

CEFTAZIDIME

INJECTION, POWDER, FOR SOLUTION

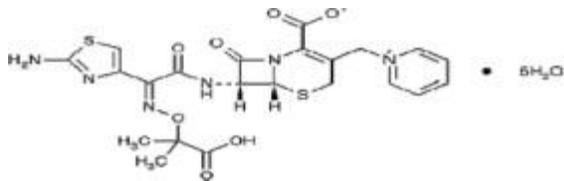
For Intravenous or Intramuscular Use

Rx Only

To reduce the development of drug-resistant bacteria and maintain the effectiveness of Ceftazidime and other antibacterial drugs, Ceftazidime should be used only to treat or prevent infections that are proven or strongly suspected to be caused by bacteria.

DESCRIPTION

Ceftazidime is a semisynthetic, broad-spectrum, beta-lactam antibiotic for parenteral administration. It is the pentahydrate of pyridinium, 1 - [[7 - [[(2 - amino - 4 - thiazolyl)((1 - carboxy - 1 - methylethoxy)imino]acetyl]amino] - 2 - carboxy - 8 - oxo - 5 - thia - 1 - azabicyclo [4.2.0]oct-2-en-3-yl]methyl]-, hydroxide, inner salt, [6R-[6 α ,7 β (Z)]]. It has the following structure:



The molecular formula is C₂₂H₃₂N₆O₁₂S₂, representing a molecular weight of 636.6.

Ceftazidime for injection, is a sterile, dry-powdered mixture of Ceftazidime pentahydrate and sodium carbonate. The sodium carbonate at a concentration of 118 mg/g of Ceftazidime activity has been admixed to facilitate dissolution. The total sodium content of the mixture is approximately 54 mg (2.3 mEq)/g of Ceftazidime activity.

The 500 mg vial contains 59 mg of sodium carbonate. The sodium content is approximately 27 mg (1.2 mEq).

The 1 g vial contains 118 mg of sodium carbonate. The sodium content is approximately 54 mg (2.3 mEq).

Ceftazidime for injection is a white or cream colored powder.

Ceftazidime in sterile crystalline form is supplied in vials equivalent to 500 mg or 1 g of anhydrous Ceftazidime. Solutions of Ceftazidime range in color from light yellow to amber, depending on the diluent and volume used. The pH of freshly constituted solutions usually ranges from 5 to 8.

CLINICAL PHARMACOLOGY

After IV administration of 500 mg and 1 g doses of Ceftazidime over 5 minutes to normal adult male volunteers, mean peak serum concentrations of 45 and 90 mcg/mL, respectively, were achieved. After IV infusion of 500 mg, 1 g, and 2 g doses of Ceftazidime over 20 to 30 minutes to normal adult male volunteers, mean peak serum concentrations of 42, 69, and 170 mcg/mL, respectively, were achieved. The average serum concentrations following IV infusion of 500 mg, 1 g, and 2 g doses to these volunteers over an 8-hour interval are given in Table 1.

Table 1. Average Serum Concentrations of Ceftazidime

Ceftazidime IV Dose	Serum Concentrations (mcg/mL)				
	0.5 hr	1 hr	2 hr	4 hr	8 hr
500 mg	42	25	12	6	2
1 g	60	39	23	11	3
2 g	129	75	42	13	5

The absorption and elimination of Ceftazidime were directly proportional to the size of the dose. The half-life following IV administration was approximately 1.9 hours. Less than 10% of Ceftazidime was protein bound. The degree of protein binding was independent of concentration. There was no evidence of accumulation of Ceftazidime in the serum in individuals with normal renal function following multiple IV doses of 1 and 2 g every 8 hours for 10 days.

Following intramuscular (IM) administration of 500 mg and 1 g doses of Ceftazidime to normal adult volunteers, the mean peak serum concentrations were 17 and 39 mcg/mL, respectively, at approximately 1 hour. Serum concentrations remained above 4 mcg/mL for 6 and 8 hours after the IM administration of 500 mg and 1 g doses, respectively. The half-life of Ceftazidime in these volunteers was approximately 2 hours.

The presence of hepatic dysfunction had no effect on the pharmacokinetics of Ceftazidime in individuals administered 2 g intravenously every 8 hours for 5 days. Therefore, a dosage adjustment from the normal recommended dosage is not required for patients with hepatic dysfunction, provided renal function is not impaired.

Approximately 80% to 90% of an IM or IV dose of Ceftazidime is excreted unchanged by the kidneys over a 24-hour period. After the IV administration of single 500 mg or 1 g doses, approximately 50% of the dose appeared in the urine in the first 2 hours. An additional 20% was excreted between 2 and 4 hours after dosing, and approximately another 12% of the dose appeared in the urine between 4 and 8 hours later. The elimination of Ceftazidime by the kidneys resulted in high therapeutic concentrations in the urine.

