A. MENARINI
FARMACEUTICA
INTERNAZIONALE SRL

COMMITTED TO FIGHTING LIFE-THREATENING BACTERIAL INFECTIONS

TENKASI®▼
oritavancin

A single-dose lipoglycopeptide with *in vitro* activity against MRSA and VRE*[1,2]

Indicated in adults for the treatment of acute bacterial skin and skin structure infections (ABSSSI)[1]

QUOFENIX®▼
delafloxacin

Oral and IV options for MRSA and *Pseudomonas aeruginosa*[3-5]

Indicated in adults for the treatment of:[3,4]

- Acute bacterial skin and skin structure infections (ABSSSI)
- Community-acquired pneumonia (CAP)

(when it is considered inappropriate to use other antibacterial agents that are commonly recommended for the initial treatment of these infections)

VABOREM®▼
meropenem/vaborbactam

Optimised for the treatment of KPC-CRE[6-10]

Indicated in adults for the treatment of:[6]

- Complicated urinary tract infection (cUTI), including pyelonephritis
- Complicated intra-abdominal infection (cIAI)
- Hospital-acquired pneumonia (HAP), including ventilator-associated pneumonia (VAP)
- Patients with bacteraemia that occurs in association with, or is suspected to be associated with, any of the infections listed above
- Infections due to aerobic Gram-negative organisms in adults with limited treatment options

Consideration should be given to official guidance on the appropriate use of antibacterial agents.[1,3,4,6]
Prescribing information can be found at the end of this material.
**In vitro* activity does not necessarily infer clinical effectiveness.
CRE, carbapenem-resistant *Enterobacterales*; IV, intravenous; KPC, *Klebsiella pneumoniae* carbapenemase; MRSA, methicillin-resistant *Staphylococcus aureus*; VRE, vancomycin-resistant enterococci.

Prepared: April 2023. PP-AI-UK-0527.

TENKASI®▼
oritavancin

A single-dose lipoglycopeptide for the treatment of ABSSSI[1]

A POTENTIAL SOLUTION FOR HARD-TO-REACH PATIENTS WITH ABSSSI

TENKASI is a lipoglycopeptide that helps tackle difficult-to-treat Gram-positive infections in a **single dose**[1,11,12] and can help **address compliance** in hard-to-reach, challenging patients such as IVDUs.[13]

- Potent *in vitro* Gram-positive activity against MSSA, MRSA, VRE (including VanA and VanB phenotypes)*[2]
- Non-inferior efficacy to twice-daily vancomycin in patients with ABSSSI[11,12]
- Generally well tolerated and does not require adjustments for mild-to-moderate renal or hepatic impairment, weight or age[1,12]
- Can be administered in an outpatient setting and helps spare OPAT resources[13]
- Can help reduce the risks associated with multiple IV administrations[12]

**In vitro* activity does not necessarily infer clinical effectiveness.
ABSSSI, acute bacterial skin and skin structure infections; IVDU, intravenous drug user; MRSA, methicillin-resistant *Staphylococcus aureus;* MSSA, methicillin-susceptible *Staphylococcus aureus;* OPAT, outpatient parenteral antibiotic therapy; VRE, vancomycin-resistant enterococci.

QUOFENIX®▼
delafloxacin

Broad-spectrum IV-to-oral monotherapy for complex patients with difficult-to-treat infections[3,4]

HELP GET PATIENTS HOME WITH IV TO ORAL STEP-DOWN THERAPY

For treatment of **ABSSSI** or **CAP** with a spectrum of activity against Gram-positive and Gram-negative bacteria, anaerobes and atypical pathogens.[3,4,14–16]

- Good *in vitro* activity against MRSA, *Streptococcus* spp. and *Pseudomonas aeruginosa*[3,4,14–16]
- Potential monotherapy for polymicrobial infections[3,4]
- Generally well tolerated with low potential for drug-drug interactions[3–5]
- Not associated with clinically relevant QTc prolongation[17] or phototoxicity[18]
- IV and oral options help facilitate hospital discharge[19]

ABSSSI, acute bacterial skin and skin structure infections; CAP, community-acquired pneumonia; MRSA, methicillin-resistant *Staphylococcus aureus*.

