Bosch

**For Medical Professional Only**

# IZILON

(MOXIFLOXACIN U.S.P.)

**Tablets / Infusion**

ایزیلون

**DESCRIPTION:**
IZILON (moxifloxacin hydrochloride) is a synthetic broad spectrum antibacterial agent and is available as IZILON Tablets for oral administration and as IZILON I.V. for intravenous administration. Moxifloxacin, a fluoroquinolone, is available as the monohydrochloride salt of 1-cyclopropyl-7-[(S,S)-2,8-diazabicyclo[4.3.0]non-8-yl]-6-fluoro-8-methoxy -1,4-dihydro-4-oxo-3 quinoline carboxylic acid. It is a slightly yellow to yellow crystalline substance with a molecular weight of 437.9. Its empirical formula is $C_{21}H_{24}FN_3O_4{\cdot}HCl$

IZILON Tablets are available as film-coated tablets containing moxifloxacin hydrochloride (equivalent to 400 mg moxifloxacin).

IZILON I.V. is available 250 mL bottle as a sterile, preservative free, isotonic solution of moxifloxacin hydrochloride (containing 400 mg moxifloxacin) with pH ranging from 4.1 to 4.6. The appearance of the intravenous solution is yellow. The color does not affect, nor is it indicative of, product stability.

**CLINICAL PHARMACOLOGY:**
**Absorption**
Moxifloxacin, given as an oral tablet, is well absorbed from the gastrointestinal tract. The absolute bioavailability of moxifloxacin is approximately 90 percent.

The mean (± SD) $C_{max}$ and AUC values following single and multiple doses of 400 mg moxifloxacin given orally are summarized below.

| | $C_{max}$ (mg/L) | AUC (mg·h/L) | Half-life (hr) |
|---|---|---|---|
| * Range of means from different studies | | | |
| Single Dose Oral | | | |
| Healthy (n = 372) | 3.1 ± 1.0 | 36.1 ± 9.1 | 11.5 - 15.6* |
| Multiple Dose Oral | | | |
| Healthy young male/female (n = 15) | 4.5 ± 0.5 | 48.0 ± 2.7 | 12.7 ± 1.9 |
| Healthy elderly male (n = 8) | 3.8 ± 0.3 | 51.8 ± 6.7 | |
| Healthy elderly female (n = 8) | 4.6 ± 0.6 | 54.6 ± 6.7 | |
| Healthy young male (n = 8) | 3.6 ± 0.5 | 48.2 ± 9.0 | |
| Healthy young female (n = 9) | 4.2 ± 0.5 | 49.3 ± 9.5 | |

The mean (± SD) $C_{max}$ and AUC values following single and multiple doses of 400 mg moxifloxacin given by 1 hour I.V. infusion are summarized below.

| | $C_{max}$ (mg/L) | AUC (mg·h/L) | Half-life (hr) |
|---|---|---|---|
| * Range of means from different studies | | | |
| ** Expected $C_{max}$ (concentration obtained around the time of the end of the infusion) | | | |
| Single Dose I.V. | | | |
| Healthy young male/female (n = 56) | 3.9 ± 0.9 | 39.3 ± 8.6 | 8.2 ± 15.4* |
| Patients (n = 118) | | | |
| Male (n = 64) | 4.4 ± 3.7 | | |
| Female (n = 54) | 4.5 ± 2.0 | | |
| < 65 years (n = 58) | 4.6 ± 4.2 | | |
| ≥ 65 years (n = 60) | 4.3 ± 1.3 | | |
| Multiple Dose I.V. | | | |
| Healthy young male (n = 8) | 4.2 ± 0.8 | 38.0 ± 4.7 | 14.8 ± 2.2 |
| Healthy elderly (n = 12; 8 male, 4 female) | 6.1 ± 1.3 | 48.2 ± 0.9 | 10.1 ± 1.6 |
| Patients ** (n = 107) | | | |
| Male (n = 58) | 4.2 ± 2.6 | | |
| Female (n = 49) | 4.6 ± 1.5 | | |
| < 65 years (n = 52) | 4.1 ± 1.4 | | |
| ≥ 65 years (n = 55) | 4.7 ± 2.7 | | |