The mean renal clearance of Ceftazidime was approximately 100 mL/min. The calculated plasma clearance of approximately 115 mL/min indicated nearly complete elimination of

Ceftazidime by the renal route. Administration of probenecid before dosing had no effect on the elimination kinetics of Ceftazidime. This suggested that Ceftazidime is eliminated by glomerular filtration and is not actively secreted by renal tubular mechanisms.

Since Ceftazidime is eliminated almost solely by the kidneys, its serum half-life is significantly prolonged in patients with impaired renal function. Consequently, dosage adjustments in such patients as described in the **DOSAGE AND ADMINISTRATION** section are suggested.

Therapeutic concentrations of Ceftazidime are achieved in the following body tissues and fluids.

Table 2. Ceftazidime Concentrations in Body Tissues and Fluids

Tissue or Fluid	Dose/Route	No. of Patients	Time of Sample Postdose	Average Tissue or Fluid Level (mcg/mL or mcg/g)
Urine	500 mg IM	6	0-2 hr	2,100
	2 g IV	6	0-2 hr	12,000
Bile	2 g IV	3	90 min	36.4
Synovial fluid	2 g IV	13	2 hr	25.6
Peritoneal fluid	2 g IV	8	2 hr	48.6
Sputum	1 g IV	8	1 hr	9
Cerebrospinal fluid (inflamed meninges)	2 g q8hr IV	5	120 min	9.8
	2 g q8hr IV	6	180 min	9.4
Aqueous humor	2 g IV	13	1-3 hr	11
Blister fluid	1 g IV	7	2-3 hr	19.7
Lymphatic fluid	1 g IV	7	2-3 hr	23.4
Bone	2 g IV	8	0.67 hr	31.1
Heart muscle	2 g IV	35	30-280 min	12.7
Skin	2 g IV	22	30-180 min	6.6
Skeletal muscle	2 g IV	35	30-280 min	9.4
Myometrium	2 g IV	31	1-2 hr	18.7

MICROBIOLOGY

Ceftazidime is bactericidal in action, exerting its effect by inhibition of enzymes responsible for cell-wall synthesis. A wide range of gram-negative organisms is susceptible to Ceftazidime in vitro, including strains resistant to gentamicin and other aminoglycosides. In addition, Ceftazidime has been shown to be active against gram-positive organisms. It is highly stable to most clinically important beta-lactamases, plasmid or chromosomal, which are produced by both gram-negative and gram-positive organisms and, consequently, is active against many strains

resistant to ampicillin and other cephalosporins.

Ceftazidime has been shown to be active against the following organisms both in vitro and in clinical infections (see **INDICATIONS AND USAGE**).

Aerobes, Gram-negative: Citrobacter spp., including Citrobacter freundii and Citrobacter diversus; Enterobacter spp., including Enterobacter cloacae and Enterobacter aerogenes; Escherichia coli; Haemophilus influenzae, including ampicillin-resistant strains; Klebsiella spp. (including Klebsiella pneumoniae); Neisseria meningitidis; Proteus mirabilis; Proteus vulgaris; Pseudomonas spp. (including Pseudomonas aeruginosa); and Serratia spp.

Aerobes, Gram-positive: Staphylococcus aureus, including penicillinase- and non-penicillinase-producing strains; Streptococcus agalactiae (group B streptococci); Streptococcus pneumoniae; and Streptococcus pyogenes (group A beta-hemolytic streptococci).

Anaerobes: Bacteroides spp. (NOTE: many strains of Bacteroides fragilis are resistant).

Ceftazidime has been shown to be active in vitro against most strains of the following organisms; however, the clinical significance of these data is unknown: Acinetobacter spp., Clostridium spp. (not including Clostridium difficile), Haemophilus parainfluenzae, Morganella morganii (formerly Proteus morganii), Neisseria gonorrhoeae, Peptococcus spp., Peptostreptococcus spp., Providencia spp. (including Providencia rettgeri, formerly Proteus rettgeri), Salmonella spp., Shigella spp., Staphylococcus epidermidis, and Yersinia enterocolitica.

Ceftazidime and the aminoglycosides have been shown to be synergistic in vitro against Pseudomonas aeruginosa and the enterobacteriaceae. Ceftazidime and carbenicillin have also been shown to be synergistic in vitro against Pseudomonas aeruginosa.

Ceftazidime is not active in vitro against methicillin-resistant staphylococci, Streptococcus faecalis and many other enterococci, Listeria monocytogenes, Campylobacter spp., or Clostridium difficile.

Susceptibility Tests

Diffusion Techniques

Quantitative methods that require measurement of zone diameters give an estimate of antibiotic susceptibility. One such procedure¹⁻³ has been recommended for use with disks to test susceptibility to Ceftazidime.