VABOREM®▼
meropenem/vaborbactam

A monotherapy solution for **carbapenem-resistant GNB infections**[6,7]

SUSPECTED KPC-CRE? THINK VABOREM

VABOREM is a combination of meropenem and vaborbactam (a first-in-class cyclic boronic acid ß-lactamase inhibitor).[6,7]

Vaborbactam inhibits ESBLs and class A carbapenemases including **KPC.**[6,20]

While optimised for the treatment of KPC-producing CRE, VABOREM also has utility for the treatment of other aerobic GNB infections with susceptibility.[6]

- Optimised for the treatment of KPC-CRE infections[7] and a preferred agent for these infections over traditional CRE therapies[21]
- Retains activity against KPC mutants resistant to ceftazidime-avibactam[22]
- In TANGO II, VABOREM monotherapy was associated with increased clinical cure rates and a marked trend towards lower mortality vs BAT*[23]
- Favourable safety profile in the TANGO II study with fewer renal AEs vs BAT[23]
- Can potentially be combined with aztreonam for treatment of MBL-producing *Enterobacterales* when there is susceptibility[24-26]

*TANGO II was a phase 3, multinational, multicentre, descriptive study; no formal power or sample size calculations were performed.[23]
AE, adverse event; BAT, best available therapies; CRE, carbapenem-resistant *Enterobacterales;* GNB, Gram-negative bacteria; KPC, *Klebsiella pneumoniae* carbapenemase; MBL, metallo-ß-lactamase.

