For Intravenous or Intramuscular Administration
Rx only

DESCRIPTION:
Methylprednisolone Sodium Succinate for Injection, USP sterile powder contains methylprednisolone sodium succinate as the active ingredient. Methylprednisolone sodium succinate, USP, occurs as a white, or nearly white, odorless, hygroscopic, amorphous solid. It is very soluble in water and in alcohol; it is insoluble in chloroform and is very slightly soluble in acetone.

The chemical name for methylprednisolone sodium succinate is pregna-1,4-diene-3,20-dione, 21-(3-carboxy-1-oxopropoxy)-11, 17-dihydroxy-6-methylmonosodium salt, (6α, 11β).

The structural formula is:

\[
\text{C}_{17}\text{H}_{21}\text{NOC}_{7}\text{H}_{7}\text{ClN}_{4}\text{O}_{2} M.W. 496.53
\]

Methylprednisolone sodium succinate is so extremely soluble in water that it may be administered in a small volume of diluent and is especially well suited for intravenous use in situations in which high blood levels of methylprednisolone are required rapidly.

Methylprednisolone Sodium Succinate for Injection, USP is available in two strengths for intravenous or intramuscular administration.

- **40 mg (Single Dose Vial)**
  Each mL (when mixed as directed) contains methylprednisolone sodium succinate equivalent to 40 mg methylprednisolone; also, 1.6 mg monobasic sodium phosphate anhydrous; 17.46 mg dibasic sodium phosphate dried; 25 mg lactose hydrous; and benzyl alcohol.

- **125 mg (Single Dose Vial)**
  Each 2 mL (when mixed as directed) contains methylprednisolone sodium succinate equivalent to 125 mg methylprednisolone; also, 1.6 mg monobasic sodium phosphate anhydrous; 17.4 mg dibasic sodium phosphate dried; and benzyl alcohol.

When necessary, the pH of each formula was adjusted with sodium hydroxide so that the pH of the reconstituted solution is within the USP specified range of 7 to 8 and the tonicities are, for the 40 mg per mL solution, 0.50 osmolar; for the 125 mg per 2 mL, 0.40 osmolar.

(ISOTONIC SALINE = 0.28 osmolar).

IMPORTANT - Use only Bacteriostatic Water For Injection with Benzyl Alcohol when reconstituting Methylprednisolone Sodium Succinate for Injection, USP.

Use within 48 hours after mixing.
CLINICAL PHARMACOLOGY:
Methylprednisolone is a potent anti-inflammatory steroid with greater anti-inflammatory potency than prednisolone and even less tendency than prednisolone to induce sodium and water retention.

Methylprednisolone sodium succinate has the same metabolic and anti-inflammatory actions as methylprednisolone. When given parenterally and in equimolar quantities, the two compounds are equivalent in biologic activity. The relative potency of methylprednisolone and hydrocortisone sodium succinate, as indicated by depression of eosinophil count, following intravenous administration, is at least four to one. This is in good agreement with the relative oral potency of methylprednisolone and hydrocortisone.

INDICATIONS AND USAGE:
When oral therapy is not feasible, and the strength, dosage form and route of administration of the drug reasonably lend the preparation to the treatment of the condition, Methylprednisolone Sodium Succinate for Injection, USP is indicated for intravenous or intramuscular use in the following conditions:

1. Endocrine Disorders
   - Primary or secondary adrenocortical insufficiency (hydrocortisone or cortisol is the drug of choice; synthetic analogs may be used in conjunction with mineralocorticoids where applicable; in infancy, mineralocorticoid supplementation is of particular importance)
   - Acute adrenocortical insufficiency (hydrocortisone or cortisol is the drug of choice; mineralocorticoid supplementation may be necessary, particularly when synthetic analogs are used)
   - Preoperatively and in the event of serious trauma or illness, in patients with known adrenal insufficiency or when adrenocortical reserve is doubtful
   - Shock unresponsive to conventional therapy if adrenocortical insufficiency exists or is suspected
   - Congenital adrenal hyperplasia
   - Hypercalcemia associated with cancer
   - Nonsuppurative thyroiditis

2. Rheumatic Disorders
   - As adjunctive therapy for short-term administration (to tide the patient over an acute episode or exacerbation) in:
     - Post-traumatic osteoarthritis
     - Synovitis of osteoarthritis
     - Rheumatoid arthritis, including juvenile
     - Rheumatoid arthritis (selected cases may require low-dose maintenance therapy)
   - Epicondylitis
   - Acute nonspecific arthritis
   - Psoriatic arthritis
   - Ankylosing spondylitis
   - Acute and subacute bursitis

