the first dose, have been reported in patients receiving quinolone therapy such as **MOXIFLOXACIN DRL.** Some reactions were accompanied by cardiovascular collapse, loss of consciousness, tingling, pharyngeal or facial oedema, dyspnoea, urticaria and itching. Serious anaphylactic reactions require immediate emergency treatment with epinephrine (adrenaline). **MOXIFLOXACIN DRL** should be discontinued at the first appearance of a skin rash or any other sign of hypersensitivity. Oxygen, intravenous steroids and airway management, including intubation, may be administered as indicated.

Severe and sometimes fatal events, some due to hypersensitivity and some of uncertain aetiology, have been reported in patients receiving therapy with **MOXIFLOXACIN DRL**. These events may be severe and generally occur following the administration of multiple doses. Clinical manifestations may include one or more of the following: rash, fever, eosinophilia, jaundice and hepatic necrosis.

Antibiotic-associated diarrhoea incl. colitis

Pseudomembranous colitis has been reported with MOXIFLOXACIN DRL and may range in severity from mild to life-threatening.

Therefore, it is important to consider this diagnosis in patients who present with diarrhoea subsequent to the administration of MOXIFLOXACIN DRL.

Treatment with **MOXIFLOXACIN DRL** alters the normal flora of the colon and may permit overgrowth of *Clostridia*. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of "antibiotic-associated colitis".

After the diagnosis of pseudomembranous colitis has been established, therapeutic measures should be initiated. Mild cases of pseudomembranous colitis usually respond to drug discontinuation alone. In moderate to severe cases consideration should be given to management with fluids and electrolytes, protein

supplementation and treatment with an antibacterial drug clinically effective against *Clostridium difficile* colitis.

Suspicion of pseudomembranous colitis requires immediate cessation of treatment.

Musculoskeletal System

Side effects of the musculoskeletal system including tendinitis, tendon rupture, myalgia, muscle weakness, arthralgia and joint swelling may occur.

Achilles and other tendon ruptures that required surgical repair or resulted in prolonged disability have been reported with quinolones. **MOXIFLOXACIN DRL** should be discontinued if the patient experiences pain, inflammation or rupture of a tendon and appropriate treatment (e.g. immobilisation) must be initiated for the affected tendon. Tendon rupture may occur within 48 hours after starting treatment with **MOXIFLOXACIN DRL** and may be bilateral.

Caution is advised when prescribing for the elderly, patients with renal impairment, patients with solid organ transplants, and those concurrently treated with corticosteroids, as the risk of fluoroquinolone-induced tendinitis and tendon rupture may be exacerbated in these patients.

Patients with myasthenia gravis

MOXIFLOXACIN DRL should be used with caution in patients with myasthenia gravis because the symptoms can be exacerbated.

Blood glucose disturbances

Disturbances in blood glucose, including both hyperglycaemia and hypoglycaemia have been reported, usually in diabetic patients receiving concomitant treatment with an oral hypoglycaemic medicine or with insulin. Cases of hypoglycaemic coma have been reported (see **SIDE EFFECTS**).

In diabetic patients, careful monitoring of blood glucose is recommended.

Renal impairment

Concomitant use of fluoroquinolones, like **MOXIFLOXACIN DRL**, and ACE inhibitors/ Renin-Angiotensin blockers may precipitate acute kidney injury in patients, especially those with moderate to severe renal impairment and elderly patients (see **CONTRAINDICATIONS**). Renal function should be assessed before initiating treatment and monitored during treatment, with fluoroquinolones and ACE inhibitors/angiotensin receptor blockers.

Risk of mitral and aortic regurgitation

There is some evidence, although inconclusive, of a possible association between oral fluoroquinolone use and

mitral valve and/or aortic valve regurgitation. A thorough cardiovascular examination including an echocardiogram, should be performed before oral fluoroquinolones are prescribed.

Fluoroquinolones should not be prescribed to patients with mitral valve and or aortic valve regurgitation (see **CONTRAINDICATIONS**).

INTERACTIONS

Food and dairy products: Absorption of moxifloxacin was not altered by food intake. Therefore, **MOXIFLOXACIN DRL** can be taken independent from food intake.

Ranitidine

The concomitant administration with ranitidine did not change the absorption characteristics of moxifloxacin significantly. Absorption parameters (C_{max}, t_{max}, AUC) were very similar indicating absence of an influence of gastric pH on **MOXIFLOXACIN DRL** uptake from the gastrointestinal tract.

