

Pr ARGATROBAN
(argatroban for injection)
100 mg/mL

Pharmacological Classification
Antithrombotic

For full product information, please refer to the Product Monograph

Action and Clinical Pharmacology

Mechanism of Action: Argatroban is a small-molecule, direct thrombin inhibitor that reversibly binds to the thrombin active site. Its mechanism of action is distinct from heparin, an indirect thrombin inhibitor, which requires the co-factor antithrombin III for antithrombotic activity. Argatroban exerts its anticoagulant effects by inhibiting thrombin-catalyzed or induced reactions, including fibrin formation; activation of coagulation factor XIII, factor V, factor VIII, and protein C; and platelet aggregation.

Argatroban is highly selective for thrombin with an inhibitory constant (K_i) of 5-39 nM. At therapeutic concentrations, Argatroban has no or minimal effect on related serine proteases (trypsin, factor Xa, plasmin, and kallikrein) .

Argatroban is also capable of inhibiting the action of clot-associated thrombin. In contrast, the heparin-antithrombin III complex is incapable of inhibiting clot-associated thrombin.

Experience in a limited number of patients who received multiple doses of Argatroban indicates no antibody formation.

Metabolism, Excretion, and Protein Binding: Using human liver microsomes and whole cell preparations *in vitro*, four oxidative metabolites were detected (M1, M2, M3 and trace amounts of M4). The formation of each of these metabolites was catalyzed *in vitro* by the human liver microsomal cytochrome P450 enzymes CYP3A4/5. The M1 oxidative metabolite was not quantifiable in plasma of volunteers who received drug. These data together with the lack of effect of erythromycin (a potent CYP3A4/5 inhibitor) on Argatroban pharmacokinetics suggest that CYP3A4/5 mediated metabolism is not an important elimination pathway *in vivo*.

The major route of excretion of Argatroban is via fecal elimination, presumably via biliary secretion. In a study in which [14 C]Argatroban (5 μ g/kg/min) was infused for 4 hours to healthy subjects, the majority of the radioactivity was recovered in the feces (approximately 65% of the administered dose) over 7 days and urine (approximately 22% of the administered dose) within 6 days. Unchanged Argatroban accounted for the majority (approximately 16% of the administered dose) of the radioactivity in urine. The precise composition of the remainder of the radioactivity in urine and feces was not fully

evaluated. Plasma radioactivity was undetectable by 24 hours. Argatroban is 54% bound to human serum proteins, with binding to albumin and α_1 -acid glycoprotein being 20% and 34%, respectively.

Pharmacokinetics and Pharmacodynamics: The pharmacokinetic profile of Argatroban is well characterized by a two compartment model with first-order elimination. Total body clearance is approximately 5.1 mL/min/kg (0.31 L/hr/kg) for infusion doses up to 40 μ g/kg/min, and the volume of the central compartment and the volume of distribution are approximately 84 and 174 mL/kg, respectively. Upon cessation of Argatroban infusion, plasma Argatroban concentrations rapidly decline with α and β elimination half-lives of approximately 7 and 54 minutes, respectively. After four hours, little or no Argatroban remains in plasma.

The plasma clearance of the *R* and *S* stereoisomers is similar. *In vivo*, the plasma concentration ratio of *R* to *S* stereoisomers remains essentially constant over time and is approximately equal to the dose ratio (65:35). Hepatic impairment appears to equally affect the plasma concentration of the *R* and *S* stereoisomers since their ratio in plasma remains unchanged relative to that observed in healthy subjects. The less common *S* isomer is approximately twice as potent as the *R* isomer.

When Argatroban is administered by continuous infusion, anticoagulant effects and plasma concentrations of Argatroban follow similar, predictable temporal response profiles, with low intersubject variability. Immediately upon initiation of Argatroban infusion, anticoagulant effects are produced as plasma Argatroban concentrations begin to rise. Steady-state levels of both drug and anticoagulant effect are typically attained in 1-3 hours and are maintained until the infusion is discontinued or the dosage adjusted. Steady-state Argatroban plasma concentrations increase proportionally with dose (for infusion doses up to 40 μ g/kg/min in healthy subjects) and are well-correlated with steady-state anticoagulant effects. For infusion doses up to 40 μ g/kg/min, Argatroban increases, in a dose-dependent fashion, the activated partial thromboplastin time (aPTT), the activated clotting time (ACT), the prothrombin time (PT) and International Normalized Ratio (INR), and the thrombin time (TT). Representative steady-state plasma Argatroban concentrations and anticoagulant effects are shown in Figure 1 for Argatroban infusion doses up to 10 μ g/kg/min.