**Distribution**
Moxifloxacin is approximately 30-50% bound to serum proteins, independent of drug concentration. The volume of distribution of moxifloxacin ranges from 1.7 to 2.7 L/kg. Moxifloxacin is widely distributed throughout the body, with tissue concentrations often exceeding plasma concentrations. Moxifloxacin has been detected in the saliva, nasal and bronchial secretions, mucosa of the sinuses, skin blister fluid, subcutaneous tissue, skeletal muscle, and abdominal tissues and fluids following oral or intravenous administration of 400 mg.

**Moxifloxacin Concentrations (mean ± SD) in Tissues and the Corresponding Plasma Concentrations After a Single 400 mg Oral or Intravenous Dose[1]**

moxifloxacin concentrations were measured 3 hours after a single 400 mg dose, except the abdominal tissue and exudate concentrations which were measured at 2 hours post-dose and the sinus concentrations which were measured 3 hours post dose after 5 days of dosing.

| Tissue or Fluid | N | Plasma Concentration (mug/mL) | Tissue or Fluid Concentration (mug/mL or mug/g) | Tissue Plasma Ratio: |
|---|---|---|---|---|
| **Respiratory** | | | | |
| Alveolar Macrophages | 5 | 3.3 ± 0.7 | 61.8 ± 27.3 | 21.2 ± 10.0 |
| Bronchial Mucosa | 8 | 3.3 ± 0.7 | 5.5 ± 1.3 | 1.7 ± 0.3 |
| Epithelial Lining Fluid | 5 | 3.3 ± 0.7 | 24.4 ± 14.7 | 8.7 ± 6.1 |
| **Sinus** | | | | |
| Maxillary Sinus Mucosa | 4 | 3.7 ± 1.1[†] | 7.6 ± 1.7 | 2.0 ± 0.3 |
| Anterior Ethmoid Mucosa | 3 | 3.7 ± 1.1[†] | 8.8 ± 4.3 | 2.2 ± 0.6 |
| Nasal Polyps | 4 | 3.7 ± 1.1[†] | 9.8 ± 4.5 | 2.6 ± 0.6 |
| **Skin, Musculoskeletal** | | | | |
| Blister Fluid | 5 | 3.0 ± 0.5 ‡ | 2.6 ± 0.9 | 0.9 ± 0.2 |
| Subcutaneous Tissue | 6 | 2.3 ± 0.4 # | 0.9 ± 0.3* | 0.4 ± 0.6 |
| Skeletal Muscle | 6 | 2.3 ± 0.4 # | 0.9 ± 0.2* | 0.4 ± 0.1 |
| **Intra-Abdominal** | | | | |
| Abdominal tissue | 8 | 2.9 ± 0.5 | 7.6 ± 2.0 | 2.7 ± 0.8 |
| Abdominal exudate | 10 | 2.3 ± 0.5 | 3.5 ± 1.2 | 1.6 ± 0.7 |
| Abscess fluid | 6 | 2.7 ± 0.7 | 2.3 ± 1.5 | 0.8 ± 0.4 |

**Metabolism**
Approximately 52% of an oral or intravenous dose of moxifloxacin is metabolized via glucuronide and sulfate conjugation. The cytochrome P450 system is not involved in moxifloxacin metabolism, and is not affected by moxifloxacin. The sulfate conjugate (M1) accounts for approximately 38% of the dose, and is eliminated primarily in the feces. Approximately 14% of an oral or intravenous dose is converted to a glucuronide conjugate (M2), which is excreted exclusively in the urine. Peak plasma concentrations of M2 are approximately 40% those of the parent drug, while plasma concentrations of M1 are generally less than 10% those of moxifloxacin.

