

**PREDNISONONE- prednisone tablet**  
**Bryant Ranch Prepack**

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**Prednisone Tablets, USP**

**PREDNISONONE TABLETS, USP**

Rx Only

**DESCRIPTION**

Each tablet for oral administration contains:

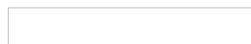
Prednisone.....5 mg, 10 mg and 20 mg

**Inactive Ingredients**

Prednisone Tablets, USP of 5 mg and 10 mg strengths contain anhydrous lactose, colloidal silicon dioxide, magnesium stearate, microcrystalline cellulose, sodium starch glycolate, and talc.

Prednisone Tablets, USP of 20 mg strength contain anhydrous lactose, D&C Yellow No. 10 Aluminum Lake, FD&C Yellow No. 6 Aluminum Lake, magnesium stearate, microcrystalline cellulose and sodium starch glycolate.

Prednisone Tablets, USP contain prednisone which is a glucocorticoid. Glucocorticoids are adrenocortical steroids, both naturally occurring and synthetic, which are readily absorbed from the gastrointestinal tract. The chemical name for prednisone is pregna-1,4-diene-3,11,20-trione monohydrate,17,21-dihydroxy-. The structural formula is represented below:



$C_{21}H_{26}O_5$  M.W. 358.43

Prednisone is a white to practically white, odorless, crystalline powder. It is very slightly soluble in water; slightly soluble in alcohol, chloroform, dioxane, and methanol.

**CLINICAL PHARMACOLOGY**

Naturally occurring glucocorticoids (hydrocortisone and cortisone), which also have salt-retaining properties, are used as replacement therapy in adrenocortical deficiency states. Their synthetic analogs are primarily used for their potent anti-inflammatory effects in disorders of many organ systems.

Glucocorticoids cause profound and varied metabolic effects. In addition, they modify the body's immune responses to diverse stimuli.

**INDICATIONS AND USAGE**

Prednisone Tablets, USP are indicated in the following conditions:

**Endocrine Disorders**

Primary or secondary adrenocortical insufficiency (hydrocortisone or cortisone is the first choice; synthetic analogs may be used in conjunction with mineralocorticoids where applicable; in infancy mineralocorticoid supplementation is of particular importance); congenital adrenal hyperplasia; hypercalcemia associated with cancer; nonsuppurative thyroiditis.

**Rheumatic Disorders**

As adjunctive therapy for short-term administration (to tide the patient over an acute episode or

exacerbation) in: psoriatic arthritis, rheumatoid arthritis, including juvenile rheumatoid arthritis (selected cases may require low-dose maintenance therapy), ankylosing spondylitis, acute and subacute bursitis, acute nonspecific tenosynovitis, acute gouty arthritis, post-traumatic osteoarthritis, synovitis of osteoarthritis, epicondylitis.

### **Collagen Diseases**

During an exacerbation or as maintenance therapy in selected cases of: systemic lupus erythematosus, systemic dermatomyositis (polymyositis), acute rheumatic carditis.

### **Dermatologic Diseases**

Pemphigus; bullous dermatitis herpetiformis; severe erythema multiforme (Stevens-Johnson syndrome); exfoliative dermatitis; mycosis fungoides; severe psoriasis; severe seborrheic dermatitis.

### **Allergic States**

Control of severe or incapacitating allergic conditions intractable to adequate trials of conventional treatment: seasonal or perennial allergic rhinitis; bronchial asthma; contact dermatitis; atopic dermatitis; serum sickness; drug hypersensitivity reactions.

### **Ophthalmic Diseases**

Severe acute and chronic allergic and inflammatory processes involving the eye and its adnexa such as: allergic corneal marginal ulcers, herpes zoster ophthalmicus, anterior segment inflammation, diffuse posterior uveitis and choroiditis, sympathetic ophthalmia, allergic conjunctivitis, keratitis, chorioretinitis, optic neuritis, iritis and iridocyclitis.