Reports from the laboratory giving results of the standard single-disk susceptibility test with a 30 mcg Ceftazidime disk should be interpreted according to the following criteria:

Susceptible organisms produce zones of 18 mm or greater, indicating that the test organism is likely to respond to therapy.

Organisms that produce zones of 15 to 17 mm are expected to be susceptible if high dosage is used or if the infection is confined to tissues and fluids (e.g., urine) in which high antibiotic levels are attained.

Resistant organisms produce zones of 14 mm or less, indicating that other therapy should be selected.

Organisms should be tested with the Ceftazidime disk since Ceftazidime has been shown by in vitro tests to be active against certain strains found resistant when other beta-lactam disks are used.

Standardized procedures require the use of laboratory control organisms. The 30 mcg Ceftazidime disk should give zone diameters between 25 and 32 mm for *Escherichia coli* ATCC 25922. For *Pseudomonas aeruginosa* ATCC 27853, the zone diameters should be between 22 and 29 mm. For *Staphylococcus aureus* ATCC 25923, the zone diameters should be between 16 and 20 mm. **Dilution Techniques**

In other susceptibility testing procedures, e.g., ICS agar dilution or the equivalent, a bacterial isolate may be considered susceptible if the minimum inhibitory concentration (MIC) value for Ceftazidime is not more than 16 mcg/mL. Organisms are considered resistant to Ceftazidime if the MIC is ≥ 64 mcg/mL. Organisms having an MIC value of < 64 mcg/mL but > 16 mcg/mL are expected to be susceptible if high dosage is used or if the infection is confined to tissues and fluids (e.g., urine) in which high antibiotic levels are attained.

As with standard diffusion methods, dilution procedures require the use of laboratory control organisms. Standard Ceftazidime powder should give MIC values in the range of 4 to 16 mcg/mL for *Staphylococcus aureus* ATCC 25923. For *Escherichia coli* ATCC 25922, the MIC range should be between 0.125 and 0.5 mcg/mL. For *Pseudomonas aeruginosa* ATCC 27853, the MIC range should be between 0.5 and 2 mcg/mL.

INDICATIONS AND USAGE

Ceftazidime is indicated for the treatment of patients with infections caused by susceptible strains of the designated organisms in the following diseases:

1. **Lower Respiratory Tract Infections**, including pneumonia, caused by *Pseudomonas aeruginosa* and other *Pseudomonas* spp.; *Haemophilus influenzae*, including ampicillin-resistant strains; *Klebsiella* spp.; *Enterobacter* spp.; *Proteus mirabilis*; *Escherichia coli*; *Serratia* spp.; *Citrobacter* spp.; *Streptococcus pneumoniae*; and *Staphylococcus aureus* (methicillin-susceptible strains).
2. **Skin and Skin-Structure Infections** caused by *Pseudomonas aeruginosa*; *Klebsiella* spp.; *Escherichia coli*; *Proteus* spp., including *Proteus mirabilis* and indole-positive *Proteus*; *Enterobacter* spp.; *Serratia* spp.; *Staphylococcus aureus* (methicillin-susceptible strains); and *Streptococcus pyogenes* (group A beta-hemolytic streptococci).
3. **Urinary Tract Infections**, both complicated and uncomplicated, caused by *Pseudomonas aeruginosa*; *Enterobacter* spp.; *Proteus* spp., including *Proteus mirabilis* and indole-positive *Proteus*; *Klebsiella* spp.; and *Escherichia coli*.
4. **Bacterial Septicemia** caused by *Pseudomonas aeruginosa*, *Klebsiella* spp., *Haemophilus influenzae*, *Escherichia coli*, *Serratia* spp., *Streptococcus pneumoniae*, and *Staphylococcus aureus* (methicillin-susceptible strains).
5. **Bone and Joint Infections** caused by *Pseudomonas aeruginosa*, *Klebsiella* spp., *Enterobacter* spp., and *Staphylococcus aureus* (methicillin-susceptible strains).
6. **Gynecologic Infections**, including endometritis, pelvic cellulitis, and other infections of the female genital tract caused by *Escherichia coli*.

7. **Intra-abdominal Infections**, including peritonitis caused by *Escherichia coli*, *Klebsiella* spp., and *Staphylococcus aureus* (methicillin-susceptible strains) and polymicrobial infections caused by aerobic and anaerobic organisms and *Bacteroides* spp. (many strains of *Bacteroides fragilis* are resistant).
8. **Central Nervous System Infections**, including meningitis, caused by *Haemophilus influenzae* and *Neisseria meningitidis*. Ceftazidime has also been used successfully in a limited number of cases of meningitis due to *Pseudomonas aeruginosa* and *Streptococcus pneumoniae*.