In vitro studies with cytochrome (CYP) P450 enzymes 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.

**Excretion**
Approximately 45% of an oral or intravenous dose of moxifloxacin is excreted as unchanged drug (~20% in urine and ~25% in feces). A total of 96% ± 4% of an oral dose is excreted as either unchanged drug or known metabolites. The mean (± SD) apparent total body clearance and renal clearance are 12 ± 2.0 L/hr and 2.6 ± 0.5 L/hr, respectively.

**Renal Insufficiency**
The pharmacokinetic parameters of moxifloxacin are not significantly altered in mild, moderate, severe, or end-stage renal disease. No dosage adjustment is necessary in patients with renal impairment, including those patients requiring hemodialysis (HD) or continuous ambulatory peritoneal dialysis (CAPD).

**Hepatic Insufficiency**
No dosage adjustment is recommended for mild or moderate hepatic insufficiency (Child Pugh Classes A and B). The pharmacokinetics of moxifloxacin in severe hepatic insufficiency (Child Pugh Class C) has not been studied.

**Drug-drug Interactions**
The potential for pharmacokinetic drug interactions between moxifloxacin and itraconazole, theophylline, warfarin, digoxin, atenolol, probenecid, morphine, oral contraceptives, ranitidine, glyburide, calcium, iron, and antacids has been evaluated. There was no clinically significant effect of moxifloxacin on itraconazole, theophylline, warfarin, digoxin, atenolol, oral contraceptives, or glyburide kinetics. Itraconazole, theophylline, warfarin, digoxin, probenecid, morphine, ranitidine, and calcium did not significantly affect the pharmacokinetics of moxifloxacin. These results and the data from in vitro studies suggest that moxifloxacin is unlikely to significantly alter the metabolic clearance of drugs metabolized by CYP3A4, CYP2D6, CYP2C9, CYP2C19, or CYP1A2 enzymes.

As with all other quinolones, iron and antacids significantly reduced bioavailability of moxifloxacin

*Itraconazole:* In a study involving 11 healthy volunteers, there was no significant effect of itraconazole (200 mg once daily for 9 days), a potent inhibitor of cytochrome P4503A4, on the pharmacokinetics of moxifloxacin (a single 400 mg dose given on the 7 th day of itraconazole dosing). In addition, moxifloxacin was shown not to affect the pharmacokinetics of itraconazole.
*Theophylline:* No significant effect of moxifloxacin (200 mg every twelve hours for 3 days) on the pharmacokinetics of theophylline (400 mg every twelve hours for 3 days) was detected in a study involving 12 healthy volunteers. In addition, theophylline was not shown to affect the pharmacokinetics of moxifloxacin. The effect of co-administration of a 400 mg dose of moxifloxacin with theophylline has not been studied, but it is not expected to be clinically significant based on in vitro metabolic data showing that moxifloxacin does not inhibit the CYP1A2 isoenzyme.
*Warfarin:* No significant effect of moxifloxacin (400 mg once daily for eight days) on the pharmacokinetics of R- and S-warfarin (25 mg single dose of warfarin sodium on the fifth day) was detected in a study involving 24 healthy volunteers. No significant change in prothrombin time was observed.
*Digoxin:* No significant effect of moxifloxacin (400 mg once daily for two days) on digoxin (0.6 mg as a single dose) AUC was detected in a study involving 12 healthy volunteers. The mean digoxin $C_{max}$ increased by about 50% during the distribution phase of digoxin. This transient increase in digoxin $C_{max}$ is not viewed to be clinically significant. Moxifloxacin pharmacokinetics were similar in the presence or absence of digoxin. No dosage adjustment for moxifloxacin or digoxin is required when these drugs are administered concomitantly.
*Atenolol:* In a crossover study involving 24 healthy volunteers (12 male; 12 female), the mean atenolol AUC following a single oral dose of 50 mg atenolol with placebo was similar to that observed when atenolol was given concomitantly with a single 400 mg oral dose of moxifloxacin. The mean $C_{max}$ of single dose atenolol decreased by about 10% following co-administration with a single dose of moxifloxacin.
*Morphine:* No significant effect of morphine sulfate (a single 10 mg intramuscular dose) on the mean AUC and $C_{max}$ of moxifloxacin (400 mg single dose) was observed in a study of 20 healthy male and female volunteers.