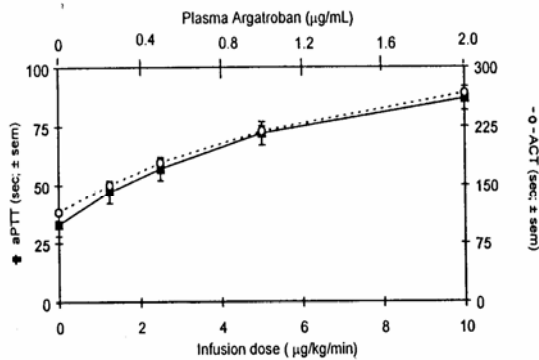
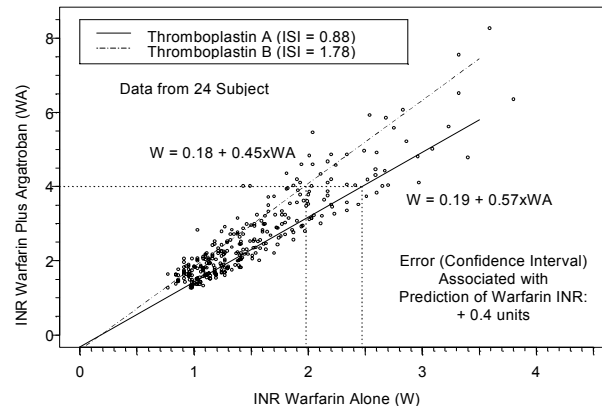


Figure 1. Relationship at Steady State between Argatroban Dose, Plasma Argatroban and Anticoagulant Effect.

Effect on International Normalized Ratio (INR): Because Argatroban is a direct thrombin inhibitor, co-administration of Argatroban and warfarin produces a combined effect on the laboratory measurement of the INR. However, concurrent therapy, compared to warfarin monotherapy, exerts no additional effect on vitamin-K-dependent factor Xa activity. It is anticipated that there will be no enhanced bleeding risk resulting from the combined effect on INR lab value.

The relationship between INR on co-therapy and warfarin alone is dependent on both the dose of Argatroban and the thromboplastin reagent used. This relationship is influenced by the International Sensitivity Index (ISI) of the thromboplastin. Data for two commonly utilized thromboplastins with ISI values of 0.88 (Innovin, Dade) and 1.78 (Thromboplastin C Plus, Dade) are presented in Figure 2 for an Argatroban dose of 2 µg/kg/min. Thromboplastins with higher ISI values than shown result in higher INRs on combined therapy of warfarin and Argatroban. These data are based on results obtained in normal individuals (see PRECAUTIONS – Drug Interactions and DOSAGE AND ADMINISTRATION, Conversion to Oral Anticoagulant Therapy).

Figure 2. Relationship of Argatroban and Warfarin on International Normalized Ratio (INR)



Predicted INR for warfarin alone from a co-therapy INR of 4.0 is demonstrated by Figure 2. To calculate INR for warfarin alone (INR_W), based on INR for co-therapy of warfarin and Argatroban (INR_{WA}), use the equation next to the appropriate curve. Example: At a dose of 2 Fg/kg/min and an INR performed with Thromboplastin A, the equation $0.19 + 0.57 (INR_{WA}) = INR_W$ would allow a prediction of the INR on warfarin alone (INR_W). Solving for an INR_{WA} value of 4.0 on combined therapy: $INR_W = 0.19 + 0.57 (4) = 2.47$ as the value for INR on warfarin alone. The error associated with a prediction is +/- 0.4 units.

Special Populations:

Age/Gender: The pharmacokinetics of Argatroban have been evaluated by age and gender in healthy subjects and in special populations including those with renal impairment, hepatic impairment, unstable angina, or patients undergoing coronary interventional procedures. There are no effects of age or gender on the pharmacokinetic parameters of Argatroban, with exception of clearance in elderly males being about 80% of that in elderly females.