VABOREM Prescribing Information

Prescribing Information: Vaborem®▼ (meropenem/vaborbactam) 1g/1g powder for concentrate for solution for infusion.
Please consult the Summary of Product Characteristics (SmPC) for full prescribing information.
Presentation: Powder for concentrate for solution for infusion.
Use: Adults: complicated urinary tract infection (cUTI), including pyelonephritis; complicated intra-abdominal infection (cIAI); hospital-acquired pneumonia (HAP), including ventilator associated pneumonia (VAP). Patients with bacteraemia that occurs in association with, or is suspected to be associated with, any of the infections listed above. Treatment of infections due to aerobic Gram-negative organisms in adults with limited treatment options.
Dosage and administration: Dose: patients with creatinine clearance ≥40ml/min, 2g/2g infused intravenously over 3 hours every 8 hours. 1g/1g infused intravenously over 3 hours every 8 hours recommended when creatinine clearance is between 20 and 39 ml/min, and every 12 hours when creatinine clearance is between 10 to 19 ml/min. When creatinine clearance is less than 10 ml/min 0.5g /0.5g should be infused intravenously over 3 hours every 12 hours. No dose adjustment for age is required, nor for hepatic impairment. Duration of treatment: *5 to 10 days* (up to 14 days) for patients with cUTI, including pyelonephritis, and cIAI. *7 to 14 days* for HAP, including VAP. *Duration variable, in accordance with the site of infection*: bacteraemia, and infections due to aerobic Gram-negative organisms in patients with limited treatment options.
Contra-indications: Hypersensitivity to any active constituent or excipient, or to any carbapenem antibacterial agent. History of severe hypersensitivity to any other type of beta-lactam antibacterial agent.
Warnings and Precautions: Serious and occasionally fatal hypersensitivity reactions have been reported with meropenem and/or meropenem/vaborbactam. Severe cutaneous adverse reactions have been reported with meropenem. Seizures have been reported with meropenem. Monitor hepatic function due to the risk of hepatic toxicity. A positive direct or indirect Coombs test may develop during treatment with meropenem/vaborbactam as seen with meropenem. The use of meropenem/vaborbactam may result in the overgrowth of non-susceptible organisms. *Clostridium difficile*-associated diarrhoea has been reported with meropenem/vaborbactam. Concomitant use with valproic acid/sodium valproate/valpromide as carbapenems may reduce plasma levels of valproic acid to concentrations below the therapeutic range. Use of Vaborem in cIAI, HAP, including VAP is based on experience with meropenem alone and pharmacokinetic-pharmacodynamic analyses for meropenem-vaborbactam. Use of Vaborem in patients with limited treatment options is based on pharmacokinetic-pharmacodynamic analyses for meropenem-vaborbactam and on limited data from a randomised clinical trial. The inhibitory spectrum of vaborbactam includes class A carbapenemases (such as KPC) and class C carbapenemases. Vaborbactam does not inhibit class D carbapenemases such as OXA-48 or class B metallo-β-lactamases such as NDM and VIM. Contains 250 mg of sodium per vial.
Interactions: Patients taking medicinal products that are predominantly metabolised by CYP1A2 (e.g theophylline), CYP3A4 (e.g alprazolam, midazolam, tacrolimus, sirolimus, cyclosporine, simvastatin, omeprazole, nifedipine, quinidine and ethinylestradiol) and/or CYP2C (e.g. warfarin, phenytoin) and/or transporters by P-gp (e.g. dabigatran, digoxin) should be monitored for possible clinical signs of altered therapeutic efficacy. Co-administration of probenecid is not recommended. When concomitant administration of valproic acid cannot be avoided, supplemental anticonvulsant therapy should be administered. Oral anticoagulants: It is recommended that the INR should be monitored frequently during and shortly after co-administration with an oral anticoagulant. Contraceptives: Women of childbearing potential should be advised to use alternative effective contraceptive methods during treatment and for a period of 28 days after discontinuation of treatment.
Pregnancy and lactation: Avoid during pregnancy. Discontinue breastfeeding prior to initiating therapy.
Side-effects: Most common adverse reactions in Phase 3 trials: headache (8.1%), diarrhoea (4.7%), infusion site phlebitis (2.2%) and nausea (2.2%). Severe and/or serious adverse effects occurred in 0.9% patients (2 infusion-related reactions and one increase of alkaline phosphatase). Additional adverse reactions with meropenem alone and/or in Phase 3 trials with Vaborem: Common: thrombocythaemia, hypokalaemia, hypoglycaemia, hypotension, vomiting, increased ALT, increased AST, increased blood alkaline phosphatase, increased blood lactate dehydrogenase, pyrexia. Uncommon: *Clostridium difficile* colitis, vulvovaginal candidiasis, oral candidiasis, leucopenia, neutropenia, eosinophilia, thrombocytopenia, anaphylactic reaction, hypersensitivity, decreased appetite, hyperkalaemia, hyperglycaemia, insomnia, hallucination, tremor, lethargy, dizziness, paraesthesia, phlebitis, vascular pain, bronchospasm, abdominal distension, abdominal pain, increased blood bilirubin, pruritus, rash, urticaria, renal impairment, incontinence, increased blood creatinine, increased blood urea, chest discomfort, infusion site reaction, infusion site erythema, injection site phlebitis, infusion site thrombosis, pain, increased blood creatine phosphokinase, infusion related reaction. Rare: convulsions. Unknown frequency: agranulocytosis, haemolytic anaemia, angioedema, delirium, severe cutaneous adverse reactions (such as toxic epidermal necrolysis, Stevens-Johnson syndrome, erythema multiforme, DRESS syndrome, acute generalised exanthematous pustulosis), direct and indirect Coombs test positive.
Package quantities and price: Packs of 6 vials: £334.00.
Legal category: POM.
Marketing Authorisation Holder: Menarini International Operations Luxembourg S.A.
Marketing Authorisation number: EU/1/18/1334/001.
Marketed by: A. Menarini Farmaceutica Internazionale SRL.
Further information is available on request to A. Menarini Farmaceutica Internazionale SRL, Menarini House, Mercury Park, Wycombe Lane, Wooburn Green, Buckinghamshire, HP10 0HH, UK or may be found in the SmPC.
Last updated: June 2022.

This medicinal product is subject to additional monitoring. Adverse events should be reported. Reporting forms and information can be found at www.mhra.gov.uk/yellowcard or search for MHRA Yellow Card in the Google Play or Apple App Store. Adverse events should also be reported to A. Menarini Farmaceutica Internazionale SRL. Phone 0800 085 8678 or email: menarini@medinformation.co.uk

QUOFENIX Prescribing Information

Prescribing Information: ▼Quofenix (delafloxacin) 300 mg powder for concentrate for solution for infusion and ▼Quofenix (delafloxacin) 450 mg tablets

Please consult the Summary of Product Characteristics (SmPC) for full prescribing information.