*Oral Contraceptives:* A placebo-controlled study in 29 healthy female subjects showed that moxifloxacin 400 mg daily for 7 days did not interfere with the hormonal suppression of oral contraception with 0.15 mg levonorgestrel/0.03 mg ethinylestradiol (as measured by serum progesterone, FSH, estradiol, and LH), or with the pharmacokinetics of the administered contraceptive agents.
*Probenecid:* Probenecid (500 mg twice daily for two days) did not alter the renal clearance and total amount of moxifloxacin (400 mg single dose) excreted renally in a study of 12 healthy volunteers.
*Ranitidine:* No significant effect of ranitidine (150 mg twice daily for three days as pretreatment) on the pharmacokinetics of moxifloxacin (400 mg single dose) was detected in a study involving 10 healthy volunteers.
*Antidiabetic agents:* In diabetics, glyburide (2.5 mg once daily for two weeks pretreatment and for five days concurrently) mean AUC and $C_{max}$ were 12% and 21% lower, respectively, when taken with moxifloxacin (400 mg once daily for five days) in comparison to placebo. Nonetheless, blood glucose levels were decreased slightly in patients taking glyburide and moxifloxacin in comparison to those taking glyburide alone, suggesting no interference by moxifloxacin on the activity of glyburide. These interaction results are not viewed as clinically significant.
*Calcium:* Twelve healthy volunteers were administered concomitant moxifloxacin (single 400 mg dose) and calcium (single dose of 500 mg Ca ++ dietary supplement) followed by an additional two doses of calcium 12 and 24 hours after moxifloxacin administration. Calcium had no significant effect on the mean AUC of moxifloxacin. The mean $C_{max}$ was slightly reduced and the time to maximum plasma concentration was prolonged when moxifloxacin was given with calcium compared to when moxifloxacin was given alone (2.5 hours versus 0.9 hours). These differences are not considered to be clinically significant.
*Antacids:* When moxifloxacin (single 400 mg tablet dose) was administered two hours before, concomitantly, or 4 hours after an aluminum/magnesium-containing antacid (900 mg aluminum hydroxide and 600 mg magnesium hydroxide as a single oral dose) to 12 healthy volunteers there was a 26%, 60% and 23% reduction in the mean AUC of moxifloxacin, respectively. Moxifloxacin should be taken at least 4 hours before or 8 hours after antacids containing magnesium or aluminum, as well as sucralfate, metal cations such as iron, and multivitamin preparations with zinc (didanosine) chewable/buffered tablets or the pediatric powder for oral solution.
*Iron:* When moxifloxacin tablets were administered concomitantly with iron (ferrous sulfate 100 mg once daily for two days), the mean AUC and $C_{max}$ of moxifloxacin was reduced by 39% and 59%, respectively. Moxifloxacin should only be taken more than 4 hours before or 8 hours after iron products.
*Electrocardiogram:* Prolongation of the QT interval in the ECG has been observed in some patients receiving moxifloxacin. Following oral dosing with 400 mg of moxifloxacin the mean (± SD) change in QTc from the pre-dose value at the time of maximum drug concentration was 6 msec (± 26) (n = 787). Following a course of daily intravenous dosing (400 mg; 1 hour infusion each day) the mean change in QTc from the Day 1 pre-dose value was 9 msec (± 24) on Day 1 (n = 69) and 3 msec (± 29) on Day 3 (n = 290).
There is limited information available on the potential for a pharmacodynamic interaction in humans between moxifloxacin and other drugs that prolong the QTc interval of the electrocardiogram. Sotalol, a Class III antiarrhythmic, has been shown to further increase the QTc interval when combined with high doses of intravenous (I.V.) moxifloxacin in dogs. Therefore, moxifloxacin should be avoided with Class IA and ClassIII antiarrhythmics.