3. Collagen Diseases
   - During an exacerbation or as maintenance therapy in selected cases of:
     - Systemic lupus erythematosus
     - Systemic dermatomyositis (polymyositis)
     - Acute rheumatic carditis

4. Dermatologic Diseases
   - Porphyria
   - Severe erythema multiforme
     - (Stevens-Johnson syndrome)
   - Erythema multiforme
   - Exfoliative dermatitis
   - Bullous dermatitis
   - Pemphigus vulgaris
   - Severe bullous dermatitis
   - Severe psoriasis
   - Mycosis fungoides

5. Allergic States
   - Control of severe or incapacitating allergic conditions intractable to adequate trials of conventional treatment in:
     - Bronchial asthma
     - Contact dermatitis
     - Atopic dermatitis
     - Serum sickness
     - Seasonal or perennial allergic rhinitis
   - Drug hypersensitivity
   - Urticarial reactions
   - Acute noninfectious laryngeal edema (epinephrine is the drug of first choice)

6. Ophthalmic Diseases
   - Severe acute and chronic allergic and inflammatory processes involving the eye, such as:
     - Herpes zoster ophthalmicus
     - Anterior segment uveitis
     - Exudative retinal detachment
     - Diffuse posterior uveitis and choroiditis
     - Optic neuritis
     - Sympathetic ophthalmia
     - Anterior segment inflammation
     - Allergic conjunctivitis
     - Allergic corneal marginal ulcers
     - Keratitis
7. Gastrointestinal Diseases
To tide the patient over a critical period of the disease in:
- Ulcerative colitis (systemic therapy)
- Regional enteritis (systemic therapy)

8. Respiratory Diseases
- Symptomatic sarcoidosis
- Loeffler’s syndrome not manageable by other means
- Fulminating or disseminated pulmonary tuberculosis when used concurrently with appropriate antituberculous chemotherapy
- Aspiration pneumonitis

9. Hematologic Disorders
- Acquired (autoimmune) hemolytic anemia
- Idiopathic thrombocytopenic purpura in adults (IV only; IM administration is contraindicated)
- Secondary thrombocytopenia in adults
- Erythroblastopenia (RBC anemia)
- Congenital (erythroid) hypoplastic anemia

10. Neoplastic Diseases
- For palliative management of:
  - Leukemias and lymphomas in adults
  - Acute leukemia of childhood

11. Edematous States
- To induce diuresis or remission of proteinuria in the nephrotic syndrome, without uremia, of the idiopathic type or that due to lupus erythematosus

12. Nervous System
- Acute exacerbations of multiple sclerosis

13. Miscellaneous
- Tuberculous meningitis with subarachnoid block or impending block when used concurrently with appropriate antituberculous chemotherapy
- Trichinosis with neurologic or myocardial involvement

CONTRAINDICATIONS:
The use of Methylprednisolone Sodium Succinate for Injection, USP is contraindicated in premature infants because the 40 mg single dose vial and the 125 mg single dose vial when reconstituted will contain benzyl alcohol. Benzyl alcohol has been reported to be associated with a fatal “Gasping Syndrome” in premature infants.

Methylprednisolone Sodium Succinate for Injection, USP is also contraindicated in systemic fungal infections and patients with known hypersensitivity to the product and its constituents.

WARNINGS:
In patients on corticosteroid therapy subjected to any unusual stress, increased dosage of rapidly acting corticosteroids before, during, and after the stressful situation is indicated.

Corticosteroids may mask some signs of infection, and new infections may appear during their use. There may be decreased resistance and inability to localize infection when corticosteroids are used.

A study has failed to establish the efficacy of methylprednisolone in the treatment of sepsis syndrome and septic shock. The study also suggests that treatment of these conditions with methylprednisolone may increase the risk of mortality in certain patients (i.e., patients with elevated serum creatinine levels or patients who develop secondary infections after methylprednisolone).

Prolonged use of corticosteroids may produce posterior subcapsular cataracts, glaucoma with possible damage to the optic nerves, and may enhance the establishment of secondary ocular infections due to fungi or viruses.

Average and large doses of cortisone or hydrocortisone can cause elevation of blood pressure, salt and water retention, and increased excretion of potassium. These effects are less likely to occur with the synthetic derivatives except when used in large doses. Dietary salt restriction and potassium supplementation may be necessary. All corticosteroids increase calcium excretion.

While on corticosteroid therapy patients should not be vaccinated against smallpox. Other immunization procedures should not be undertaken in patients who are on corticosteroids, especially on high dose, because of possible hazards of neurological complications and a lack of antibody response.

The use of methylprednisolone in active tuberculosis should be restricted to those cases of fulminating or disseminated tuberculosis in which the corticosteroid is used for the management of the disease in conjunction with appropriate antituberculous regimens.
If corticosteroids are indicated in patients with latent tuberculosis or tuberculin reactivity, close observation is necessary as reactivation of the disease may occur. During prolonged corticosteroid therapy, these patients should receive chemoprophylaxis.