### **Respiratory Diseases**

Symptomatic sarcoidosis; Loeffler's syndrome not manageable by other means; berylliosis; fulminating or disseminated pulmonary tuberculosis when used concurrently with appropriate antituberculous chemotherapy; aspiration pneumonitis.

### **Hematologic Disorders**

Idiopathic thrombocytopenic purpura in adults; secondary thrombocytopenia in adults; acquired (autoimmune) hemolytic anemia; erythroblastopenia (RBC anemia); congenital (erythroid) hypoplastic anemia.

### **Neoplastic Diseases**

For palliative management of: leukemias and lymphomas in adults, acute leukemia of childhood.

### **Edematous States**

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

### **Gastrointestinal Diseases**

To tide the patient over a critical period of the disease in: ulcerative colitis, regional enteritis.

### **Miscellaneous**

Tuberculous meningitis with subarachnoid block or impending block when used concurrently with appropriate antituberculous chemotherapy; trichinosis with neurologic or myocardial involvement.

## **CONTRAINDICATIONS**

Prednisone tablets are contraindicated in systemic fungal infections and known hypersensitivity to components.

## **WARNINGS**

### **General**

Rare instances of anaphylactoid reactions have occurred in patients receiving corticosteroid therapy (See **ADVERSE REACTIONS: Allergic Reactions**).

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

### **Cardio-Renal**

Average and large doses of hydrocortisone or cortisone 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.

Literature reports suggest an apparent association between use of corticosteroids and left ventricular free wall rupture after a recent myocardial infarction; therefore, therapy with corticosteroids should be used with great caution in these patients.

### **Endocrine**

Corticosteroids can produce reversible hypothalamic-pituitary adrenal (HPA) axis suppression with the potential for corticosteroid insufficiency after withdrawal of treatment. Adrenocortical insufficiency may result from too rapid withdrawal of corticosteroids and may be minimized by gradual reduction of dosage. This type of relative insufficiency may persist for up to 12 months after discontinuation of therapy; therefore, in any situation of stress occurring during that period, hormone therapy should be reinstated. If the patient is receiving steroids already, dosage may have to be increased.

Metabolic clearance of corticosteroids is decreased in hypothyroid patients and increased in hyperthyroid patients. Changes in thyroid status of the patient may necessitate adjustment in dosage.

### **Infection**

#### General

Patients who are on corticosteroids are more susceptible to infections than are healthy individuals. There may be decreased resistance and inability to localize infection when corticosteroids are used. Infection with any pathogen (viral, bacterial, fungal, protozoan or helminthic) in any location of the body may be associated with the use of corticosteroids alone or in combination with other immunosuppressive agents that affect cellular immunity, humoral immunity, or neutrophil function.<sup>1</sup> These infections may be mild, but may be severe and at times fatal. With increasing doses of corticosteroids, the rate of occurrence of infectious complications increases.<sup>2</sup> Corticosteroids may also mask some signs of current infection.

#### Fungal Infections

Corticosteroids may exacerbate systemic fungal infections and therefore should not be used in the presence of such infections unless they are needed to control life-threatening drug reactions. There have been cases reported in which concomitant use of amphotericin B and hydrocortisone was followed by cardiac enlargement and congestive heart failure (See **PRECAUTIONS: Drug Interactions: Amphotericin B Injection and Potassium-Depleting Agents**).

#### Special Pathogens

Latent disease may be activated or there may be an exacerbation of intercurrent infections due to pathogens, including those caused by *Amoeba*, *Candida*, *Cryptococcus*, *Mycobacterium*, *Nocardia*, *Pneumocystis*, *Toxoplasma*.

It is recommended that latent amebiasis or active amebiasis be ruled out before initiating corticosteroid therapy in any patient who has spent time in the tropics or any patient with unexplained diarrhea.