Renal Impairment: Renal dysfunction did not affect the pharmacokinetic or pharmacodynamic parameters of Argatroban.

Hepatic Impairment: Moderate hepatic impairment is associated with a four-fold decreased clearance for Argatroban as well as an increased elimination half-life of 2.5 hours (see DOSAGE AND ADMINISTRATION).

Indications and Clinical Use

Argatroban is indicated as anticoagulant therapy in patients with heparin-induced thrombocytopenia syndrome, who, in the opinion of their attending physician, require anticoagulation.

Contraindications

Argatroban is contraindicated in patients with active major bleeding, or in patients hypersensitive to Argatroban injection concentrate.

Warnings

Argatroban is intended for intravenous administration. All parenteral anticoagulants must be discontinued before administration of Argatroban.

Hemorrhage: Hemorrhage can occur at virtually any site in the body in patients receiving Argatroban. An unexplained fall in hematocrit, fall in blood pressure, or any other unexplained symptom should lead to serious consideration of a hemorrhagic event. Argatroban should be used with extreme caution in disease states and other circumstances in which there is an increased danger of hemorrhage. These include severe hypertension; immediately following lumbar puncture; spinal anesthesia; major surgery especially involving the brain, spinal cord, or eye; hematologic conditions associated with increased bleeding tendencies such as hemophilia; gastrointestinal lesions such as ulcerations.

Use in pregnancy: There are no adequate and well controlled studies in which pregnant women have received Argatroban. Although animal reproductive studies have not revealed harm to the fetus (see Toxicology), these studies are not always predictive of the effects of a drug in humans. Argatroban should only be used in pregnancy if the benefits outweigh the risks.

Nursing Mothers should discontinue breast feeding while taking Argatroban because of the potential risk for serious adverse reactions in nursing infants. Although it is not known whether this drug is excreted in human milk, experiments in rats show that Argatroban is detected in milk.

Pediatric Use: The safety and effectiveness of Argatroban in patients below the age of 18 years have not been established.

Precautions

Hepatic Impairment: Caution should be exercised when administering Argatroban to patients with hepatic disease, by starting with a lower dose and carefully titrating until the desired level of anticoagulation is achieved. Also, upon cessation of Argatroban infusion in patients with hepatic impairment, full reversal of anticoagulant effects may require longer than 4 hours due to decreased clearance and increased elimination half-life of Argatroban (see DOSAGE AND ADMINISTRATION).

Laboratory Tests: Anticoagulation effects associated with Argatroban infusion at doses up to 40 mg/kg/min are well-correlated with the activated partial thromboplastin time (aPTT). If aPTT monitoring is problematic (such as for those having antiphospholipid antibodies), other global clot-based tests sensitive to Argatroban include the prothrombin time (PT), the International Normalized Ratio (INR), the activated clotting time (ACT) and thrombin time (TT). Plasma Argatroban concentrations also correlate well with anticoagulant effects (see ACTION AND CLINICAL PHARMACOLOGY).

The concomitant use of Argatroban and warfarin results in prolongation of the PT and INR beyond that produced by warfarin alone. Alternative approaches for monitoring concurrent Argatroban and warfarin therapy are described in a subsequent section (see DOSAGE AND ADMINISTRATION).

Drug Interactions:

Heparin: Heparin is contraindicated in patients with heparin-induced thrombocytopenia; therefore, co-administration of Argatroban and heparin is unlikely. If Argatroban is to be initiated after cessation of heparin therapy, sufficient time should be allowed for the effects of heparin on the aPTT to decrease prior to the initiation of Argatroban therapy. As the half-life of heparin is highly variable, the maximum being about 2 hours, a period of time equal to two half-lives, or 4 hours, is recommended. Nevertheless, because of the variability in heparin metabolism, aPTT should always be the primary indicator as to when Argatroban therapy may be initiated.

Aspirin/Acetaminophen: There are no pharmacokinetic or pharmacodynamic drug-drug interactions between Argatroban and concomitantly administered aspirin or acetaminophen.

