

DEXAMETHASONE SODIUM PHOSPHATE- dexamethasone sodium phosphate injection
Cardinal Health 107, LLC

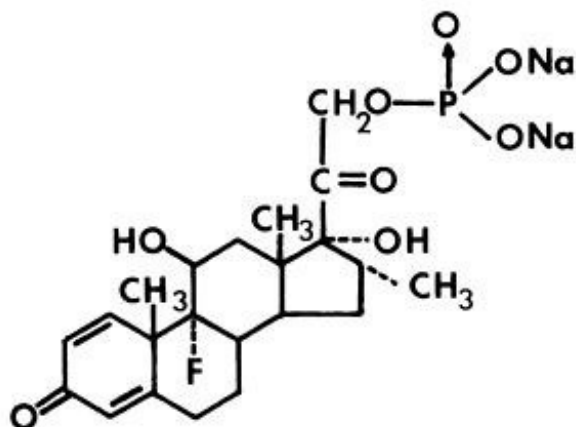
Dexamethasone Sodium Phosphate Injection, USP
Rx only

DESCRIPTION

Dexamethasone sodium phosphate injection, USP is a water-soluble inorganic ester of dexamethasone which produces a rapid response even when injected intramuscularly.

Dexamethasone sodium phosphate, a synthetic adrenocortical steroid, is a white or slightly yellow crystalline powder. It is freely soluble in water and is exceedingly hygroscopic. The molecular weight is 516.41. It is designated chemically as 9-fluoro-11 β ,17-dihydroxy-16 α -methyl-21-(phosphonoxy)pregna-1,4-diene-3, 20-dione disodium salt.

The molecular formula is: C₂₂H₂₈FN₂O₈P and the structural formula is:



Dexamethasone Sodium Phosphate Injection is a sterile solution of dexamethasone sodium phosphate for intravenous and intramuscular use. The 4 mg/mL strength may also be used for intra-articular, intralesional and soft tissue administration.

Each mL of Dexamethasone Sodium Phosphate Injection 4 mg/mL contains dexamethasone sodium phosphate, equivalent to 4 mg dexamethasone phosphate or 3.33 mg dexamethasone. Inactive ingredients per mL: 1 mg sodium sulfite anhydrous, 19.4 mg sodium citrate anhydrous and 10.42 mg (0.01 mL) benzyl alcohol (preservative) in Water for Injection.

Each mL of Dexamethasone Sodium Phosphate Injection 10 mg/mL contains dexamethasone sodium phosphate, equivalent to 10 mg dexamethasone phosphate or 8.33 mg dexamethasone. Inactive ingredients per mL: 1.5 mg sodium sulfite anhydrous, 16.5 mg sodium citrate anhydrous and 10.42 mg (0.01 mL) benzyl alcohol

(preservative) in Water for Injection.

The pH of both concentrations is 7.0-8.5; sodium hydroxide and/or citric acid used, if needed, for pH adjustment. Sealed under nitrogen.

ACTIONS

Naturally occurring glucocorticoids (hydrocortisone), 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

A. Intravenous or intramuscular administration. 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, those products labeled for intravenous or intramuscular use are indicated as follows:

1. Endocrine disorders

Primary or secondary adrenocortical insufficiency (hydrocortisone or cortisone 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 cortisone 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

Nonsuppurative thyroiditis

Hypercalcemia associated with cancer

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)

Acute and subacute bursitis
Epicondylitis
Acute nonspecific tenosynovitis
Acute gouty arthritis
Psoriatic arthritis
Ankylosing spondylitis

3. Collagen diseases

During an exacerbation or as maintenance therapy in selected cases of:

Systemic lupus erythematosus
Acute rheumatic carditis

4. Dermatologic diseases

Pemphigus
Severe erythema multiforme (Stevens-Johnson Syndrome)
Exfoliative dermatitis
Bullous dermatitis herpetiformis
Severe seborrheic 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 reactions
Urticarial transfusion 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
Iritis, iridocyclitis

Chorioretinitis
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
Berylliosis
Fulminating or disseminated pulmonary tuberculosis when used concurrently with appropriate anti-tuberculosis chemotherapy
Loeffler's syndrome not manageable by other means
Aspiration pneumonitis

9. *Hematologic disorders*

Acquired (autoimmune) hemolytic anemia
Idiopathic thrombocytopenic purpura in adults (I.V. only; I.M. 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 anti-tuberculosis chemotherapy

Trichinosis with neurologic or myocardial involvement

Diagnostic testing of adrenocortical hyperfunction

Cerebral edema of diverse etiologies in conjunction with adequate neurological evaluation and management.