Similarly, corticosteroids should be used with great care in patients with known or suspected *Strongyloides* (threadworm) infestation. In such patients, corticosteroid-induced immunosuppression may lead to *Strongyloides* hyperinfection and dissemination with widespread larval migration, often accompanied by severe enterocolitis and potentially fatal gram-negative septicemia.

Corticosteroids should not be used in cerebral malaria.

#### Tuberculosis

The use of prednisone in active tuberculosis should be restricted to those cases of fulminating or disseminated tuberculosis in which the corticosteroid is used for management of the disease in conjunction with an appropriate antituberculous regimen.

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.

#### Vaccination

**Administration of live or live, attenuated vaccines is contraindicated in patients receiving immunosuppressive doses of corticosteroids. Killed or inactivated vaccines may be administered. However, the response to such vaccines may be diminished and cannot be predicted.** Indicated immunization procedures may be undertaken in patients receiving nonimmunosuppressive doses of corticosteroids as replacement therapy (e.g., for Addison's disease).

#### Viral Infections

Chickenpox and measles can have a more serious or even fatal course in pediatric and adult patients on corticosteroids. In pediatric and adult patients who have not had these diseases, particular care should be taken to avoid exposure. How the dose, route and duration of corticosteroid administration affect 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 chickenpox, 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 chickenpox develops, treatment with antiviral agents may be considered.

#### Ophthalmic

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 bacteria, fungi or viruses. The use of oral corticosteroids is not recommended in the treatment of optic neuritis and may lead to an increase in the risk of new episodes. Corticosteroids should not be used in active ocular herpes simplex because of possible corneal perforation.

## PRECAUTIONS

### General Precautions

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

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.

Kaposi's sarcoma has been reported to occur in patients receiving corticosteroid therapy, most often for chronic conditions.

Discontinuation of corticosteroids may result in clinical improvement.

### Cardio-Renal

As sodium retention with resultant edema and potassium loss may occur in patients receiving corticosteroids, these agents should be used with caution in patients with congestive heart failure, hypertension, or renal insufficiency.

## **Endocrine**

Drug-induced secondary adrenocortical insufficiency may be minimized by gradual reduction of dosage. This type of relative insufficiency may persist for up to 12 months after discontinuation of therapy following large doses for prolonged periods; 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.

## **Gastrointestinal**

Steroids should be used with caution in active or latent peptic ulcers, diverticulitis, fresh intestinal anastomoses, and nonspecific ulcerative colitis, since they may increase the risk of a perforation. Signs of peritoneal irritation following gastrointestinal perforation in patients receiving corticosteroids may be minimal or absent.

There is an enhanced effect due to decreased metabolism of corticosteroids in patients with cirrhosis.

## **Musculoskeletal**

Corticosteroids decrease bone formation and increase bone resorption both through their effect on calcium regulation (i.e., decreasing absorption and increasing excretion) and inhibition of osteoblast function. This, together with a decrease in the protein matrix of the bone secondary to an increase in protein catabolism, and reduced sex hormone production, may lead to inhibition of bone growth in pediatric patients and the development of osteoporosis at any age. Growth and development of infants and children on prolonged corticosteroid therapy should be carefully observed. Special consideration should be given to patients at increased risk of osteoporosis (e.g., postmenopausal women) before initiating corticosteroid therapy.

Inclusion of therapy for osteoporosis prevention or treatment should be considered. To minimize the risk of glucocorticoid-induced bone loss, the smallest possible effective dosage and duration should be used. Lifestyle modification to reduce the risk of osteoporosis (e.g., cigarette smoking cessation, limitation of alcohol consumption, participation in weight-bearing exercise for 30-60 minutes daily) should be encouraged. Calcium and vitamin D supplementation, bisphosphonate (e.g., alendronate, risedronate), and a weight-bearing exercise program that maintains muscle mass are suitable first-line therapies aimed at reducing the risk of adverse bone effects. Current recommendations suggest that all interventions be initiated in any patient in whom glucocorticoid therapy with at least the equivalent of 5 mg of prednisone for at least 3 months is anticipated; in addition, sex hormone replacement therapy (combined estrogen and progestin in women; testosterone in men) should be offered to such patients who are hypogonadal or in whom replacement is otherwise clinically indicated and bisphosphonate therapy should be initiated (if not already) if bone mineral density (BMD) of the lumbar spine and/or hip is below normal.