Oral anticoagulant agents: There are no pharmacokinetic drug-drug interactions between Argatroban and warfarin. However, the concomitant use of Argatroban and warfarin results in prolongation of the prothrombin time (PT) and International Normalized Ratio (INR), therefore, previously established relationships between PT/INR and bleeding risk no longer apply (see ACTION AND CLINICAL PHARMACOLOGY and DOSAGE AND ADMINISTRATION).

Thrombolytic agents: Argatroban at doses up to 3µg/kg/min has been administered in two clinical studies with either rt-PA or streptokinase. No clinically significant safety concerns were noted in these studies.

Digoxin: In 12 healthy volunteers, a 5 day intravenous infusion of Argatroban (2 µg/kg/min) did not affect the steady-state pharmacokinetics of oral digoxin (0.375 mg daily for 15 days).

Lidocaine: Argatroban (1.5 µg/kg/min for 16 hours), did not inhibit the metabolism of concomitantly administered lidocaine (a CYP3A4/5 substrate) using a 1.5 mg/kg bolus plus 2 mg/kg/hour infusion for 16 hours.

Erythromycin: In 10 healthy subjects, orally administered erythromycin (both a substrate for and a potent inhibitor of CYP3A4/5) at 500 mg QID for 7 days had no effect on the pharmacokinetics of Argatroban at a dose of 1 µg/kg/min for 5 hours. These data suggest oxidative metabolism by CYP3A4/5 is not an important elimination pathway *in vivo* for Argatroban. Based on these results, other CYP3A4/5 inhibitors such as ketoconazole and itraconazole are unlikely to inhibit the metabolism of Argatroban. As there has been no clinical experience with the co-administration of Argatroban and other CYP3A4/5 - metabolized drugs, such as fluconazole, indinavir, ritonavir, cyclosporine, simvastatin, nefazodone or their analogues, the potential for possible interaction is unknown.

Geriatric Use: In the prospective study in HIT and HITTS, the effectiveness of Argatroban was not affected by patient age.

Adverse Reactions

The following safety information is based upon the 568 patients treated with Argatroban in the prospective pivotal clinical studies in patients with heparin-induced thrombocytopenia with and without thrombosis syndrome.

Serious Adverse Events: Study Days 0-37: Table 1 shows the incidence of the primary efficacy endpoints [death (all cause), amputations (all cause), or new thrombosis, during study days 0 - 37; recorded as the most severe event] in the prospective and follow-on trials combined. These events qualify as (Serious Adverse Events). Table 1 illustrates the safety profile of Argatroban with regard to these serious outcomes as compared to a historical control group.

Table 1. Serious Adverse Events

	HIT		HITTS	
	Argatroban	Historical Control	Argatroban	Historical Control
	N=285	N=147	N=283	N=46
Death, N(%)	48 (17)	32 (22)	61 (22)	13 (28)
Amputation, N(%)	9 (3)	3 (2)	32 (11)	4 (9)
New Thrombosis, N(%)	16 (6)	22 (15)	27 (10)	9 (20)

Bleeding Event Frequency: In the first prospective pivotal trial, no statistically significant differences in the incidence of major bleeding were observed between the historical control group and the Argatroban group in either the HIT arm (8.2% versus 3.1%; $p=0.0784$) or HITTS arm (2.2% versus 10.4%; $p=0.124$). In the second pivotal trial, no statistically significant differences in the incidence of major bleeding were observed between the historical control group and the Argatroban group in either the HIT arm (8.2% vs. 3.2%; $p=0.1190$) or HITTS arm (2.2% vs. 4.3%; $p=0.683$). No clinically significant difference in minor bleed incidence was observed in either trial comparing Argatroban treated patients to historical controls. There were no cases of drug-related intracranial hemorrhage noted in either trial.

Most Common Reported Adverse Events in the Prospective Pivotal Clinical Trials:

The adverse events reported in this section are consistent with those which would be anticipated for a severely-ill patient population who present with HIT/HITTS syndrome. In general, these patients had a mean age of 60+ years and were on complex concomitant medications. No clinically significant safety trends with regard to Argatroban exposure are apparent from both pivotal trials adverse event data. There may be some evidence of a clinical trend for treated patients to experience more mild gastrointestinal disturbances, such as nausea, or diarrhea.