Ceftazidime may be used alone in cases of confirmed or suspected sepsis. Ceftazidime has been used successfully in clinical trials as empiric therapy in cases where various concomitant therapies with other antibiotics have been used.

Ceftazidime may also be used concomitantly with other antibiotics, such as aminoglycosides, vancomycin, and clindamycin; in severe and life-threatening infections; and in the immunocompromised patient. When such concomitant treatment is appropriate, prescribing information in the labeling for the other antibiotics should be followed. The dose depends on the severity of the infection and the patient's condition.

To reduce the development of drug-resistant bacteria and maintain the effectiveness of Ceftazidime and other antibacterial drugs, Ceftazidime should be used only to treat or prevent infections that are proven or strongly suspected to be caused by susceptible bacteria. When culture and susceptibility information are available, they should be considered in selecting or modifying antibacterial therapy. In the absence of such data, local epidemiology and susceptibility patterns may contribute to the empiric selection of therapy.

CONTRAINDICATIONS

Ceftazidime is contraindicated in patients who have shown hypersensitivity to Ceftazidime or the cephalosporin group of antibiotics.

WARNINGS

BEFORE THERAPY WITH Ceftazidime IS INSTITUTED, CAREFUL INQUIRY SHOULD BE MADE TO DETERMINE WHETHER THE PATIENT HAS HAD PREVIOUS HYPERSENSITIVITY REACTIONS TO Ceftazidime, CEPHALOSPORINS, PENICILLINS, OR OTHER DRUGS. IF THIS PRODUCT IS TO BE GIVEN TO PENICILLIN-SENSITIVE PATIENTS, CAUTION SHOULD BE EXERCISED BECAUSE CROSS-HYPERSENSITIVITY AMONG BETA-LACTAM ANTIBIOTICS HAS BEEN CLEARLY DOCUMENTED AND MAY OCCUR IN UP TO 10% OF PATIENTS WITH A HISTORY OF PENICILLIN ALLERGY. IF AN ALLERGIC REACTION TO Ceftazidime OCCURS, DISCONTINUE THE DRUG. SERIOUS ACUTE HYPERSENSITIVITY REACTIONS MAY REQUIRE TREATMENT WITH EPINEPHRINE AND OTHER EMERGENCY MEASURES, INCLUDING OXYGEN, IV FLUIDS, IV ANTIHISTAMINES, CORTICOSTEROIDS, PRESSOR AMINES, AND AIRWAY MANAGEMENT, AS CLINICALLY INDICATED.

Clostridium difficile associated diarrhea (CDAD) has been reported with use of nearly all antibacterial agents, including Ceftazidime, and may range in severity from mild diarrhea to fatal colitis. Treatment with antibacterial agents alters the normal flora of the colon leading to overgrowth of *C. difficile*.

C. difficile produces toxins A and B which contribute to the development of CDAD. Hypertoxin producing strains of *C. difficile* cause increased morbidity and mortality, as these infections can be refractory to antimicrobial therapy and may require colectomy. CDAD must be considered in all patients who present with diarrhea following antibiotic use. Careful medical history is necessary since CDAD has been reported to occur over two months after the administration of antibacterial agents.

If CDAD is suspected or confirmed, ongoing antibiotic use not directed against *C. difficile* may need to be discontinued. Appropriate fluid and electrolyte management, protein supplementation, antibiotic treatment of *C. difficile*, and surgical evaluation should be instituted as clinically indicated.

Elevated levels of Ceftazidime in patients with renal insufficiency can lead to seizures, encephalopathy, coma, asterixis, neuromuscular excitability, and myoclonia (see **PRECAUTIONS**).

PRECAUTIONS

General

High and prolonged serum Ceftazidime concentrations can occur from usual dosages in patients with transient or persistent reduction of urinary output because of renal insufficiency. The total daily dosage should be reduced when Ceftazidime is administered to patients with renal insufficiency (see **DOSAGE AND ADMINISTRATION**). Elevated levels of Ceftazidime in these patients can lead to seizures, encephalopathy, coma, asterixis, neuromuscular excitability, and myoclonia. Continued dosage should be determined by degree of renal impairment, severity of infection, and susceptibility of the causative organisms.

As with other antibiotics, prolonged use of Ceftazidime may result in overgrowth of nonsusceptible organisms. Repeated evaluation of the patient's condition is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Inducible type I beta-lactamase resistance has been noted with some organisms (e.g., *Enterobacter* spp., *Pseudomonas* spp., and *Serratia* spp.). As with other extended-spectrum beta-lactam antibiotics, resistance can develop during therapy, leading to clinical failure in some cases. When treating infections caused by these organisms, periodic susceptibility testing should be performed when clinically appropriate. If patients fail to respond to monotherapy, an aminoglycoside or similar agent should be considered.