Because rare instances of anaphylactic (e.g., bronchospasm) reactions have occurred in patients receiving parenteral corticosteroid therapy, appropriate precautionary measures should be taken prior to administration, especially when the patient has a history of allergy to any drug.

There are reports of cardiac arrhythmias and/or circulatory collapse and/or cardiac arrest following the rapid administration of large IV doses of methylprednisolone (greater than 0.5 gram administered over a period of less than 10 minutes). Bradycardia has been reported during or after the administration of large doses of methylprednisolone sodium succinate, and may be unrelated to the speed or duration of infusion.

Persons who are on drugs which suppress the immune system are more susceptible to infections than healthy individuals. Chicken pox and measles, for example, can have a more serious or even fatal course in non-immune children or adults on corticosteroids. In such children or adults who have not had these diseases, particular care should be taken to avoid exposure. How the dose, route and duration of corticosteroid administration affects the risk of developing a disseminated infection is not known. The contribution of the underlying disease and/or prior corticosteroid treatment to the risk is also not known. If exposed to chicken pox, prophylaxis with varicella zoster immune globulin (VZIG) may be indicated. If exposed to measles, prophylaxis with pooled intramuscular immunoglobulin (IG) may be indicated. (See the respective package inserts for complete VZIG and IG prescribing information.) If chicken pox develops, treatment with antiviral agents may be considered.

Usage in Pregnancy
Since adequate human reproduction studies have not been done with corticosteroids, the use of these drugs in pregnancy, nursing mothers, or women of child-bearing potential requires that the possible benefits of the drug be weighed against the potential hazards to the mother and embryo or fetus. Infants born of mothers who have received substantial doses of corticosteroids during pregnancy should be carefully observed for signs of hypoadrenalism.

PRECAUTIONS:
General Precautions
Drug-induced secondary adrenocortical insufficiency may be minimized by gradual reduction of dosage. This type of relative insufficiency may persist for months after discontinuation of therapy; therefore, in any situation of stress occurring during that period, hormone therapy should be reinstated. Since mineralocorticoid secretion may be impaired, salt and/or a mineralocorticoid should be administered concurrently.

There is an enhanced effect of corticosteroids on patients with hypothyroidism and in those with cirrhosis. Corticosteroids should be used cautiously in patients with ocular herpes simplex because of possible corneal perforation.

The lowest possible dose of corticosteroid should be used to control the condition under treatment, and when reduction in dosage is possible, the reduction should be gradual.

Psychic derangements may appear when corticosteroids are used, ranging from euphoria, insomnia, mood swings, personality changes, and severe depression, to frank psychotic manifestations. Also, existing emotional instability or psychotic tendencies may be aggravated by corticosteroids.

Steroids should be used with caution in nonspecific ulcerative colitis, if there is a probability of impending perforation, abscess or other pyogenic infection; diverticulitis; fresh intestinal anastomoses; active or latent peptic ulcer; renal insufficiency; hypertension; osteoporosis; and myasthenia gravis.
Growth and development of infants and children on prolonged corticosteroid therapy should be carefully observed. Although controlled clinical trials have shown corticosteroids to be effective in speeding the resolution of acute exacerbations of multiple sclerosis, they do not show that corticosteroids affect the ultimate outcome or natural history of the disease. The studies do show that relatively high doses of corticosteroids are necessary to demonstrate a significant effect (see DOSAGE AND ADMINISTRATION).

Since complications of treatment with glucocorticoids are dependent on the size of the dose and the duration of treatment, a risk/benefit decision must be made in each individual case as to dose and duration of treatment and as to whether daily or intermittent therapy should be used.

Convulsions have been reported with concurrent use of methylprednisolone and cyclosporin. Since concurrent use of these agents results in a mutual inhibition of metabolism, it is possible that adverse events associated with the individual use of either drug may be more apt to occur.

Aspirin should be used cautiously in conjunction with corticosteroids in patients suffering from hypoprothrombinemia.

Information for the Patient

Persons who are on immunosuppressant doses of corticosteroids should be warned to avoid exposure to chicken pox or measles. Patients should also be advised that if they are exposed, medical advice should be sought without delay.