Comparative Summary of Adverse Events for Prospective Pivotal Clinical Trials:

The following is a comparative summary of non-hemorrhagic adverse events in pivotal studies that were experienced in heparin-induced thrombocytopenia (HIT) patients treated with Argatroban. All adverse events occurring with frequency of $\geq 5\%$ in treated patients, in either trial, are listed in descending order of frequency as they occurred in the first pivotal trial.

Table 2. Comparative Summary of Adverse Events - HIT

Adverse Event	ARG-911 n = 160	ARG-915 n = 125	Historic Control; n = 147
≥5%	%	%	%
Diarrhea	11	2	2
Dyspnea	8	9	9
Hypotension	7	5	3
Apnea	6	0	5
Chest Pain	6	2	2
Sepsis	6	3	14
Dizziness	5	2	0
Vomiting	5	3	0
Fever	4	6	2
Nausea	4	6	0
Tachycardia Ventricular	3	7	3

The following is a comparative summary of non-hemorrhagic adverse events in pivotal studies that were experienced in heparin-induced thrombocytopenia with thrombotic syndrome (HITTS) patients treated with Argatroban. All adverse events occurring with frequency of ≥5% in treated patients, in either trial, are listed in descending order of frequency as they occurred in the first pivotal trial.

Table 3. Comparative Summary of Adverse Events - HITTS

Adverse Event	ARG-911 n = 149	ARG-915 n = 139	Historic Control n = 46
≥5%	%	%	%
Hypotension	9	8	0
Pain	9	3	4
Apnea	8	0	7
Cardiac Arrest	8	8	9
Constipation	8	1	2
Fever	8	9	2
Peripheral Ischemia	8	6	7
Urinary Tract Infection	8	4	4
Infection	7	4	4
Pulmonary Embolism	7	4	13
Rash	7	4	2
Thrombophlebitis	7	0	2
Confusion	6	1	0
Sepsis	6	8	9
Thrombophlebitis (Deep)	6	4	15
Vomiting	6	3	0
Peripheral Gangrene	5	1	4
Pleural Effusion	5	3	4

Dyspnea	4	12	9
Diarrhea	4	7	0
Tachycardia Ventricular	4	5	4
Acute Renal Failure	3	5	7
Nausea	3	6	2
Pneumonia	2	5	15
Respiratory Insufficiency	1	6	0
Cardiac Failure	0	5	0

Adverse Events Resulting from Repeated or Chronic Administration: Adverse event rates in patients receiving multiple courses of Argatroban were similar to rates observed in patients receiving short courses of the drug. Patients receiving chronic administration (greater than 14 days of continuous therapy) of Argatroban had adverse event rates at a similar frequency to those receiving shorter courses of Argatroban.

Symptoms and Treatment of Overdosage

Symptoms/Treatment: Excessive anticoagulation, with or without bleeding, may be controlled by discontinuing Argatroban or by decreasing the Argatroban infusion dosage. In clinical trials, anticoagulation parameters generally returned to baseline within 2 to 4 hours after discontinuation of the drug (although this may take longer for those with hepatic impairment). Argatroban infusion doses of up to 40 µg/kg/min have been administered to healthy subjects up to four hours without drug-related adverse events.

No specific antidote to Argatroban is available; if life-threatening bleeding occurs and excessive plasma levels of Argatroban are suspected, the following steps should be followed:

- Stop or reduce Argatroban administration immediately;
- Determine activated partial thromboplastin time (aPTT) and other coagulation indices as appropriate;
- Provide symptomatic and supportive therapy.

Dosage and Administration

Argatroban, as supplied, is a concentrated drug which must be diluted prior to its infusion. Argatroban should not be mixed with other drugs prior to dilution in a suitable intravenous fluid.

Preparation for Intravenous Administration: Argatroban should be diluted in 0.9% Sodium Chloride Injection, USP; 5% Dextrose injection, USP or Lactated Ringer's Injection, USP; to a final concentration of 1 mg/mL. Use 1 vial (for 2.5 mL total) per 250 mL diluent bag, or 2 vials (for 5.0 mL total) per 500 mL diluent bag. The constituted solution must be mixed by repeated inversion of the diluent bag for one minute. Upon preparation, the solution may show slight but brief haziness due to the formation of microprecipitates that rapidly dissolve upon mixing. The pH of the intravenous solution prepared as recommended is 3.2-7.5.