Presentation: Powder for concentrate for solution for infusion (powder for concentrate). Oblong biconvex tablets.

Use: Adults: Treatment of acute bacterial skin and skin structure infections (ABSSSI) and community-acquired pneumonia (CAP) when considered inappropriate to use other antibacterial agents commonly recommended for initial treatment of these infections.

Dosage and administration: Infusion: 300 mg every 12 hours administered over 60 minutes by intravenous infusion. Switch to 450 mg tablet orally every 12 hours is possible at the physician's discretion. Tablets: 450 mg every 12 hours with or without food. Duration of treatment: 5 to 14 days for ABSSSI and 5 to 10 days for CAP. No adjustment for age required, nor for hepatic impairment. Renal impairment: Not recommended in End Stage Renal Disease (ESRD). *Infusion:* No dosage adjustment for mild to moderate renal impairment. Severe renal impairment (CrCl of <30 mL/min) decrease dose to 200 mg every 12 hours; alternatively give 450 mg delafloxacin orally every 12 hours. *Tablets:* No dose adjustment necessary in patients with mild to severe renal impairment.

Contraindications: Hypersensitivity to the active substance, any of the excipients, or to any fluoroquinolone/quinolone. History of tendon disorders related to fluoroquinolones. Pregnancy, women of childbearing potential not using contraception, breast-feeding. Children or adolescents below 18 years of age.

Warnings and Precautions: Patients who have previously experienced serious adverse reactions using quinolone/fluoroquinolones: avoid use. Treatment of these patients should only be initiated in the absence of alternatives and after careful risk/benefit assessment. Contraception: effective contraception must be used during treatment of sexually mature women. Aortic aneurysm and dissection, and heart valve regurgitation/incompetence: epidemiology studies report an increased risk of aortic aneurysm and dissection, particularly in elderly patients, and of aortic and mitral valve regurgitation after intake of fluoroquinolones. Cases of aortic aneurysm and dissection, sometimes complicated by rupture (including fatal ones), and of regurgitation/incompetence of any of the heart valves have been reported in patients receiving fluoroquinolones. Therefore, fluoroquinolones should only be used after careful benefit-risk assessment and after consideration of other therapeutic options in patients with positive family history of aneurysm disease or congenital heart valve disease, or in patients diagnosed with pre-existing aortic aneurysm and/or aortic dissection or heart valve disease, or in presence of other risk factors or conditions predisposing for both aortic aneurysm and dissection and heart valve regurgitation/incompetence. The risk of aortic aneurysm and dissection, and their rupture may also be increased in patients treated concurrently with systemic corticosteroids. In case of sudden abdominal, chest or back pain, patients should be advised to immediately consult a physician in an emergency department. Patients should be advised to seek immediate medical attention in case of acute dyspnoea, new onset of heart palpitations, or development of oedema of the abdomen or lower extremities. Tendinitis and tendon rupture: this may occur within 48 hours of starting treatment with quinolones/fluoroquinolones up to several months after discontinuation. Risk increased in older patients, renal impairment, solid organ transplants, and those treated concurrently with corticosteroids. Therefore, avoid comcomitant use with corticosteroids. Discontinue at first sign of tendinitis. Peripheral neuropathy: sensory or sensorimotor polyneuropathy resulting in paraesthesia, hypaesthesia, dysaesthesia or weakness reported with quinolones/fluoroquinolones. CNS effects: Fluoroquinolones have been associated with increased risk of central nervous system (CNS) reactions, including convulsions, increased intracranial pressure and toxic psychosis. Fluoroquinolones may also cause CNS reactions: nervousness, agitation, insomnia, anxiety, nightmares, paranoia, dizziness, confusion, tremors, hallucinations, depression and suicidal thoughts/ acts which may occur following first dose. If these reactions occur, discontinue delafloxacin immediately and institute appropriate measures. Myasthenia gravis: fluoroquinolones may exacerbate muscle weakness in myasthenia gravis. *Clostridioides difficile*-associated disease has been reported with systemic antibacterial medicinal products. Medicinal products inhibiting peristalsis contraindicated if *Clostridioides difficile*-associated disease suspected. Hypersensitivity reactions: serious and occasionally fatal reactions have been reported with fluoroquinolones. Discontinue immediately if an anaphylactic reaction occurs and institute appropriate therapy. Renal impairment: Not recommended in ESRD. *Infusion:* Dose adjustment needed in patients with severe renal impairment. Safety and efficacy of dose adjustment guidance in these patients has not been clinically evaluated and is based on pharmacokinetic modelling data. Only use in such patients when expected clinical benefit outweighs potential risk. Clinical response to treatment and renal function should be closely monitored in these patients. Accumulation of the intravenous vehicle sulfobutylbetadex sodium occurs in patients with moderate to severe renal impairment; therefore serum creatinine levels should be monitored closely in these patients, and, if increases occur, consider switching to tablets, 450 mg every 12 hours. *Tablets:* Safety and efficacy in patients with severe renal impairment has not been clinically evaluated and is based on pharmacokinetic modelling data. Only use in such patients when the expected clinical benefit outweighs the potential risk. Clinical response to treatment and renal function should be closely monitored in these patients. Administration in patients with severe renal impairment and low body weight may lead to increased systemic exposures. Limitations of clinical data: trials in ABSSSI included cellulitis/erysipelas, abscesses and wound infections only. Other skin infections not studied. In the CAP study population 90.7% of patients had a CURB-65 score of ≤2. However 69.3% of patients were PORT class III, and 30.7% of patients had PORT scores >III. Prolonged, disabling and potenitally irreversible serious adverse drug reactions (ADR): very rare cases of such reactions affecting different, sometimes multiple, body systems reported with quinolones/fluoroquinolones irrespective of age and pre-existing risk factors. Discontinue immediately at the first signs of any serious ADRs. Superinfection: fluoroquinolone non-susceptible microorganisms may result in superinfection. Dysglycaemia: as with all quinolones, blood glucose disturbances, including hypoglycaemia and hyperglycaemia have been reported, usually in diabetic patients receiving concomitant oral hypoglycaemic agent or insulin. Serious bullous skin reactions: Stevens-Johnson syndrome, toxic epidermal necrolysis, reported with other fluoroquinolones. Glucose-6-phosphate dehydrogenase deficiency: caution in patients with history or family history of G6PD deficiency. Sodium content: powder for infusion and tablets contain sodium.