Cephalosporins may be associated with a fall in prothrombin activity. Those at risk include patients with renal and hepatic impairment, or poor nutritional state, as well as patients receiving a protracted course of antimicrobial therapy. Prothrombin time should be monitored in patients at risk and exogenous vitamin K administered as indicated.

Ceftazidime should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Distal necrosis can occur after inadvertent intra-arterial administration of Ceftazidime.

Prescribing Ceftazidime in the absence of a proven or strongly suspected bacterial infection or a

prophylactic indication is unlikely to provide benefit to the patient and increases the risk of the development of drug-resistant bacteria.

Information for Patients

Patients should be counseled that antibacterial drugs, including Ceftazidime, should only be used to treat bacterial infections. They do not treat viral infections (e.g., the common cold). When Ceftazidime is prescribed to treat a bacterial infection, patients should be told that although it is common to feel better early in the course of therapy, the medication should be taken exactly as directed. Skipping doses or not completing the full course of therapy may: (1) decrease the effectiveness of the immediate treatment, and (2) increase the likelihood that bacteria will develop resistance and will not be treatable by Ceftazidime or other antibacterial drugs in the future.

Diarrhea is a common problem caused by antibiotics which usually ends when the antibiotic is discontinued. Sometimes after starting treatment with antibiotics, patients can develop watery and bloody stools (with or without stomach cramps and fever) even as late as two or more months after having taken the last dose of the antibiotic. If this occurs, patients should contact their physician as soon as possible.

Drug Interactions

Nephrotoxicity has been reported following concomitant administration of cephalosporins with aminoglycoside antibiotics or potent diuretics such as furosemide. Renal function should be carefully monitored, especially if higher dosages of the aminoglycosides are to be administered or if therapy is prolonged, because of the potential nephrotoxicity and ototoxicity of aminoglycosidic antibiotics. Nephrotoxicity and ototoxicity were not noted when Ceftazidime was given alone in clinical trials.

Chloramphenicol has been shown to be antagonistic to beta-lactam antibiotics, including Ceftazidime, based on in vitro studies and time kill curves with enteric gram-negative bacilli. Due to the possibility of antagonism in vivo, particularly when bactericidal activity is desired, this drug combination should be avoided.

In common with other antibiotics, Ceftazidime may affect the gut flora, leading to lower estrogen reabsorption and reduced efficacy of combined oral estrogen/progesterone contraceptives.

Drug/Laboratory Test Interactions

The administration of Ceftazidime may result in a false-positive reaction for glucose in the urine when using CLINITEST® tablets, Benedict's solution, or Fehling's solution. It is recommended that glucose tests based on enzymatic glucose oxidase reactions (such as CLINISTIX®) be used.

Carcinogenesis, Mutagenesis, Impairment of Fertility

Long-term studies in animals have not been performed to evaluate carcinogenic potential. However, a mouse Micronucleus test and an Ames test were both negative for mutagenic effects.

Pregnancy

Teratogenic effects

Pregnancy Category B. Reproduction studies have been performed in mice and rats at doses

up to 40 times the human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceftazidime. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers

Ceftazidime is excreted in human milk in low concentrations. Caution should be exercised when Ceftazidime is administered to a nursing woman.

Pediatric Use

(see **DOSAGE AND ADMINISTRATION**).

Geriatric Use

Of the 2,221 subjects who received Ceftazidime in 11 clinical studies, 824 (37%) were 65 and over while 391 (18%) were 75 and over. No overall differences in safety or effectiveness were observed between these subjects and younger subjects, and other reported clinical experience has not identified differences in responses between the elderly and younger patients, but greater susceptibility of some older individuals to drug effects cannot be ruled out. This drug is known to be substantially excreted by the kidney, and the risk of toxic reactions to this drug may be greater in patients with impaired renal function. Because elderly patients are more likely to have decreased renal function, care should be taken in dose selection, and it may be useful to monitor renal function (see **DOSAGE AND ADMINISTRATION**).

ADVERSE REACTIONS

Ceftazidime is generally well tolerated. The incidence of adverse reactions associated with the administration of Ceftazidime was low in clinical trials. The most common were local reactions following IV injection and allergic and gastrointestinal reactions. Other adverse reactions were encountered infrequently. No disulfiram-like reactions were reported.

The following adverse effects from clinical trials were considered to be either related to Ceftazidime therapy or were of uncertain etiology:

Local Effects, reported in fewer than 2% of patients, were phlebitis and inflammation at the site of injection (1 in 69 patients).

Hypersensitivity Reactions, reported in 2% of patients, were pruritus, rash, and fever. Immediate reactions, generally manifested by rash and/or pruritus, occurred in 1 in 285 patients. Toxic epidermal necrolysis, Stevens-Johnson syndrome, and erythema multiforme have also been reported with cephalosporin antibiotics, including Ceftazidime. Angioedema and anaphylaxis (bronchospasm and/or hypotension) have been reported very rarely.