B. Intra-articular or soft tissue administration. When the strength and dosage form of the drug lend the preparation to the treatment of the condition, those products labeled for intra-articular or soft tissue administration are indicated as adjunctive therapy for short-term administration (to tide the patient over an acute episode or exacerbation) in:

Synovitis of osteoarthritis

Rheumatoid arthritis

Acute and subacute bursitis

Acute gouty arthritis

Epicondylitis

Acute nonspecific tenosynovitis

Post-traumatic osteoarthritis

C. Intralesional administration. When the strength and dosage form of the drug lend the preparation to the treatment of the condition, those products labeled for intralesional administration are indicated for:

Keloids

Localized hypertrophic, infiltrated, inflammatory lesions of: lichen planus, psoriatic plaques, granuloma annulare, and lichen simplex chronicus (neurodermatitis)

Discoid lupus erythematosus

Necrobiosis lipoidica diabetorum

Alopecia areata

They also may be useful in cystic tumors of an aponeurosis tendon (ganglia).

CONTRAINDICATIONS

Systemic fungal infections.

WARNINGS

Serious Neurologic Adverse Reactions with Epidural Administration

Serious neurologic events, some resulting in death, have been reported with epidural injection of corticosteroids. Specific events reported include, but are not limited to, spinal cord infarction, paraplegia, quadriplegia, cortical blindness, and stroke. These serious neurologic events have been reported with and without use of fluoroscopy. The safety and effectiveness of epidural administration of corticosteroids have not been established, and corticosteroids are not approved for this use.

In patients on corticosteroid therapy subject 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.

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.

Children who are on immunosuppressant drugs are more susceptible to infections than healthy children. Chickenpox and measles, for example, can have a more serious or even fatal course in children on immunosuppressant corticosteroids. In such children, or in adults who have not had these diseases, particular care should be taken to avoid exposure. If exposed, therapy with varicella zoster immune globulin (VZIG) or pooled intravenous immunoglobulin (IVIG), as appropriate, may be indicated. If chickenpox develops, treatment with antiviral agents may be considered.

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.

Usage in Pregnancy

Since adequate human reproduction studies have not been done with corticosteroids, use of these drugs in pregnancy, nursing mothers or women of childbearing 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.

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. Patients with a stressed myocardium should be observed carefully and the drug administered slowly since premature ventricular contractions may occur with rapid administration. 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 in high doses, because of possible hazards of neurological complications and lack of antibody response.

The use of Dexamethasone Sodium Phosphate Injection 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 an appropriate anti-tuberculosis 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.

Because rare instances of anaphylactoid 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.

Dexamethasone Sodium Phosphate Injection contains sodium sulfite, a sulfite that may cause allergic type reactions including anaphylactic symptoms and life-threatening or less severe asthmatic episodes in certain susceptible people. The overall prevalence of sulfite sensitivity in the general population is unknown and probably low. Sulfite sensitivity is seen more frequently in asthmatic than in nonasthmatic people.

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 in patients with hypothyroidism and in those with cirrhosis.

Corticosteroids should be used cautiously in patients with ocular herpes simplex for fear of 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 must 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.

Aspirin should be used cautiously in conjunction with corticosteroids in hypoprothrombinemia.

Steroids should be used with caution in nonspecific ulcerative colitis, if there is a probability of impending perforation, abscess, or other pyogenic infection, also in 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 followed.

Patients who are on immunosuppressant doses of corticosteroids should be warned to avoid exposure to chickenpox or measles and, if exposed, to obtain medical advice.

Intra-articular injection of a corticosteroid may produce systemic as well as local effects.

Appropriate examination of any joint fluid present is necessary to exclude a septic process.

A marked increase in pain accompanied by local swelling, further restriction of joint motion, fever, and malaise are suggestive of septic arthritis. If this complication occurs and the diagnosis of sepsis is confirmed, appropriate antimicrobial therapy should be instituted.

Local injection of a steroid into a previously infected joint is to be avoided. Corticosteroids should not be injected into unstable joints.

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 Section).

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.