Antacids, minerals and multivitamins

Concomitant ingestion of **MOXIFLOXACIN DRL** together with antacids, minerals and multivitamins may result in impaired absorption of the drug due to formation of chelate complexes with the multi-valent cations contained in these preparations. This may lead to plasma concentrations considerably lower than desired. Hence, antacids, anti-retroviral medicines and other preparations containing magnesium, aluminium and other minerals such as iron should be administered at least 4 hours before or 2 hours after ingestion of an oral moxifloxacin dose.

Warfarin

No interaction during concomitant treatment with warfarin on prothrombin time and other coagulation parameters has been observed.

Digoxin

The pharmacokinetics of digoxin are not significantly influenced by **MOXIFLOXACIN DRL**(and vice versa).

Itraconazole

The pharmacokinetics of moxifloxacin are not significantly altered by itraconazole. No dose adjustment is necessary for itraconazole when given with **MOXIFLOXACIN DRL** and *vice versa*.

Theophylline

No influence of **MOXIFLOXACIN DRL** on theophylline pharmacokinetics (and vice versa) at steady state was

detected. Hence, no recommendations with respect to theophylline dosing need to be given.

Probenecid

No significant effect on apparent total body clearance and renal clearance of moxifloxacin was found in a clinical study investigating the impact of probenecid on renal excretion. Therefore, dosing adjustments need not be made when both drugs are administered concomitantly.

Antidiabetics

Concomitant administration of **MOXIFLOXACIN DRL** with glibenclamide may result in a decrease of approximately 21 % in the peak plasma concentrations of glibenclamide.

Oral contraceptives

No interaction has occurred following concomitant oral administration of moxifloxacin with oral contraceptives.

Medicines metabolised by Cytochrome P450 enzymes

In vitro studies with cytochrome P450 isoenzyrnes (CYP) indicate that moxifloxacin does not inhibit CYP3A4, CYP2D6, CYP2C9, CYP2C19 or CYP1A2, suggesting that moxifloxacin is unlikely to alter the pharmacokinetics of drugs metabolized by these enzymes (e.g. midazolam, cyclosporine, warfarin, theophylline).

Nonsteroidal anti-inflammatory drugs (NSAIDs)

Although not observed with moxifloxacin in preclinical and clinical trials, the concomitant administration of NSAIDs with **MOXIFLOXACIN DRL** may increase the risk of CNS stimulation and convulsions (see WARNINGS AND SPECIAL PRECAUTIONS).

Charcoal

Concomitant administration of charcoal with a dose of 400 mg **MOXIFLOXACIN DRL** will reduce systemic availability of the drug by more than 80 %.

ACE inhibitors/renin angiotensin receptor blockers

Concomitant use of fluoroquinolones and ACE inhibitors/angiotensin receptor blockers may precipitate acute kidney injury in patients with moderate to severe renal impairment and the elderly (see **CONTRAINDICATIONS**).

The use of enalapril, an angiotensin converting enzyme (ACE) inhibitor, may lead to renal impairment due to altered renal haemodynamics in particular clinical situations or with other medicines that affect glomerular filtration. Increased serum creatinine and blood urea nitrogen, and more rarely crystalluria and macrohaematuria, have been observed in patients taking **MOXIFLOXACIN DRL**.

PREGNANCY AND LACTATION

Quinolones pass and are present in breast milk of lactating women. The use of **MOXIFLOXACIN DRL** in pregnancy and nursing mothers is contraindicated.

DOSAGE AND DIRECTIONS FOR USE

Adults: The recommended dose for **MOXIFLOXACIN DRL** is 400 mg once-daily for all indications.

Swallow the tablet whole with a glass of water. **MOXIFLOXACIN DRL** can be taken independent of food intake.

The duration of treatment to contain and eradicate an infection depends upon the type and severity of the infection, immunological status, clinical response and bacteriological findings. In general, antibiotic therapy should continue for 3 to 4 days after the manifestations of the infection have cleared.

The following general recommendations for the treatment of upper and lower respiratory tract infections are made:

Acute exacerbation of chronic obstructive pulmonary disease (COPD) including chronic bronchitis

5 days

Community acquired pneumonia	10 days
Acute sinusitis	10 days

The recommended duration of treatment in skin and soft tissue infections is 10 days.

Special Populations

Elderly

No adjustment of dosage is required in the elderly.

Children

The use of **MOXIFLOXACIN DRL** in children and adolescents under 18 years in the growth phase is contraindicated.

Hepatic impairment

No dosage adjustment is required in patients with slightly impaired liver function (Child-Pugh A). No pharmacokinetic data is available for patients with moderate to severely impaired liver function (Child-Pugh B, C). Due to the lack of data, **MOXIFLOXACIN DRL** is contraindicated in patients with moderate or severe hepatic impairment.