Gastrointestinal Symptoms, reported in fewer than 2% of patients, were diarrhea (1 in 78), nausea (1 in 156), vomiting (1 in 500), and abdominal pain (1 in 416). The onset of pseudomembranous colitis symptoms may occur during or after treatment (see **WARNINGS**).

Central Nervous System Reactions (fewer than 1%) included headache, dizziness, and paresthesia. Seizures have been reported with several cephalosporins, including Ceftazidime.

In addition, encephalopathy, coma, asterixis, neuromuscular excitability, and myoclonia have been reported in renally impaired patients treated with unadjusted dosing regimens of Ceftazidime (see **PRECAUTIONS, General**).

Less Frequent Adverse Events (fewer than 1%) were candidiasis (including oral thrush) and vaginitis.

Hematologic: Rare cases of hemolytic anemia have been reported.

Laboratory Test Changes noted during clinical trials with Ceftazidime were transient and included: eosinophilia (1 in 13), positive Coombs test without hemolysis (1 in 23), thrombocytosis (1 in 45), and slight elevations in one or more of the hepatic enzymes, aspartate aminotransferase (AST, SGOT) (1 in 16), alanine aminotransferase (ALT, SGPT) (1 in 15), LDH (1 in 18), GGT (1 in 19), and alkaline phosphatase (1 in 23). As with some other cephalosporins, transient elevations of blood urea, blood urea nitrogen, and/or serum creatinine were observed occasionally. Transient leukopenia, neutropenia, agranulocytosis, thrombocytopenia, and lymphocytosis were seen very rarely.

POSTMARKETING EXPERIENCE WITH CEFTAZIDIME PRODUCTS

In addition to the adverse events reported during clinical trials, the following events have been observed during clinical practice in patients treated with Ceftazidime and were reported spontaneously. For some of these events, data are insufficient to allow an estimate of incidence or to establish causation.

General: Anaphylaxis; allergic reactions, which, in rare instances, were severe (e.g., cardiopulmonary arrest); urticaria; pain at injection site.

Hepatobiliary Tract: Hyperbilirubinemia, jaundice.

Renal and Genitourinary: Renal impairment.

Cephalosporin-Class Adverse Reactions: In addition to the adverse reactions listed above that have been observed in patients treated with Ceftazidime, the following adverse reactions and altered laboratory tests have been reported for cephalosporin-class antibiotics:

Adverse Reactions: Colitis, toxic nephropathy, hepatic dysfunction including cholestasis, aplastic anemia, hemorrhage.

Altered Laboratory Tests: Prolonged prothrombin time, false-positive test for urinary glucose, pancytopenia.

OVERDOSAGE

Ceftazidime overdosage has occurred in patients with renal failure. Reactions have included seizure activity, encephalopathy, asterixis, neuromuscular excitability, and coma. Patients who receive an acute overdosage should be carefully observed and given supportive treatment. In the presence of renal insufficiency, hemodialysis or peritoneal dialysis may aid in the removal of Ceftazidime from the body.

DOSAGE AND ADMINISTRATION

The usual adult dosage is 1 gram administered intravenously or intramuscularly every 8 to 12 hours. The dosage and route should be determined by the susceptibility of the causative organisms, the severity of infection, and the condition and renal function of the patient.

The guidelines for dosage of Ceftazidime are listed in Table 3. The following dosage schedule is recommended.

Table 3. Recommended Dosage Schedule

	Dose	Frequency
* Although clinical improvement has been shown, bacteriologic cures cannot be expected in patients with chronic respiratory disease and cystic fibrosis.		
† The higher dose should be reserved for immunocompromised pediatric patients or pediatric patients with cystic fibrosis or meningitis.		
Adults		
Usual recommended dosage	1 gram IV or IM	q8-12hr
Uncomplicated urinary tract infections	250 mg IV or IM	q12hr
Bone and joint infections	2 grams IV	q12hr
Complicated urinary tract infections	500 mg IV or IM	q8-12hr
Uncomplicated pneumonia; mild skin and skin-structure infections	500 mg-1 gram IV or IM	q8hr
Serious gynecologic and intra-abdominal infections	2 grams IV	q8hr
Meningitis	2 grams IV	q8hr
Very severe life-threatening infections, especially in immunocompromised patients	2 grams IV	q8hr
Lung infections caused by <i>Pseudomonas</i> spp. in patients with cystic fibrosis with normal renal function*	30-50 mg/kg IV to a maximum of 6 grams per day	q8hr
Neonates (0-4 weeks)	30 mg/kg IV	q12hr
Infants and children (1 month-12 years)	30-50 mg/kg IV to a maximum of 6 grams per day †	q8hr

Impaired Hepatic Function

No adjustment in dosage is required for patients with hepatic dysfunction.