**MICROBIOLOGY**
Moxifloxacin has been shown to be active against most strains of the following microorganisms, both in vitro and in clinical infections

*Aerobic Gram-positive microorganisms*
- Enterococcus faecalis (many strains are only moderately susceptible)
- Staphylococcus aureus (methicillin-susceptible strains only)
- Streptococcus anginosus
- Streptococcus constellatus
- Streptococcus pneumoniae (including multi-drug resistant strains [MDRSP] * )
- Streptococcus pyogenes

* MDRSP, Multi-drug resistant Streptococcus pneumoniae includes isolates previously known as PRSP (Penicillin-resistant S. pneumoniae), and are strains resistant to two or more of the following antibiotics: penicillin (MIC ≥ 2 mug/mL), 2 nd generation cephalosporins (e.g., cefuroxime), macrolides, tetracyclines, and trimethoprim/sulfamethoxazole.
The following in vitro data are available, but their clinical significance is unknown.

*Aerobic Gram-negative microorganisms*
- Enterobacter cloacae
- Escherichia coli
- Haemophilus influenzae
- Haemophilus parainfluenzae
- Klebsiella pneumoniae
- Moraxella catarrhalis
- Proteus mirabilis

*Anaerobic microorganisms*
- Bacteroides fragilis
- Bacteroides thetaiotaomicron
- Clostridium perfringens
- Peptostreptococcus species

*Other microorganisms*
- Chlamydia pneumoniae
- Mycoplasma pneumoniae

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*
- Staphylococcus epidermidis (methicillin-susceptible strains only)
- Streptococcus agalactiae
- Streptococcus viridans group

*Aerobic Gram-negative microorganisms*
- Citrobacter freundii
- Klebsiella oxytoca
- Legionella pneumophila

*Anaerobic microorganisms*
- Fusobacterium species
- Prevotella species

**INDICATIONS AND USAGE**
IZILON Tablets and I.V. are indicated for the treatment of adults (≥18 years of age) with infections caused by susceptible strains of the designated microorganisms in the conditions listed below

**Acute Bacterial Sinusitis** caused by Streptococcus pneumoniae, Haemophilus influenzae, or Moraxella catarrhalis.
**Acute Bacterial Exacerbation of Chronic Bronchitis** caused by Streptococcus pneumoniae, Haemophilus influenzae, Haemophilus parainfluenzae, Klebsiella pneumoniae, methicillin-susceptible Staphylococcus aureus, or Moraxella catarrhalis.
**Community Acquired Pneumonia** caused by Streptococcus pneumoniae (including multi-drug resistant strains*), Haemophilus influenzae, Moraxella catarrhalis, methicillin-susceptible Staphylococcus aureus, Klebsiella pneumoniae, Mycoplasma pneumoniae, or Chlamydia pneumoniae.

* MDRSP, Multi-drug resistant Streptococcus pneumoniae includes isolates previously known as PRSP (Penicillin-resistant S. pneumoniae), and are strains resistant to two or more of the following antibiotics: penicillin (MIC ≥ 2 mug/mL), 2 nd generation cephalosporins (e.g., cefuroxime), macrolides, tetracyclines, and trimethoprim/sulfamethoxazole.

**Uncomplicated Skin and Skin Structure Infections** caused by methicillin-susceptible Staphylococcus aureus or Streptococcus pyogenes.
**Complicated Intra-Abdominal Infections** including polymicrobial infections such as abscess caused by Escherichia coli , Bacteroides fragilis, Streptococcus anginosus, Streptococcus constellatus , Enterococcus faecalis , Proteus mirabilis , Clostridium perfringens , Bacteroides thetaiotaomicron , or Peptostreptococcus species.
**Complicated Skin and Skin Structure Infections** caused by methicillin-susceptible Staphylococcus aureus , Escherichia coli , Klebsiella pneumoniae , or Enterobacter cloacae
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. Therapy with IZILON may be initiated before results of these tests are known; once results become available, appropriate therapy should be continued.