Initial Dosage for Patients with Heparin-Induced Thrombocytopenia: Discontinue heparin therapy and obtain baseline aPTT. The recommended initial dose of Argatroban for adult patients without hepatic impairment is 2 µg/kg/min, administered as a continuous infusion (see Table 4).

Table 4
Standard Infusion Rates for 2.0 µg/kg/min Dose
(1 mg/ml final concentration)

Body Weight (kg)	Infusion Rate (ml/hr)
50	6
60	7
70	8
80	10
90	11
100	12
110	13
120	14
130	16
140	17

Monitoring therapy: In general, therapy with Argatroban is monitored using the aPTT. Anticoagulant effects (including the aPTT) typically attain steady-state levels within 2.5 hours following initiation of Argatroban or with dosage adjustment. Check the aPTT two hours after initiation of therapy to confirm that the patient has attained the desired therapeutic range.

Dosage adjustment: The dose can be adjusted as clinically indicated (not to exceed 10 µg/kg/min), until the steady-state aPTT is 1.5 to 3.0 times the initial baseline value (not to exceed 100 seconds).

Patients with Hepatic Impairment: For patients with heparin-induced thrombocytopenia with hepatic impairment, the initial dose of Argatroban should be reduced. For patients with moderate hepatic impairment, an initial dose of 0.5 µg/kg/min is recommended, based on the approximate four-fold decrease in Argatroban clearance relative to those with normal hepatic function. The aPTT should be monitored closely and the dosage should be adjusted as clinically indicated.

Patients with Renal Impairment: In a study of over 20 patients with renal impairment, and some who required dialysis, dosage adjustment was not necessary and dosages up to 5.0 µg/kg/min were administered with no medically significant safety concerns.

Conversion to oral anticoagulant therapy:

Initiating Oral Anticoagulant Therapy: When converting to oral anticoagulant therapy, a loading dose of warfarin should **not** be used because of the potential for combined effects on INR by the combination of Argatroban and warfarin. Initiate therapy using the expected daily dose of warfarin.

Co-Administration of Warfarin and Argatroban at Doses up to 2 µg/kg/min: The concomitant use of Argatroban with warfarin results in prolongation of INR beyond that produced by warfarin alone. Therefore, the previously established relationship between INR and bleeding risk are altered (for details, see ACTION AND CLINICAL PHARMACOLOGY). INR should be measured daily while Argatroban and warfarin are co-administered. In general, with doses of Argatroban up to 2 µg/kg/min, Argatroban can be discontinued when the INR is >4.0. After Argatroban is discontinued, repeat the INR measurement in 4 to 6 hours. If the repeat INR is below the desired therapeutic range, resume the infusion of Argatroban and repeat the procedure daily until the desired therapeutic range on warfarin alone is reached. The relationship between INR on combined therapy and warfarin alone is dependent on both the dose of Argatroban and the thromboplastin reagent used.

Co-Administration of Warfarin and Argatroban at Doses Greater than 2 µg/kg/min: For doses greater than 2 µg/kg/min, the relationship between INR on warfarin alone, and

warfarin plus Argatroban is less predictable. In this case, in order to predict the INR on warfarin alone, temporarily reduce the dose of Argatroban to a dose of 2 µg/kg/min. Repeat the INR on Argatroban and warfarin 4 to 6 hours after Argatroban reduction and follow the process outlined above for dosing Argatroban at up to 2 µg/kg/min.

Pharmaceutical Information

Drug substance

Common Name: Argatroban

Chemical Name: 1-[5-[(aminoiminomethyl)amino]-1-oxo-2[[[(1,2,3,4-tetrahydro-3-methyl-8-quinolinyl)sulfonyl]amino]pentyl]-4-methyl-2-piperidinecarboxylic acid, monohydrate.

