

ZCORT 7 DAY (dexamethasone tablets, USP 1.5 mg)

7-DAY DOSEPAK

TABLET BLISTER PANEL

ZCORT 7-DAY

☀ AM 🌙 PM

DAY 1 Take 3 tablets before breakfast Take 3 tablets after evening meal

DAY 2 Take 3 tablets before breakfast Take 2 tablets after evening meal

DAY 3 Take 2 tablets before breakfast Take 2 tablets after evening meal

DAY 4 Take 2 tablets before breakfast Take 2 tablets after evening meal

DAY 5 Take 2 tablets before breakfast Take 1 tablet after evening meal

DAY 6 Take 1 tablet before breakfast Take 1 tablet after evening meal

DAY 7 Take 1 tablet before breakfast

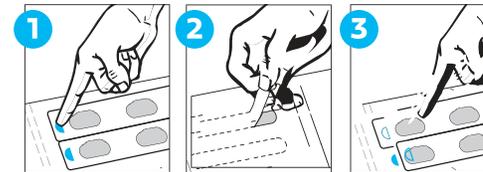
INSTRUCTIONS PANEL

Unless otherwise instructed by your healthcare practitioner, the first six (6) tablets should be taken on the day you received your prescription. If the medication is received late in the day, take three (3) tablets with evening meal and three (3) tablets at bedtime. These doses should be at least three (3) hours apart. Follow the dosage instructions listed below thereafter.

Do not discontinue this medication without consulting your healthcare practitioner.

ZCORT 7-DAY (dexamethasone tablets, USP 1.5 mg)

KEEP OUT OF REACH OF CHILDREN



INSTRUCTIONS:

1. Push through half-circle to open tab on front
2. Turn card over and peel tab to expose foil.
3. Push on plastic blister to dispense.

INDICATIONS AND USAGE

Allergic States: Control of severe or incapacitating allergic conditions intractable to adequate trials of conventional treatment in asthma, atopic dermatitis, contact dermatitis, drug hypersensitivity reactions, perennial or seasonal allergic rhinitis, and serum sickness.

Dermatologic Diseases: Bullous dermatitis herpetiformis, exfoliative erythroderma, mycosis fungoides, pemphigus, and severe erythema multiforme (Stevens-Johnson syndrome).

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

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

Hematologic Disorders: Acquired (autoimmune) hemolytic anemia, congenital (erythroid) hypoplastic anemia (Diamond-Blackfan anemia), idiopathic thrombocytopenic purpura in adults, pure red cell aplasia, and selected cases of secondary thrombocytopenia.

Miscellaneous: Diagnostic testing of adrenocortical hyperfunction, trichinosis with neurologic or myocardial involvement, tuberculous meningitis with subarachnoid block or impending block when used with appropriate antituberculous chemotherapy.

Neoplastic Diseases: For the palliative management of leukemias and lymphomas.

Nervous System: Acute exacerbations of multiple sclerosis, cerebral edema associated with primary or metastatic brain tumor, craniotomy, or head injury.

Ophthalmic Diseases: Sympathetic ophthalmia, temporal arteritis, uveitis, and ocular inflammatory conditions unresponsive to topical corticosteroids.

Renal Diseases:

To induce a diuresis or remission of proteinuria in idiopathic nephrotic syndrome or that due to lupus erythematosus.

Respiratory Diseases: Berylliosis, fulminating or disseminated pulmonary tuberculosis when used concurrently with appropriate antituberculous chemotherapy, idiopathic eosinophilic pneumonias, symptomatic sarcoidosis.

Rheumatic Disorders: As adjunctive therapy for short-term administration (to tide the patient over an acute episode or exacerbation) in acute gouty arthritis, acute rheumatic carditis, ankylosing spondylitis, psoriatic arthritis, rheumatoid arthritis, including juvenile rheumatoid arthritis (selected cases may require low-dose maintenance therapy). For the treatment of dermatomyositis, polymyositis, and systemic lupus erythematosus.

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CONTRAINDICATIONS

Contraindicated in systemic fungal infections and patients with known hypersensitivity to the product and its constituent.

WARNINGS

General

Rare instances of anaphylactoid reactions have occurred in patients receiving corticosteroid therapy.

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 cortico-steroids can cause elevation of blood pressure, sodium 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 in the event of surgical 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 months after discontinuation of therapy; therefore, in any situation of stress occurring during this period, normal therapy should be reinstituted. 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.

Infections

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 and should be considered with other possible causative agents. These infections may be mild to severe. With increasing doses of corticosteroids, the rate of occurrence of infectious complications increases. 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.

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 caution 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 corticosteroids in active tuberculosis should be restricted to those cases fulfilling one of disseminated tuberculosis in which the corticosteroid is used for the management of the disease in conjunction with an appropriate anti-tuberculous 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 cannot be predicted. Immunization procedures may be performed in patients who are receiving 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. 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 immune globulin (IG) may be indicated. (See the respective package inserts for VZIG and IG for complete prescribing information.) If chickenpox develops, treatment with antiviral agents should 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.