ADVERSE REACTIONS:

Fluid and Electrolyte Disturbances

| Sodium retention | Potassium loss |
| Fluid retention | Hypokalemic alkalosis |
| Congestive heart failure in susceptible patients | Hypertension |

Musculoskeletal

| Muscle weakness | Aseptic necrosis of femoral and humeral heads |
| Steroid myopathy | Pathologic fracture of long bones |
| Loss of muscle mass | Osteoporosis |

Gastrointestinal

| Peptic ulcer with possible perforation and hemorrhage | Pancreatitis |
| Deteriorating wound healing | Facial erythema |
| Thin fragile skin with petechiae and ecchymoses | May suppress reactions to skin tests |

Neurological

| Increased intracranial pressure with papilledema (Pseudo-tumor cerebri) usually after treatment | Convulsions |
| Vertigo |

Endocrine

| Development of Cushingoid state | Suppression of growth in children |
| Secondary adrenocortical and pituitary unresponsiveness, particularly in times of stress, as in trauma, surgery or illness | Monstrous irregularities |
| Decreased carbohydrate tolerance | Manifestations of latent diabetes mellitus |
| Increased requirements for insulin or oral hypoglycemic agents in diabetics |

Ophthalmic

| Posterior subcapsular cataracts | Glaucoma |
| Increased intraocular pressure | Esophimbal |

Metabolic

| Negative nitrogen balance due to protein catabolism |
| The following additional adverse reactions are related to parenteral corticosteroid therapy: Hyperpigmentation or hypopigmentation |
| Subcutaneous and cutaneous atrophy |
| Sterile abscesses |
| Anaphylactic reaction with or without circulatory collapse, cardiac arrest, bronchospasm |
| Urticaria |
| Nausea and vomiting |
| Cardiac arrhythmias; hypotension or hypertension |
DOSAGE AND ADMINISTRATION:
When high dose therapy is desired, the recommended dose of Methylprednisolone Sodium Succinate for Injection, USP is 30 mg/kg administered intravenously over at least 30 minutes. This dose may be repeated every 4 to 6 hours for 48 hours.

In general, high dose corticosteroid therapy should be continued only until the patient’s condition has stabilized; usually not beyond 48 to 72 hours. Although adverse effects associated with high dose short-term corticosteroid therapy are uncommon, peptic ulceration may occur. Prophylactic antacid therapy may be indicated.

In other indications initial dosage will vary from 10 to 40 mg of methylprednisolone depending on the clinical problem being treated. The larger doses may be required for short-term management of severe, acute conditions. The initial dose usually should be given intravenously over a period of several minutes. Subsequent doses may be given intravenously or intramuscularly at intervals dictated by the patient’s response and clinical condition. Corticoid therapy is an adjunct to, and not replacement for conventional therapy.

Dosage may be reduced for infants and children but should be governed more by the severity of the condition and response of the patient than by age or size. It should not be less than 0.5 mg per kg every 24 hours. Dosage must be decreased or discontinued gradually when the drug has been administered for more than a few days. If a period of spontaneous remission occurs in a chronic condition, treatment should be discontinued. Routine laboratory studies, such as urinalysis, two-hour postprandial blood sugar, determination of blood pressure and body weight, and a chest X-ray should be made at regular intervals during prolonged therapy. Upper GI X-rays are desirable in patients with an ulcer history or significant dyspepsia.

Methylprednisolone Sodium Succinate for Injection, USP may be administered by intravenous or intramuscular injection or by intravenous infusion, the preferred method for initial emergency use being intravenous injection. To administer by intravenous (or intramuscular) injection, reconstitute the 40 mg/vial product with 1 mL of Bacteriostatic Water for Injection with Benzyl Alcohol, or reconstitute the 125 mg/vial product with 2 mL of Bacteriostatic Water for Injection with Benzyl Alcohol. The desired dose may be administered intravenously over a period of several minutes.

To prepare solutions for intravenous infusion, first prepare the solution for injection as directed. This solution may then be added to indicated amounts of 5% dextrose in water, isotonic saline solution or 5% dextrose in isotonic saline solution.

Multiple Sclerosis
In treatment of acute exacerbations of multiple sclerosis, daily doses of 200 mg of prednisolone for a week followed by 80 mg every other day for a month have been shown to be effective (4 mg of methylprednisolone is equivalent to 5 mg of prednisolone).

STORAGE CONDITIONS:
Protect from light.
Store unreconstituted product at 20° to 25°C (68° to 77°F) [see USP Controlled Room Temperature].
Store solution at 20° to 25°C (68° to 77°F) [see USP Controlled Room Temperature].
Use solution within 48 hours after mixing.

HOW SUPPLIED:
Product No. NDC No.
275503 63323-255-03 Methylprednisolone Sodium Succinate for Injection USP, 40 mg/vial, 3 mL single dose vial, in packages of 25.
275803 63323-258-03 Methylprednisolone Sodium Succinate for Injection USP, 125 mg/vial, 3 mL single dose vial, in packages of 25.

Vial stoppers do not contain natural rubber latex.

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