Interactions: Chelation active substance: antacids, sucralfate, metal cations, multivitamins, didanosine. Tablets: Take tablets at least 2 hours before or 6 hours after these agents. Infusion: Do not co-administer infusion with any solution containing multivalent cations, e.g. magnesium, through the same intravenous line.

Pregnancy and lactation: Contraindicated during pregnancy and in women of childbearing potential not using contraception. Breast-feeding is contraindicated.

Side-effects: as reported in phase 2/3 studies. Common: most frequently reported were diarrhoea, nausea, and hypertransaminasaemia. Other common reactions were vomiting, headache, pruritis, fungal infection and, with IV dosing only, infusion site reaction. Uncommon: *Clostridioides difficile* infection, hypersensitivity, hyperglycaemia, decreased appetite, insomnia, peripheral neuropathy, dizziness, dysgeusia, blurred vision, palpitations, hypertension, hypotension, flushing, dyspnoea, stomatitis, abdominal pain, dyspepsia, dry mouth, flatulence, constipation, blood alkaline phosphatase increased, allergic dermatitis, urticaria, rash, hyperhidrosis, arthralgia, myalgia, tendonitis, musculoskeletal pain, muscle weakness, blood creatine phosphokinase increased, renal impairment, pyrexia, local swelling, fatigue. Rare: urinary tract infection, sinusitis, thrombocytopenia, neutropenia, international normalised ratio increased, seasonal allergy, hypoglycaemia, hyperuricaemia, hypokalaemia, blood potassium increased, auditory hallucinations, anxiety, abnormal dreams, confusional state, presyncope, somnolence, dry eye, vertigo, tinnitus, vestibular disorder, sinus tachycardia, bradycardia, deep vein thrombosis, phlebitis, cough, dry throat, erosive gastritis, gastrooesophageal reflux disease, oral paraesthesia, oral hypoaesthesia, glossodynia, discoloured faeces, blood albumin decreased, gamma-glutamyltransferase increased, alopecia, cold sweats, night sweats, reactive arthritis, myositis, muscle spasm, haematuria, crystal urine present, peripheral oedema, chills, medical device complications and wound complications. Very rare cases of prolonged, disabling and potentially irreversible serious drug reactions affecting several, sometimes multiple, system organ classes and senses reported with use of quinolones/fluoroquinolones in some cases irrespective of pre-existing risk factors. Cases of aortic aneurysm and dissection, sometimes complicated by rupture (including fatal ones), and of regurgitation/incompetence of any of the heart valves have been reported in patients receiving fluoroquinolones. Refer to the SmPC for more detail.