## **Neuro-Psychiatric**

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 they 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: Multiple Sclerosis.**)

An acute myopathy has been observed with the use of high doses of corticosteroids, most often occurring in patients with disorders of neuromuscular transmission (e.g., myasthenia gravis), or in patients receiving concomitant therapy with neuromuscular blocking drugs (e.g., pancuronium). This acute myopathy is generalized, may involve ocular and respiratory muscles, and may result in quadriplegia. Elevation of creatinine kinase may occur. Clinical improvement or recovery after stopping corticosteroids may require weeks to years. Psychiatric 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.

### **Ophthalmic**

Intraocular pressure may become elevated in some individuals. If steroid therapy is continued for more than 6 weeks, intraocular pressure should be monitored.

### **Information for Patients**

Patients should be warned not to discontinue the use of corticosteroids abruptly or without medical supervision. As prolonged use may cause adrenal insufficiency and make patients dependent on corticosteroids, they should advise any medical attendants that they are taking corticosteroids and they should seek medical advice at once should they develop an acute illness including fever or other signs of infection. Following prolonged therapy, withdrawal of corticosteroids may result in symptoms of the corticosteroid withdrawal syndrome including, myalgia, arthralgia, and malaise.

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

### **Drug Interactions**

#### **Amphotericin B Injection and Potassium-Depleting Agents**

When corticosteroids are administered concomitantly with potassium-depleting agents (e.g., **amphotericin B, diuretics**), patients should be observed closely for development of hypokalemia. In addition, there have been cases reported in which concomitant use of amphotericin B and hydrocortisone was followed by cardiac enlargement and congestive heart failure.

#### **Antibiotics**

Macrolide antibiotics have been reported to cause a significant decrease in corticosteroid clearance (See **PRECAUTIONS: Drug Interactions: Hepatic Enzyme Inducers, Inhibitors and Substrates**).

#### **Anticholinesterases**

Concomitant use of anticholinesterase agents (e.g., **neostigmine, pyridostigmine**) and corticosteroids may produce severe weakness in patients with myasthenia gravis. If possible, anticholinesterase agents should be withdrawn at least 24 hours before initiating corticosteroid therapy. If concomitant therapy must occur, it should take place under close supervision and the need for respiratory support should be anticipated.

#### **Anticoagulants, Oral**

Co-administration of corticosteroids and **warfarin** usually results in inhibition of response to warfarin, although there have been some conflicting reports. Therefore, coagulation indices should be monitored frequently to maintain the desired anticoagulant effect.

#### **Antidiabetics**

Because corticosteroids may increase blood glucose concentrations, dosage adjustments of antidiabetic agents may be required.

#### **Antitubercular Drugs**

Serum concentrations of **isoniazid** may be decreased.

#### **Bupropion**

Since systemic steroids, as well as bupropion, can lower the seizure threshold, concurrent administration should be undertaken only with extreme caution; low initial dosing and small gradual increases should be employed.

#### **Cholestyramine**

Cholestyramine may increase the clearance of corticosteroids.

### Cyclosporine

Increased activity of both cyclosporine and corticosteroids may occur when the two are used concurrently. Convulsions have been reported with this concurrent use.

### Digitalis Glycosides

Patients on digitalis glycosides may be at increased risk of arrhythmias due to hypokalemia.

### Estrogens, Including Oral Contraceptives

Estrogens may decrease the hepatic metabolism of certain corticosteroids, thereby increasing their effect.