Renal impairment

No dose adjustment is required in patients with any degree of renal impairment (including creatinine clearance ≤ 30 ml/min/1,73 m^2).

SIDE EFFECTS

Infections and infestations

Frequent: Oral and vaginal candidiasis

Blood and lymphatic system disorders

Less frequent: Anaemia, leukopenia, thrombocytopenia, blood eosinophilia, thrombocythemia, prothrombin time prolonged/INR increased, prothrombin level increased/ INR decreased, thromboplastin decrease

Immune system disorders

Less frequent: Allergic reaction, anaphylactic reaction, anaphylactic shock

Metabolism and nutritional disorders

Less frequent: Hyperlipidaemia, hyperglycaemia, hypoglycaemia (particularly in diabetic patients), hyperuricaemia

Frequency not known: Hypoglycaemic coma

Psychiatric disorders

Less frequent: Anxiety, confusion, depression, hallucinations, emotional lability, agitation, abnormal thinking, depersonalisation

Nervous system disorders

Less frequent: Headache, dizziness, malaise, insomnia, vertigo, somnolence, tremor, parasthesia,

nervousness, incoordination, amnesia, speech disorder or aphasia, abnormal dreams, convulsions, hypoesthesia, hypertonia, disturbed coordination leading to falls with injuries, especially in the elderly; Guillain-Barré Syndrome

Eye disorders

Less frequent: Amblyopia, abnormal vision

Ear and labyrinth disorders

Less frequent: Tinnitus

Cardiac disorders

Frequent: QT prolongation

Less frequent: Palpitations, tachycardia, chest pain, ventricular dysrhythmias: aortic aneurysm and dissection

Vascular disorders

Less frequent: Peripheral oedema, hypertension, hypotension, vasodilation

Respiratory, thoracic and mediastinal disorders

Less frequent: Dyspnoea, asthma

Gastrointestinal disorders

Frequent: Abdominal pain, nausea, diarrhoea, vomiting, dyspepsia

Less frequent: Taste perversion, dry mouth, flatulence, constipation, anorexia, stomatitis, glossitis, increased amylase, gastritis, tongue discolouration, dysphagia, pseudomembranous colitis

Hepato-biliary disorders

Frequent: Increase in transaminases

Less frequent: Increase in gamma-glutamyl-transferase (gGT), hepatic impairment including LDH increase, increased bilirubin, increase in alkaline phosphatase, jaundice

Skin and subcutaneous tissue disorders

Less frequent: Pruritus, urticaria, sweating, rash (maculopapular, purpuric, pustular)

Musculoskeletal, connective tissue and bone disorders

Less frequent: Asthenia, back pain, leg pain, arthralgia, myalgia, tendonitis, arthritis, tendon rupture

Renal and urinary disorders

Less frequent: Renal impairment

Reproductive system and breast disorders

Less frequent: Vaginitis

General disorders and administration site conditions

Less frequent: Pain (including pain in back, chest, pelvis and extremities), face oedema

Investigations

The most common changes in laboratory parameters not listed above include increased and decreased haematocrit, increased WBC, increased and decreased RBC, hypoglycaemia, decreased haemoglobin, increased SGOT/AST, increased SGPT/ALT, increased urea, increased creatinine. It is not known whether these laboratory alterations are caused by **MOXIFLOXACIN DRL** or by the underlying condition being treated.

Post-marketing Experience:

Cases of mitral valve and/or aortic valve regurgitation were reported in patients treated with oral fluoroquinolones. Due to insufficient post marketing information in the reported cases, it is unknown whether fluoroquinolone use was the causative factor, or a contributory factor or played no role in the reported cases where mitral cases and/or aortic regurgitation was diagnosed.

KNOWN SYMPTOMS OF OVERDOSAGE AND PARTICULARS OF ITS TREATMENT

No specific countermeasures after accidental over dosage are recommended. General symptomatic therapy should be initiated. Concomitant administration of charcoal with a dose of 400 mg oral **MOXIFLOXACIN DRL** will reduce systemic availability of the medicine by more than 80 %.

IDENTIFICATION

Beige coloured, modified capsule shaped, biconvex film-coated tablets debossed with the Dr Reddy's logo on one side and '112' on other side.

PRESENTATION

30 film-coated tablets packed in white HDPE bottles or in cartons comprising of Alu/Alu blister strips of 5's or 10's.

STORAGE INSTRUCTIONS

Store at or below 25 °C.

Keep the blisters in the carton until required for use.

Keep the HDPE containers well closed

KEEP OUT OF REACH OF CHILDREN

REGISTRATION NUMBER

42/20.1.1/0442

NAME AND BUSINESS ADDRESS OF THE HOLDER OF THE

CERTIFICATE OF REGISTRATION

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