Molecular Formula: C₂₃H₃₆N₆O₅S.H₂O

Molecular Weight: 526.66

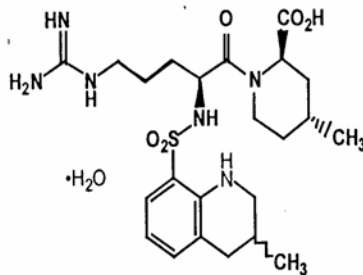
Description:

Argatroban is a synthetic, small-molecule, direct thrombin inhibitor derived from L-arginine. Argatroban has 4 asymmetric carbons. One of the asymmetric carbons has an *R* configuration (stereoisomer Type I) and an *S* configuration (stereoisomer Type II). Argatroban consists of a mixture of *R* and *S* stereoisomers at a ratio of approximately 65:35.

Argatroban is a white, odorless crystalline powder that is freely soluble in glacial acetic acid, slightly soluble in ethanol, and insoluble in acetone, ethyl acetate and ether.

Structural Formula:

Figure 3. Argatroban Structural Formula



Composition: Argatroban injection concentrate is a sterile clear, colorless to pale yellow, slightly viscous solution. Each mL of sterile, nonpyrogenic solution contains 100 mg Argatroban. Inert ingredients: D-sorbitol JP, dehydrated alcohol, USP and water for injection.

Stability and storage recommendations: Vials of Argatroban injection concentrate are stable until the date indicated on the package when stored at 15- 25°C. If the solution is cloudy, or if an insoluble precipitate is noted, the vial should be discarded.

Store the vials in original cartons at room temperature (15-25°C, 59-77°F). Do not refrigerate. Store in carton until use. PROTECT FROM LIGHT.

Parenteral products:

N x Vial size	Volume of diluent	Recommended diluents*	Concentration
1 x 2.5 mL (100 mg/mL)	250 mL	0.9% Sodium Chloride Injection, USP; or 5% Dextrose Injection, USP; or Lactated Ringer's Injection	1 mg/mL
2 x 2.5 mL (100 mg/mL)	500 mL	Same recommended diluents	1 mg/mL

*The constituted solution must be mixed by repeated inversion of the diluent bag for one minute.

Diluted solutions: Solutions prepared as recommended (see DOSAGE AND ADMINISTRATION) are stable at 15-25°C in ambient indoor light for 24 hours; therefore, light resistant measures such as foil protection for intravenous lines are unnecessary. Solutions are physically and chemically stable for up to 48 hours when stored at 2 to 8°C in the dark. Prepared solutions should not be exposed to direct sunlight. No significant potency losses have been noted following simulated delivery of the solution through intravenous tubing.

Special instructions: As with all parenteral drug products, intravenous admixtures should be inspected visually for clarity, particulate matter, precipitate, discoloration and leakage prior to administration, whenever solution and container permit. Solutions showing haziness, particulate matter, precipitate, discoloration or leakage should not be used. Discard unused portion.

Availability of Dosage Form

Argatroban Injection Concentrate is supplied in 2.5 mL solution in single-use vials at the concentration of 100 mg/mL. Each vial contains 250 mg of Argatroban.

Information to the Patient

Argatroban is administered in the hospital setting under medical surveillance

Toxicology

Mutagenicity

Carcinogenesis, Mutagenesis, Impairment of Fertility: *In vitro* assays designed to assess the mutagenic potential of Argatroban in bacteria (Ames, rec-A), effects on DNA synthesis (W1-38 cells), or the ability of Argatroban to induce chromosomal aberrations were conducted both in the presence or absence of metabolic activation. The results indicate that Argatroban does not possess mutagenic potential.

Reproduction and Teratology

Reproduction studies in rats and rabbits at doses up to two times the recommended dose in man have revealed no evidence of impaired fertility or harm to the fetus due to Argatroban.

Overall, in reproductive studies with Argatroban in animals, there were no indications of impaired parental reproductive capacity, embryotoxicity, fetotoxicity, teratogenicity, or effects on weaning, lactation, normal development, or reproductive competence of progeny. The parental "no-effect doses" were 54.9 mg/m² in rats and 127.4 mg/m² in rabbits; fetal "no-effect doses" were 164.7 mg/m² in rats and 127.4 mg/m² in rabbits.

Pregnancy in Animals: Reproduction studies performed in rats and rabbits at doses up to two times the recommended dose in man have revealed no evidence of impaired fertility or harm to the fetus due to Argatroban.

Nursing Mothers: Experiments in rats show that Argatroban is detected in milk. It is not known whether this drug is excreted in human milk.

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Mississauga, Ontario L4W 4Y3