### Fluoroquinolones

Post-marketing surveillance reports indicate that the risk of tendon rupture may be increased in patients receiving concomitant fluoroquinolones (e.g., **ciprofloxacin, levofloxacin**) and corticosteroids, especially in the elderly. Tendon rupture can occur during or after treatment with quinolones.

### Hepatic Enzyme Inducers, Inhibitors and Substrates

Drugs which **induce** cytochrome P450 3A4 (CYP 3A4) enzyme activity (e.g., **barbiturates, phenytoin, carbamazepine, rifampin**) may enhance the metabolism of corticosteroids and require that the dosage of the corticosteroid be increased. Drugs which **inhibit** CYP 3A4 (e.g., **ketoconazole, itraconazole, ritonavir, indinavir, macrolide antibiotics such as erythromycin**) have the potential to result in increased plasma concentrations of corticosteroids. Glucocorticoids are moderate inducers of CYP 3A4. Co-administration with other drugs that are metabolized by CYP 3A4 (e.g., **indinavir, erythromycin**) may increase their clearance, resulting in decreased plasma concentration.

### Ketoconazole

Ketoconazole has been reported to decrease the metabolism of certain corticosteroids by up to 60%, leading to increased risk of corticosteroid side effects. In addition, ketoconazole alone can inhibit adrenal corticosteroid synthesis and may cause adrenal insufficiency during corticosteroid withdrawal.

### Nonsteroidal Anti-Inflammatory Agents (NSAIDs)

Concomitant use of **aspirin** (or other **nonsteroidal anti-inflammatory agents**) and corticosteroids increases the risk of gastrointestinal side effects. Aspirin should be used cautiously in conjunction with corticosteroids in hypoprothrombinemia. The clearance of salicylates may be increased with concurrent use of corticosteroids; this could lead to decreased salicylate serum levels or increase the risk of salicylate toxicity when corticosteroid is withdrawn.

### Phenytoin

In post-marketing experience, there have been reports of both increases and decreases in phenytoin levels with dexamethasone co-administration, leading to alterations in seizure control. Phenytoin has been demonstrated to increase the hepatic metabolism of corticosteroids, resulting in a decreased therapeutic effect of the corticosteroid.

### Quetiapine

Increased doses of quetiapine may be required to maintain control of symptoms of schizophrenia in patients receiving a glucocorticoid, a hepatic enzyme inducer.

### Skin Tests

Corticosteroids may suppress reactions to skin tests.

### Thalidomide

Co-administration with thalidomide should be employed cautiously, as toxic epidermal necrolysis has been reported with concomitant use.

### Vaccines

Patients on corticosteroid therapy may exhibit a diminished response to toxoids and live or inactivated vaccines due to inhibition of antibody response. Corticosteroids may also potentiate the replication of some organisms contained in live attenuated vaccines. Routine administration of vaccines or toxoids should be deferred until corticosteroid therapy is discontinued if possible (See **WARNINGS:**

**Infection:** Vaccination).

### **Carcinogenesis, Mutagenesis, Impairment of Fertility**

No adequate studies have been conducted in animals to determine whether corticosteroids have a potential for carcinogenesis or mutagenesis. Steroids may increase or decrease motility and number of spermatozoa in some patients.

### **Pregnancy**

Teratogenic Effects

#### ***Pregnancy Category C***

Corticosteroids have been shown to be teratogenic in many species when given in doses equivalent to the human dose. Animal studies in which corticosteroids have been given to pregnant mice, rats, and rabbits have yielded an increased incidence of cleft palate in the offspring. There are no adequate and well-controlled studies in pregnant women. Corticosteroids should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. Infants born to mothers who have received substantial doses of corticosteroids during pregnancy should be carefully observed for signs of hypoadrenalism.