Impaired Renal Function

Ceftazidime is excreted by the kidneys, almost exclusively by glomerular filtration. Therefore, in patients with impaired renal function (glomerular filtration rate [GFR] <50 mL/min), it is recommended that the dosage of Ceftazidime be reduced to compensate for its slower excretion. In patients with suspected renal insufficiency, an initial loading dose of 1 gram of

Ceftazidime may be given. An estimate of GFR should be made to determine the appropriate maintenance dosage. The recommended dosage is presented in Table 4.

Table 4. Recommended Maintenance Dosages of Ceftazidime in Renal Insufficiency NOTE: IF THE DOSE RECOMMENDED IN TABLE 3 ABOVE IS LOWER THAN THAT RECOMMENDED FOR PATIENTS WITH RENAL INSUFFICIENCY AS OUTLINED IN TABLE 4, THE LOWER DOSE SHOULD BE USED.

Creatinine Clearance (mL/min)	Recommended Unit Dose of Ceftazidime	Frequency of Dosing
50-31	1 gram	q12hr
30-16	1 gram	q24hr
15-6	500 mg	q24hr
<5	500 mg	q48hr

When only serum creatinine is available, the following formula (Cockcroft's equation)⁴ may be used to estimate creatinine clearance. The serum creatinine should represent a steady state of renal function:

$$\text{Males: Creatinine clearance (mL/min)} = \frac{\text{Weight (kg)} \times (140 - \text{age})}{72 \times \text{serum creatinine (mg/dL)}}$$

Females: 0.85 x male value

In patients with severe infections who would normally receive 6 grams of Ceftazidime daily were it not for renal insufficiency, the unit dose given in the table above may be increased by 50% or the dosing frequency may be increased appropriately. Further dosing should be determined by therapeutic monitoring, severity of the infection, and susceptibility of the causative organism.

In pediatric patients as for adults, the creatinine clearance should be adjusted for body surface area or lean body mass, and the dosing frequency should be reduced in cases of renal insufficiency.

In patients undergoing hemodialysis, a loading dose of 1 gram is recommended, followed by 1 gram after each hemodialysis period.

Ceftazidime can also be used in patients undergoing intraperitoneal dialysis and continuous ambulatory peritoneal dialysis. In such patients, a loading dose of 1 gram of Ceftazidime may be given, followed by 500 mg every 24 hours. In addition to IV use, Ceftazidime can be incorporated in the dialysis fluid at a concentration of 250 mg for 2 L of dialysis fluid.

Note: Generally Ceftazidime should be continued for 2 days after the signs and symptoms of infection have disappeared, but in complicated infections longer therapy may be required.

Administration

Ceftazidime may be given intravenously or by deep IM injection into a large muscle mass such as the upper outer quadrant of the gluteus maximus or lateral part of the thigh. Intra-arterial administration should be avoided (see **PRECAUTIONS**).

Intramuscular Administration

For IM administration, Ceftazidime should be constituted with one of the following diluents: Sterile Water for Injection, Bacteriostatic Water for Injection, or 0.5% or 1% Lidocaine Hydrochloride Injection. Refer to **Table 5**.

Intravenous Administration

The IV route is preferable for patients with bacterial septicemia, bacterial meningitis, peritonitis, or other severe or life-threatening infections, or for patients who may be poor risks because of lowered resistance resulting from such debilitating conditions as malnutrition, trauma, surgery, diabetes, heart failure, or malignancy, particularly if shock is present or pending.

For direct intermittent IV administration, constitute Ceftazidime as directed in Table 5 with Sterile Water for Injection. Slowly inject directly into the vein over a period of 3 to 5 minutes or give through the tubing of an administration set while the patient is also receiving one of the compatible IV fluids (see **Compatibility and Stability**).

For IV infusion

Constitute the 500 mg, 1 gram or 2 gram vial and add an appropriate quantity of the resulting solution to an IV container with one of the compatible IV fluids.

Intermittent IV infusion with a Y-type administration set can be accomplished with compatible solutions. However, during infusion of a solution containing Ceftazidime, it is desirable to discontinue the other solution.

Table 5. Preparation of Solutions of Ceftazidime

Size	Amount of Diluent to be Added (mL)	Approximate Available Volume (mL)	Approximate Ceftazidime Concentration (mg/mL)
* Toobtain a dose of 500 mg, withdraw 5 mL from the vial following reconstitution.			
† Toobtain a dose of 1 g, withdraw 10 mL from the vial following reconstitution.			
‡ Toobtain a dose of 2 g, withdraw 11.5 mL from the vial following reconstitution.			
Intramuscular			
500 mg vial	1.5	1.8	280
1 gram vial	3	3.6	280
Intravenous			
500 mg vial	5.3	5.7*	100
1 gram vial	10	10.8†	100
2 gram vial	10	11.5‡	170

All vials of Ceftazidime as supplied are under reduced pressure. When Ceftazidime is dissolved, carbon dioxide is released and a positive pressure develops. For ease of use please follow the recommended techniques of constitution described on the detachable Instructions for Constitution section of this insert.