Package quantities and price: 300 mg Powder for concentrate for solution for infusion: 10 vials £615.00; 450 mg Tablets: 10 tablets £615.00.

Legal category: POM.

Marketing Authorisation Holder: A. Menarini Industrie Farmaceutiche Riunite s.r.l. Via Sette Santi 3, 50131 Florence, Italy.

Marketing Authorisation Number: EU/1/19/1393/001-002.

Marketed by: A. Menarini Farmaceutica Internazionale SRL. Menarini House, Mercury Park, Wycombe Lane, Wooburn Green, Buckinghamshire, HP10 0HH. Further information is available on request to A. Menarini Farmaceutica Internazionale SRL, or may be found in the SmPC.

Last revised: March 2023

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PP-QUO-UK-0250 Date of preparation: April 2023

TENKASI Prescribing Information

▼ TENKASI (oritavancin) Prescribing Information
Please consult the Summary of Product Characteristics (SmPC) for full prescribing information.
Presentation: Tenkasi 400 mg powder for concentrate for solution for infusion. Each vial contains oritavancin diphosphate equivalent to 400 mg oritavancin. **Indication**: Treatment of acute bacterial skin and skin structure infections (ABSSSI) in adults. Consideration should be given to official guidance on appropriate use of antibacterial agents. **Dosage and administration**: 1200 mg administered as a single dose by intravenous infusion over 3 hours. Elderly: No dosage adjustment required for patients ≥ 65 years of age. Renal impairment: No dosage adjustment required for mild or moderate renal impairment. (Pharmacokinetics of oritavancin in severe renal impairment has not been evaluated). Oritavancin is not removed from blood by haemodialysis procedures. Hepatic impairment: No dosage adjustment for hepatic impairment but caution in patients with severe hepatic impairment (Child-Pugh Class C). Paediatric population: safety and efficacy in patients <18 years not yet established. **Contraindications**: Hypersensitivity to active substance or to any excipient. Use of intravenous heparin sodium is contraindicated for 120 hours after oritavancin administration because activated partial thromboplastin time (aPTT) test results may remain falsely elevated for up to 120 hours after oritavancin administration. **Warnings and Precautions**: Hypersensitivity reactions Serious hypersensitivity reactions, including anaphylactic reactions and anaphylactic shock have been reported. Cross-hypersensitivity: there should be careful monitoring of patients with any history of glycopeptide hypersensitivity during and after infusion. Infusion related reactions Oritavancin can cause reactions that resemble "red man syndrome", including flushing of the upper body, urticaria, pruritis and/or rash. Infusion-associated reactions characterized by chest pain, chest discomfort, chills, tremor, back pain, neck pain, dyspnoea, hypoxia, abdominal pain and fever have been observed. Need for additional antibacterial agents Oritavancin is active against Gram-positive bacteria only. In mixed infections where Gram negative and/or certain types of anaerobic bacteria are suspected, oritavancin should be co-administered with appropriate antibacterial agent(s). Concomitant use of warfarin Oritavancin artificially prolongs prothrombin time (PT) and international normalised ratio (INR) for up to 12 hours, making the monitoring of the anticoagulation effect of warfarin unreliable up to 12 hours after an oritavancin dose. Interference with assay for coagulation tests Oritavancin concentrations that are found in the blood of patients following administration of a single dose have been shown to artificially prolong: aPTT for up to 120 hours, PT and INR for up to 12 hours, *Activated Clotting Time* for up to 24 hours, *Silica Clot Time* for up to 18 hours, and *Dilute Russell's Viper Venom Test* for up to 72 hours. *Clostridioides difficile*-associated