### **Nursing Mothers**

Systemically administered corticosteroids appear in human milk and could suppress growth, interfere with endogenous corticosteroid production, or cause other untoward effects. Because of the potential for serious adverse reactions in nursing infants from corticosteroids, 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**

The efficacy and safety of corticosteroids in the pediatric population are based on the well-established course of effect of corticosteroids, which is similar in pediatric and adult populations. Published studies provide evidence of efficacy and safety in pediatric patients for the treatment of nephrotic syndrome (patients >2 years of age), and aggressive lymphomas and leukemias (patients >1 month of age). Other indications for pediatric use of corticosteroids, e.g., severe asthma and wheezing, are based on adequate and well-controlled trials conducted in adults, on the premises that the course of the diseases and their pathophysiology are considered to be substantially similar in both populations.

The adverse effects of corticosteroids in pediatric patients are similar to those in adults (See **ADVERSE REACTIONS**). Like adults, pediatric patients should be carefully observed with frequent measurements of blood pressure, weight, height, intraocular pressure, and clinical evaluation for the presence of infection, psychosocial disturbances, thromboembolism, peptic ulcers, cataracts, and osteoporosis. Pediatric patients who are treated with corticosteroids by any route, including systemically administered corticosteroids, may experience a decrease in their growth velocity. This negative impact of corticosteroids on growth has been observed at low systemic doses and in the absence of laboratory evidence of hypothalamic-pituitary-adrenal (HPA) axis suppression (i.e., cosyntropin stimulation and basal cortisol plasma levels). Growth velocity may therefore be a more sensitive indicator of systemic corticosteroid exposure in pediatric patients than some commonly used tests of HPA axis function. The linear growth of pediatric patients treated with corticosteroids should be monitored, and the potential growth effects of prolonged treatment should be weighed against clinical benefits obtained and the availability of treatment alternatives. In order to minimize the potential growth effects of corticosteroids, pediatric patients should be titrated to the lowest effective dose.

### **Geriatric Use**

Clinical studies did not include sufficient numbers of subjects aged 65 and over to determine whether they respond differently from younger subjects. Other reported clinical experience has not identified



differences in responses between the elderly and younger patients. In general, dose selection for an elderly patient should be cautious, usually starting at the low end of the dosing range, reflecting the greater frequency of decreased hepatic, renal, or cardiac function, and of concomitant disease or other drug therapy. In particular, the increased risk of diabetes mellitus, fluid retention and hypertension in elderly patients treated with corticosteroids should be considered.

## **ADVERSE REACTIONS**

**(listed alphabetically, under each subsection)**

The following adverse reactions have been reported with prednisone or other corticosteroids:

### **Allergic Reactions**

anaphylactoid or hypersensitivity reactions, anaphylaxis, angioedema.

### **Cardiovascular System**

bradycardia, cardiac arrest, cardiac arrhythmias, cardiac enlargement, circulatory collapse, congestive heart failure, ECG changes caused by potassium deficiency, edema, fat embolism, hypertension or aggravation of hypertension, hypertrophic cardiomyopathy in premature infants, myocardial rupture following recent myocardial infarction (See **WARNINGS: Cardio-Renal**), necrotizing angitis, pulmonary edema, syncope, tachycardia, thromboembolism, thrombophlebitis, vasculitis.

### **Dermatologic**

acne, acneiform eruptions, allergic dermatitis, alopecia, angioedema, angioneurotic edema, atrophy and thinning of skin, dry scaly skin, ecchymoses and petechiae (bruising), erythema, facial edema, hirsutism, impaired wound healing, increased sweating, Kaposi's sarcoma (See **PRECAUTIONS: General Precautions**), lupus erythematosus-like lesions, perineal irritation, purpura, rash, striae, subcutaneous fat atrophy, suppression of reactions to skin tests, striae, telangiectasis, thin fragile skin, thinning scalp hair, urticaria.