ADVERSE REACTIONS

Fluid and electrolyte disturbances:

Sodium retention

Fluid retention

Congestive heart failure in susceptible patients

Potassium loss

Hypokalemic alkalosis

Hypertension

Musculoskeletal:

Muscle weakness

Steroid myopathy

Loss of muscle mass

Osteoporosis

Vertebral compression fractures

Aseptic necrosis of femoral and humeral heads

Pathologic fracture of long bones

Gastrointestinal:

Peptic ulcer with possible subsequent perforation and hemorrhage

Pancreatitis

Abdominal distention

Ulcerative esophagitis

Dermatological:

Impaired wound healing

Thin fragile skin

Facial erythema

Increased sweating

May suppress reactions to skin tests

Petechiae and ecchymoses

Neurological:

Convulsions

Increased intracranial pressure with papilledema (pseudotumor cerebri) usually after treatment

Vertigo

Headache

Ophthalmic:

Posterior subcapsular cataracts

Increased intraocular pressure

Glaucoma

Endocrine:

Menstrual irregularities

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

Decreased carbohydrate tolerance

Manifestations of latent diabetes mellitus

Increased requirements for insulin or oral hypoglycemic agents in diabetics

Metabolic:

Negative nitrogen balance due to protein catabolism

Miscellaneous:

Hyperpigmentation or hypopigmentation

Subcutaneous and cutaneous atrophy

Sterile abscess

Postinjection flare following intra-articular use
Charcot-like arthropathy
Itching, burning, tingling in the ano-genital region

DOSAGE AND ADMINISTRATION

A. Intravenous or intramuscular administration.

The initial dosage of Dexamethasone Sodium Phosphate Injection may vary from 0.50 mg/day to 9.0 mg/day depending on the specific disease entity being treated. In situations of less severity, lower doses will generally suffice while in selected patients higher initial doses may be required. Usually the parenteral dosage ranges are one-third to one-half the oral dose given every 12 hours. However, in certain overwhelming, acute, life-threatening situations, administration of dosages exceeding the usual dosages may be justified and may be in multiples of the oral dosages.

For the treatment of unresponsive shock high pharmacologic doses of this product are currently recommended. Reported regimens range from 1 to 6 mg/kg of body weight as a single intravenous injection to 40 mg initially followed by repeat intravenous injection every 2 to 6 hours while shock persists.

For the treatment of cerebral edema in adults an initial intravenous dose of 10 mg is recommended followed by 4 mg intramuscularly every six hours until maximum response has been noted. This regimen may be continued for several days postoperatively in patients requiring brain surgery. Oral dexamethasone, 1 to 3 mg t.i.d., should be given as soon as possible and dosage tapered off over a period of five to seven days. Nonoperative cases may require continuous therapy to remain free of symptoms of increased intracranial pressure. The smallest effective dose should be used in children, preferably orally. This may approximate 0.2 mg/kg/24 hours in divided doses.

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 or 4-8 mg dexamethasone every other day for 1 month have been shown to be effective.

The initial dosage should be maintained or adjusted until a satisfactory response is noted. If after a reasonable period of time there is a lack of satisfactory clinical response, Dexamethasone Sodium Phosphate Injection should be discontinued and the patient transferred to other appropriate therapy. It should be emphasized that dosage requirements are variable and must be individualized on the basis of the disease under treatment and the response of the patient.

After a favorable response is noted, the proper maintenance dosage should be determined by decreasing the initial drug dosage in small decrements at appropriate time intervals until the lowest dosage which will maintain an adequate clinical response is reached. It should be kept in mind that constant monitoring is needed in regard to drug dosage. Included in the situations which may make dosage adjustments necessary are changes in clinical status secondary to remissions or exacerbations in the disease process, the patient's individual drug responsiveness and the effect of patient exposure to stressful situations not directly related to the disease entity under treatment. In this latter situation it may be necessary to increase the dosage of dexamethasone sodium

phosphate injection, USP for a period of time consistent with the patient's condition. If after a long-term therapy the drug is to be stopped, it is recommended that it be withdrawn gradually rather than abruptly.

B. Intra-articular, soft tissue or intralesional administration.

The dose for intrasynovial administration is usually 2 to 4 mg for large joints and 0.8 to 1 mg for small joints. For soft tissue and bursal injections a dose of 2 to 4 mg is recommended. Ganglia require a dose of 1 to 2 mg. A dose of 0.4 to 1 mg is used for injection into tendon sheaths. Injection into intervertebral joints should not be attempted at any time and hip joint injection cannot be recommended as an office procedure.

Intrasynovial and soft tissue injections should be employed only when affected areas are limited to 1 or 2 sites. It should be remembered that corticoids provide palliation only and that other conventional or curative methods of therapy should be employed when indicated.