Solutions of Ceftazidime, like those of most beta-lactam antibiotics, should not be added to solutions of aminoglycoside antibiotics because of potential interaction.

However, if concurrent therapy with Ceftazidime and an aminoglycoside is indicated, each of these antibiotics can be administered separately to the same patient.

Compatibility and Stability

Intramuscular: Ceftazidime, when constituted as directed with Sterile Water for Injection, Bacteriostatic Water for Injection, or 0.5% or 1% Lidocaine Hydrochloride Injection, maintains satisfactory potency for 24 hours at room temperature or for 7 days under refrigeration. Solutions in Sterile Water for Injection that are frozen immediately after constitution in the original container are stable for 3 months when stored at -20°C. Once thawed, solutions should not be refrozen. Thawed solutions may be stored for up to 8 hours at room temperature or for 4 days in a refrigerator.

Intravenous: Ceftazidime, when constituted as directed with Sterile Water for Injection, maintains satisfactory potency for 24 hours at room temperature or for 7 days under refrigeration. More concentrated solutions in Sterile Water for Injection in the original container that are frozen immediately after constitution are stable for 3 months when stored at -20°C. Once thawed, solutions should not be refrozen. Thawed solutions may be stored for up to 8 hours at room temperature or for 4 days in a refrigerator.

Ceftazidime is compatible with the more commonly used IV infusion fluids. Solutions at concentrations between 1 and 40 mg/mL in 0.9% Sodium Chloride Injection; 1/6 M Sodium Lactate Injection; 5% Dextrose Injection; 5% Dextrose and 0.225% Sodium Chloride Injection; 5% Dextrose and 0.45% Sodium Chloride Injection; 5% Dextrose and 0.9% Sodium Chloride Injection; 10% Dextrose Injection; Ringer's Injection; Lactated Ringer's Injection; 10% Invert Sugar in Water for Injection; and NORMOSOL®-M in 5% Dextrose Injection may be stored for up to 24 hours at room temperature or for 7 days if refrigerated.

Ceftazidime is less stable in Sodium Bicarbonate Injection than in other IV fluids. It is not recommended as a diluent. Solutions of Ceftazidime in 5% Dextrose Injection and 0.9% Sodium Chloride Injection are stable for at least 6 hours at room temperature in plastic tubing, drip chambers, and volume control devices of common IV infusion sets.

Ceftazidime at a concentration of 4 mg/mL has been found compatible for 24 hours at room temperature or for 7 days under refrigeration in 0.9% Sodium Chloride Injection or 5% Dextrose Injection when admixed with: cefuroxime sodium 3 mg/mL, heparin 10 or 50 U/mL, or potassium chloride 10 or 40 mEq/L.

Vancomycin solution exhibits a physical incompatibility when mixed with a number of drugs, including Ceftazidime. The likelihood of precipitation with Ceftazidime is dependent on the concentrations of vancomycin and Ceftazidime present. It is therefore recommended, when both drugs are to be administered by intermittent IV infusion, that they be given separately, flushing the IV lines (with 1 of the compatible IV fluids) between the administration of these 2 agents.

Note: Parenteral drug products should be inspected visually for particulate matter before administration whenever solution and container permit.

As with other cephalosporins, Ceftazidime powder, as well as solutions, tend to darken depending on storage conditions; within the stated recommendations, however, product potency is not adversely affected.

HOW SUPPLIED

Ceftazidime for Injection is a white or cream colored powder supplied in vials as follows:

Ceftazidime for Injection 500 mg* vials in a Box of 10

Ceftazidime for Injection 1 g* vials in a Box of 10

* Equivalent to anhydrous Ceftazidime.

Before Constitution, store at 20° to 25°C (68° to 77°F) [see USP Controlled Room Temperature] and protect from light.

REFERENCES

1. Bauer AW, Kirby WMM, Sherris JC, Turck M. Antibiotic susceptibility testing by a standardized single disk method. *Am J Clin Pathol.* 1966;45:493-496.
2. National Committee for Clinical Laboratory Standards. Approved Standard: Performance Standards for Antimicrobial Disc Susceptibility Tests. (M2-A3). December 1984.
3. Certification procedure for antibiotic sensitivity discs (21 CFR 460.1). Federal Register. May 30, 1974;39:19182-19184.
4. Cockcroft DW, Gault MH. Prediction of creatinine clearance from serum creatinine. *Nephron.* 1976;16:31-41.

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