### **Endocrine**

Adrenal insufficiency-greatest potential caused by high potency glucocorticoids with long duration of action (associated symptoms include: arthralgias, buffalo hump, dizziness, life-threatening hypotension, nausea, severe tiredness or weakness), amenorrhea, postmenopausal bleeding or other menstrual irregularities, decreased carbohydrate and glucose tolerance, development of cushingoid state, diabetes mellitus (new onset or manifestations of latent), glycosuria, hyperglycemia, hypertrichosis, hyperthyroidism (See **WARNINGS: Endocrine**), hypothyroidism, increased requirements for insulin or oral hypoglycemic agents in diabetics, lipids abnormal, moon face, negative nitrogen balance caused by protein catabolism, secondary adrenocortical and pituitary unresponsiveness (particularly in times of stress, as in trauma, surgery or illness) (See **WARNINGS: Endocrine**), suppression of growth in pediatric patients.

### **Fluid and Electrolyte Disturbances**

congestive heart failure in susceptible patients, fluid retention, hypokalemia, hypokalemic alkalosis, metabolic alkalosis, hypotension or shock-like reaction, potassium loss, sodium retention with resulting edema.

### **Gastrointestinal**

abdominal distention, abdominal pain, anorexia which may result in weight loss, constipation, diarrhea, elevation in serum liver enzyme levels (usually reversible upon discontinuation), gastric irritation, hepatomegaly, increased appetite and weight gain, nausea, oropharyngeal candidiasis, pancreatitis, peptic ulcer with possible perforation and hemorrhage, perforation of the small and large intestine

(particularly in patients with inflammatory bowel disease), ulcerative esophagitis, vomiting.

### **Hematologic**

anemia, neutropenia (including febrile neutropenia).

### **Metabolic**

negative nitrogen balance due to protein catabolism.

### **Musculoskeletal**

arthralgias, aseptic necrosis of femoral and humeral heads, increase risk of fracture, loss of muscle mass, muscle weakness, myalgias, osteopenia, osteoporosis (See **PRECAUTIONS: Musculoskeletal**), pathologic fracture of long bones, steroid myopathy, tendon rupture (particularly of the Achilles tendon), vertebral compression fractures.

### **Neurological/Psychiatric**

amnesia, anxiety, benign intracranial hypertension, convulsions, delirium, dementia (characterized by deficits in memory retention, attention, concentration, mental speed and efficiency, and occupational performance), depression, dizziness, EEG abnormalities, emotional instability and irritability, euphoria, hallucinations, headache, impaired cognition, incidence of severe psychiatric symptoms, increased intracranial pressure with papilledema (pseudotumor cerebri) usually following discontinuation of treatment, increased motor activity, insomnia, ischemic neuropathy, long-term memory loss, mania, mood swings, neuritis, neuropathy, paresthesia, personality changes, psychiatric disorders including steroid psychoses or aggravation of pre-existing psychiatric conditions, restlessness, schizophrenia, verbal memory loss, vertigo, withdrawn behavior.

### **Ophthalmic**

blurred vision, cataracts (including posterior subcapsular cataracts), central serous chorioretinopathy, establishment of secondary bacterial, fungal and viral infections, exophthalmos, glaucoma, increased intraocular pressure (See **PRECAUTIONS: Ophthalmic**), optic nerve damage, papilledema.

### **Other**

abnormal fat deposits, aggravation/masking of infections, decreased resistance to infection (See **WARNINGS: Infection**), hiccups, immunosuppression, increased or decreased motility and number of spermatozoa, malaise, insomnia, moon face, pyrexia.

To report SUSPECTED ADVERSE REACTIONS, contact West-Ward Pharmaceuticals Corp. at 1-877-233-2001, or the FDA at 1-800-FDA-1088 or [www.fda.gov/medwatch](http://www.fda.gov/medwatch).