**CONTRAINDICATIONS**
Moxifloxacin is contraindicated in persons with a history of hypersensitivity to moxifloxacin or any member of the quinolone class of antimicrobial agents.

**WARNINGS**
THE SAFETY AND EFFECTIVENESS OF MOXIFLOXACIN IN PEDIATRIC PATIENTS, ADOLESCENTS (LESS THAN 18 YEARS OF AGE), PREGNANT WOMEN, AND LACTATING WOMEN HAVE NOT BEEN ESTABLISHED PRECAUTIONS

**PRECAUTIONS**
**General:** Quinolones may cause central nervous system (CNS) events, including: nervousness, agitation, insomnia, anxiety, nightmares or paranoia

Prescribing IZILON 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.

**Pregnancy: Teratogenic Effects. Pregnancy Category C:**Since there are no adequate or well-controlled studies in pregnant women, moxifloxacin should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

**Nursing Mothers:** Moxifloxacin is excreted in the breast milk of rats. Moxifloxacin may also be excreted in human milk. Because of the potential for serious adverse reactions in infants who are nursing from mothers taking moxifloxacin, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

**Pediatric Use:** Safety and effectiveness in pediatric patients and adolescents less than 18 years of age have not been established. Moxifloxacin causes arthropathy in juvenile animals

**Geriatric Use:** In controlled multiple-dose clinical trials, 23% of patients receiving oral moxifloxacin were greater than or equal to 65 years of age and 9% were greater than or equal to 75 years of age. The clinical trial data demonstrate that there is no difference in the safety and efficacy of oral moxifloxacin in patients aged 65 or older compared to younger adults.

**ADVERSE REACTIONS**
Clinical efficacy trials enrolled over 9,200 moxifloxacin orally and intravenously treated patients, of whom over 8,600 patients received the 400 mg dose. Most adverse events reported in moxifloxacin trials were described as mild to moderate in severity and required no treatment. Moxifloxacin was discontinued due to adverse reactions thought to be drug-related in 2.9% of orally treated patients and 6.3% of sequentially (intravenous followed by oral) treated patients. The latter studies were conducted in community acquired pneumonia and complicated skin and skin structure infections and complicated intra-abdominal infections with, in general, a sicker patient population compared to the tablet studies.

Adverse reactions, judged by investigators to be at least possibly drug-related, occurring in greater than or equal to 2% of moxifloxacin treated patients were: nausea (6%), diarrhea (5%), dizziness (2%).

**OVERDOSAGE**
Single oral overdoses up to 2.8 g were not associated with any serious adverse events. In the event of acute overdose, the stomach should be emptied and adequate hydration maintained. ECG monitoring is recommended due to the possibility of QT interval prolongation. The patient should be carefully observed and given supportive treatment. The administration of activated charcoal as soon as possible after oral overdose may prevent excessive increase of systemic moxifloxacin exposure. About 3% and 9% of the dose of moxifloxacin, as well as about 2% and 4.5% of its glucuronide metabolite are removed by continuous ambulatory peritoneal dialysis and hemodialysis, respectively.