PRECAUTIONS

General

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 corticosteroids 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.

Endocrine

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 reinstituted. Since mineralocorticoid secretion may be impaired, salt and/or a mineralocorticoid should be administered concurrently.

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. Special consideration should be given to patients at increased risk of osteoporosis (e.g., postmenopausal women) before initiating corticosteroid therapy.

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.

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 creatine kinase may occur. Clinical improvement or recovery after stopping corticosteroids may require weeks to years.

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.

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 if 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

Aminoglutethimide: Aminoglutethimide may diminish adrenal suppression by corticosteroids.

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.

Anticholinesterases: Concomitant use of anticholinesterase agents 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.

Anticoagulants, Oral: Co-administration of corticosteroids and warfarin usually results in inhibition of response to warfarin, although there have been some conflicting reports. Close patient monitoring is necessary and should be 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.

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.

Dexamethasone Suppression Test (DSD: False-negative results in the dexamethasone suppression test (DSD in patients being treated with indomethacin have been reported. Thus, results of the DST should be interpreted with caution in these patients.

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

Ephedrine: Ephedrine may enhance the metabolic clearance of corticosteroids, resulting in decreased blood levels and lessened physiologic activity, thus requiring an increase in corticosteroid dosage.

Estrogens, including Oral Contraceptives: Estrogens may decrease the hepatic metabolism of certain corticosteroids, thereby increasing their effect.

Hepatic Enzyme Inducers, Inhibitors and Substrates: Drugs which induce cytochrome P450 3A4 (CYP 3A4) enzyme activity (e.g., carbamazepine, phenytoin, rifampin, phenobarbital) may enhance the metabolism of corticosteroids and require that the dosage of the corticosteroid be increased. Drugs which inhibit CYP 3A4 (e.g., ketoconazole, macrolide antibiotics such as erythromycin) have the potential to result in increased plasma concentrations of corticosteroids. Dexamethasone is a moderate CYP 3A4 inhibitor. Concomitant use 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 antiinflammatory 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.

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.

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.

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 should be avoided during pregnancy unless 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/or 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. Like adults, pediatric patients should be carefully observed with frequent measurements of blood pressure, weight, height, intraocular pressure, and clinical signs/symptoms of the presence of infection, psychosocial disturbances, thrombocytolism, 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 near 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 addition, 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 dexamethasone or other corticosteroids:

Allergic Reactions: Anaphylactoid reaction, anaphylaxis, angioedema.

Cardiovascular: Bradycardia, cardiac arrest, cardiac arrhythmias, cardiac enlargement, circulatory collapse, congestive heart failure, fat embolism, hypertension, hypertrophic cardiomyopathy in premature infants, myocardial rupture following recent myocardial infarction, edema, euglycemic hypokalemia, stroke, thrombocytopenia, thromboembolism, thrombophlebitis, vasculitis.

Dermatologic: Acne, allergic dermatitis, dry scaly skin, eczema, erythema and petechiae, erythema, impetigo, wound healing, increased sweating rash, striae, suppression of reactions to skin tests, thin fragile skin, thinning scalp hair, urticaria.

Endocrine: Decreased carbohydrate and glucose tolerance, development of cushingoid state, hyperglycemia, glycosuria, hirsutism, hypertrichosis, increased requirements for insulin or oral hypoglycemic agents in diabetes, manifestations of latent diabetes mellitus, menstrual irregularities, secondary adrenocortical and pituitary unresponsiveness (particularly in times of stress, as in trauma, surgery, or illness), suppression of growth in pediatric patients.

Fluid and Electrolyte Disturbances: Congestive heart failure in susceptible patients, fluid retention, hypokalemic alkalosis, potassium loss, sodium retention, tumor lysis syndrome.

Gastrointestinal: Abdominal distention, elevation in serum liver enzyme levels (usually reversible upon discontinuation), hepatomegaly, increased appetite, nausea, pancreatitis, peptic ulcer with possible perforation and hemorrhage, perforation of the small and large intestine (particularly associated with inflammatory bowel disease), ulcerative esophagitis.

Metabolic: Negative nitrogen balance due to protein catabolism.

Musculoskeletal: Aseptic necrosis of femoral and humeral heads, loss of muscle mass, muscle weakness, osteoporosis, pathologic fracture of long bones, steroid myopathy, tendon rupture, vertebral compression fractures.

Neurological/Psychiatric: Convulsions, depression, emotional instability, euphoria, headache, increased intracranial pressure with papilledema (pseudotumor cerebri) usually following discontinuation of treatment, insomnia, mood swings, neuritis, neuropathy, paresthesia, personality changes, psychic disorders, vertigo.

Ophthalmic: Exophthalmos, glaucoma, increased intraocular pressure, posterior subcapsular cataracts.

Other: Abnormal fat deposits, decreased resistance to infection, hiccups, increased or decreased motility and number of spermatozoa, malaise, moon face, weight gain.

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