Parenteral drug products should be inspected visually for particulate matter and discoloration prior to administration, whenever solution and container permit.

Frequency of injection usually ranges from once every 3 to 5 days to once every 2 to 3 weeks. Frequent intra-articular injection may cause damage to joint tissue.

HOW SUPPLIED

Dexamethasone Sodium Phosphate Injection, USP is available in the following package:

10 mg/mL

Overbagged with 5 x 1 mL vials per bag, NDC 55154-5118-5

Storage

Protect from light: Keep covered in carton until time of use. Store at 20° to 25°C (68° to 77°F), excursions permitted to 15° to 30°C (59° to 86°F) [See USP Controlled Room Temperature]. Avoid freezing. Do not use if solution is hazy or has a precipitate. Do not autoclave.

To report SUSPECTED ADVERSE REACTIONS, contact Hikma Pharmaceuticals USA Inc. at 1-877-845-0689, or the FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.

For Product Inquiry call 1-877-845-0689.

Manufactured by:

Hikma Pharmaceuticals USA Inc.
Berkeley Heights, NJ 07922 USA

Distributed by:

Cardinal Health

Dublin, OH 43017

L36082130124

Revised December 2022

462-331-07


Package/Label Display Panel

Dexamethasone Sodium Phosphate Injection, USP

10 mg/ml

Dexamethasone Phosphate Equivalent

5 x 1 ml Vials



***F39**

NDC 55154-5118-5

**DEXAMETHASONE SODIUM PHOSPHATE
INJECTION, USP 10 mg/mL
Dexamethasone Phosphate Equivalent**

5 x 1 ML VIALS

FOR INTRAVENOUS OR INTRAMUSCULAR USE ONLY

Each mL contains dexamethasone sodium phosphate (equivalent to 10 mg dexamethasone phosphate), sodium sulfite anhydrous 1.5 mg, sodium citrate anhydrous 16.5 mg and benzyl alcohol 10.42 mg (0.01 mL) in Water for Injection. pH 7.0-8.5; sodium hydroxide and/or citric acid used, if needed, for pH adjustment.

Usual Dosage: See product insert for prescribing information, precautions and warnings.
Do not autoclave.

STORAGE: Store at 20° to 25° C (68° to 77° F) [See USP Controlled Room Temperature]. Avoid freezing.
PROTECT FROM LIGHT: Light Sensitive: Keep covered until time of use.

RX ONLY

WARNING: This Unit Dose package is not child resistant and is Intended for Institutional Use Only.
Keep this and all drugs out of the reach of children.

Manufactured by
Hikma®
Eatontown, NJ 07724 USA

Distributed by Cardinal Health
Dublin, OH 43017
L36082130124

DEXAMETHASONE SODIUM PHOSPHATE

dexamethasone sodium phosphate injection

Product Information

Product Type	HUMAN PRESCRIPTION DRUG	Item Code (Source)	NDC:55154-5118(NDC:0641-0367)
Route of Administration	INTRAVENOUS, INTRAMUSCULAR		

Active Ingredient/Active Moiety

Ingredient Name	Basis of Strength	Strength
DEXAMETHASONE SODIUM PHOSPHATE (UNII: AI9376Y64P) (DEXAMETHASONE - UNII: 7S517G3JQL)	DEXAMETHASONE PHOSPHATE	10 mg in 1 mL

Inactive Ingredients

Ingredient Name	Strength
SODIUM SULFATE ANHYDROUS (UNII: 36KCS0R750)	1.5 mg in 1 mL
ANHYDROUS TRISODIUM CITRATE (UNII: RS7A450LGA)	16.5 mg in 1 mL
BENZYL ALCOHOL (UNII: LKG8494WBH)	10.42 mg in 1 mL
water (UNII: 059QF0KO0R)	
sodium hydroxide (UNII: 55X04QC32I)	
CITRIC ACID MONOHYDRATE (UNII: 2968PHW8QP)	

Packaging

#	Item Code	Package Description	Marketing Start Date	Marketing End Date
1	NDC:55154-5118-5	5 in 1 BAG	09/07/1982	
1		1 mL in 1 VIAL, SINGLE-DOSE; Type 0: Not a Combination Product		

Marketing Information

Marketing Category	Application Number or Monograph Citation	Marketing Start Date	Marketing End Date
ANDA	ANDA087702	09/07/1982	

Labeler - Cardinal Health 107, LLC (118546603)