## **DOSAGE AND ADMINISTRATION**

Product: 71335-0464

NDC: 71335-0464-0 10 TABLET in a BOTTLE

NDC: 71335-0464-1 21 TABLET in a BOTTLE

NDC: 71335-0464-2 40 TABLET in a BOTTLE

NDC: 71335-0464-3 30 TABLET in a BOTTLE

NDC: 71335-0464-4 20 TABLET in a BOTTLE

NDC: 71335-0464-5 15 TABLET in a BOTTLE

NDC: 71335-0464-6 50 TABLET in a BOTTLE

NDC: 71335-0464-7 60 TABLET in a BOTTLE

NDC: 71335-0464-8 42 TABLET in a BOTTLE

NDC: 71335-0464-9 48 TABLET in a BOTTLE

## Prednisone 10mg Tablet

*Packaged by Bryant Ranch* *Barboursville, WV 26031*

**Prednisone  
10mg Tablet**

LOT 114422

WHITE ROUND TL 173:

Take with food

Keep all drugs out of reach of children

Store at room temp of 20-25 C (68-77F)

Compare To:  
Prednisone 10mg Tablet

JUBILANT CADI STA PHARMACEUTICALS INC.

# 21 Exp: MM/YY

RX Only

NDC 7133504641 015791114422

## PREDNISONE

prednisone tablet

### Product Information

Product Type	HUMAN PRESCRIPTION DRUG	Item Code (Source)	NDC:71335-0464(NDC:0143-9739)
Route of Administration	ORAL		

### Active Ingredient/Active Moiety

Ingredient Name	Basis of Strength	Strength
PREDNISONE (UNII: VB0R961HZT) (PREDNISONE - UNII:VB0R961HZT)	PREDNISONE	10 mg

### Inactive Ingredients

Ingredient Name	Strength
ANHYDROUS LACTOSE (UNII: 3SY5LH9PMK)	
SILICON DIOXIDE (UNII: ETJ7Z6XBU4)	
MAGNESIUM STEARATE (UNII: 70097M6I30)	
MICROCRYSTALLINE CELLULOSE (UNII: OP1R32D61U)	
SODIUM STARCH GLYCOLATE TYPE A POTATO (UNII: 5856J3G2A2)	
TALC (UNII: 7SEV7J4R1U)	

### Product Characteristics

Color	WHITE	Score	2 pieces
Shape	ROUND	Size	9mm

<b>Flavor</b>		<b>Imprint Code</b>	Westward;473	
<b>Contains</b>				
<b>Packaging</b>				
#	Item Code	Package Description	Marketing Start Date	Marketing End Date
1	NDC:71335-0464-3	30 in 1 BOTTLE; Type 0: Not a Combination Product	10/29/2013	
2	NDC:71335-0464-9	48 in 1 BOTTLE; Type 0: Not a Combination Product	10/29/2013	
3	NDC:71335-0464-0	10 in 1 BOTTLE; Type 0: Not a Combination Product	10/29/2013	
4	NDC:71335-0464-6	50 in 1 BOTTLE; Type 0: Not a Combination Product	10/29/2013	
5	NDC:71335-0464-1	21 in 1 BOTTLE; Type 0: Not a Combination Product	10/29/2013	
6	NDC:71335-0464-4	20 in 1 BOTTLE; Type 0: Not a Combination Product	10/29/2013	
7	NDC:71335-0464-7	60 in 1 BOTTLE; Type 0: Not a Combination Product	10/29/2013	
8	NDC:71335-0464-5	15 in 1 BOTTLE; Type 0: Not a Combination Product	10/29/2013	
9	NDC:71335-0464-8	42 in 1 BOTTLE; Type 0: Not a Combination Product	10/29/2013	
10	NDC:71335-0464-2	40 in 1 BOTTLE; Type 0: Not a Combination Product	10/29/2013	
<b>Marketing Information</b>				
Marketing Category	Application Number or Monograph Citation	Marketing Start Date	Marketing End Date	
ANDA	ANDA088832	08/03/2009		

**Labeler** - Bryant Ranch Prepack (171714327)

### Establishment

Name	Address	ID/FEI	Business Operations
Bryant Ranch Prepack		171714327	REPACK(71335-0464) , RELABEL(71335-0464)

Revised: 1/2020

Bryant Ranch Prepack