**DOSAGE AND ADMINISTRATION**
The dose of IZILON is 400 mg (orally or as an intravenous infusion) once every 24 hours. The duration of therapy depends on the type of infection as described below.

| Infection* | Daily Dose | Duration |
|---|---|---|
| * due to the designated pathogens | | |
| Acute Bacterial Sinusitis | 400mg | 10 days |
| Acute Bacterial Exacerbation of Chronic Bronchitis | 400mg | 5 days |
| Community Acquired Pneumonia | 400mg | 7-14 days |
| Uncomplicated Skin and Skin Structure Infections | 400mg | 7 days |
| Complicated Skin and Skin Structure Infections | 400mg | 7-21 days |
| Complicated Intra-Abdominal Infections | 400mg | 5-14 days |

For Complicated Intra-Abdominal Infections, therapy should be initiated with the intravenous formulation. When switching from intravenous to oral dosage administration, no dosage adjustment is necessary. Patients whose therapy is started with IZILON I.V. may be switched to IZILON Tablets when clinically indicated at the discretion of the physician.
Oral doses of moxifloxacin should be administered at least 4 hours before or 8 hours after antacids containing magnesium or aluminum, as well as sucralfate, metal cations such as iron, and multivitamin preparations with zinc,

**Impaired Renal Function**
No dosage adjustment is required in renally impaired patients, including those on either hemodialysis or continuous ambulatory peritoneal dialysis.

**Impaired Hepatic Function**
No dosage adjustment is required in patients with mild or moderate hepatic insufficiency (Child Pugh Classes A and B). The pharmacokinetics of moxifloxacin in patients with severe hepatic insufficiency (Child Pugh Class C) have not been studied.
IZILON I.V. should be administered by INTRAVENOUS infusion only. It is not intended for intra-arterial, intramuscular, intrathecal, intraperitoneal, or subcutaneous administration.
IZILON I.V. should be administered by intravenous infusion over a period of 60 minutes by direct infusion.
CAUTION: RAPID OR BOLUS INTRAVENOUS INFUSION MUST BE AVOIDED.
IZILON I.V. is compatible with the following intravenous solutions at ratios from 1:10 to 10:1:

| | |
|---|---|
| 0.9% Sodium Chloride Injection, USP | Sterile Water for Injection, USP |
| 1M Sodium Chloride Injection | 10% Dextrose for Injection, USP |
| 5% Dextrose Injection, USP | Lactated Ringer's for Injection |

**HOW SUPPLIED**
**Tablets:** IZILON (moxifloxacin hydrochloride) Tablets are available in cold form cold seal pack of 1×5's tablets containing 400 mg moxifloxacin.
**Intravenous Solution ready to use bottle:** IZILON I.V. (moxifloxacin hydrochloride) is available in ready-to-use 250 mL bottle containing 400 mg of moxifloxacin. NO FURTHER DILUTION OF THIS PREPARATION IS NECESSARY.
Product should be inspected visually for particulate matter prior to administration. If it contains leakage and visible particulates should not be used. Do not refrigerate or freeze, store in carton until the time of use.
**Tablets:** Protect form light and moisture, Store below 30°C.
**Infusion:** Protect from light, Store below 25°C.
Keep out of the reach of children.
**WARNING:** To be sold on the prescription of a registered medical practitioner only.

## ہدایات :

ٹیبلٹ: روشنی اور نمی سے محفوظ ۳۰ ڈگری سینٹی گریڈ سے کم درجہ حرارت پر رکھیں۔
انفیوژن: روشنی سے محفوظ ۲۵ ڈگری سینٹی گریڈ سے کم درجہ حرارت پر رکھیں۔
بچوں کی پہنچ سے دُور رکھیں۔
ڈاکٹر کی ہدایت کے مطابق استعمال کریں۔

**انتباہ :** صرف رجسٹرڈ میڈیکل پریکٹیشنر کے نسخے پر فروخت کے لئے۔

Infusion Manufactured by:
**Bosch Pharmaceuticals (Pvt) Ltd.**
209, Sector 23, Korangi Industrial Area, Karachi - Pakistan.
For **Bosch Pharmaceuticals (Pvt.) Ltd.**
221-223, Sector 23, K.I.A. Karachi-Pakistan.

Tablet Manufactured by:
**Bosch Pharmaceuticals (Pvt) Ltd.**
221-223, Sector 23, Korangi Industrial Area,
Karachi-Pakistan.

ISO 9001:2015 Certified Company