diarrhoea Antibacterial-associated colitis and pseudomembranous colitis have been reported for oritavancin and may range in severity from mild to life-threatening diarrhoea. Superinfection Antibacterial products may increase the risk of overgrowth of non-susceptible micro-organisms. Osteomyelitis In phase 3 trials, more cases of osteomyelitis were reported in the oritavancin-treated arm than in the vancomycin-treated arm. Monitor patients for signs and symptoms of osteomyelitis after administration of oritavancin. Abscess In phase 3 trials, slightly more newly emergent abscesses were reported in the oritavancin-treated arm than in the vancomycin-treated arm (4.6% vs 3.4%). Limitations of the clinical data In the two major trials in ABSSSI, infections treated were confined to cellulitis, abscesses and wound infections. Interactions: Oritavancin is a weak *inhibitor* (CYP2C9 and CYP2C19) and weak *inducer* (CYP3A4 and CYP2D6) of several CYP isoforms. Caution when administering oritavancin concomitantly with products that have a narrow therapeutic window and are predominantly metabolised by affected CYP450 enzymes (e.g. warfarin), as co-administration may alter concentrations of the narrow therapeutic range product. Incompatibilities: Sodium chloride solution should not be used for dilution as it may cause precipitation. Therefore, other substances, additives or other medicinal products mixed in sodium chloride solution for intravenous use should not be added to oritavancin single-use vials or infused simultaneously through the same intravenous line or through a common intravenous port. In addition, medicinal products formulated at a basic or neutral pH may be incompatible with oritavancin. Reconstitution: Oritavancin powder must be reconstituted with water for injections and the resulting concentrate must be diluted in a glucose 5% intravenous infusion bag prior to use. For single use only. Prepare oritavancin using aseptic technique in a pharmacy. Pregnancy and lactation: Avoid oritavancin during pregnancy unless potential benefit justifies potential risk to the foetus. Breast-feeding: a risk to the newborns/infants cannot be excluded. Driving and use of machinary: Dizziness may occur which can affect driving and use of machines. **Adverse reactions**: The most commonly reported adverse reactions were nausea, hypersensitivity and infusion site reactions, and headache. The most commonly reported serious adverse reaction was cellulitis (1.1%). The most common reported reasons for discontinuation were cellulitis (0.4%) and osteomyelitis (0.3%). Common adverse reactions as reported in pooled phase 3 ABSSSI trials (and not listed above) included abscess, anaemia, dizziness, tachycardia, vomiting, diarrhoea, constipation, abnormal liver function tests, urticaria, rash, pruritis, myalgia, infusion site reactions (including phlebitis, erythema, extravasation, induration, peripheral oedema). Uncommon and rare: hypoglycaemia, increased blood bilirubin, hyperuricaemia, eosinophilia, thrombocytopenia, hypersensitivity, anaphylactic reaction, anaphylactic shock [unknown frequency], tremor*, bronchospasm, wheezing, dyspnoea*, hypoxia*, back/neck/chest/abdominal pain*, chest discomfort*, pyrexia*, chills*, leucocytoclastic vasculitis, angioedema, erythema multiforme, flushing, red man syndrome, tenosynovitis. [* may be infusion-related]. In the event of overdose, supportive measures should be taken. Refer to SmPC for detail.
Package quantities and price: £1500 per pack (containing 3 vials of oritavancin 400 mg).
Legal category: POM.
Marketing Authorisation Holder: Menarini International Operations Luxembourg S.A.
Marketing Authorisation number: EU/1/15/989/001.
Marketed by: A. Menarini Farmaceutica Internazionale SRL. Menarini House, Mercury Park, Wycombe Lane, Wooburn Green, Buckinghamshire, HP10 0HH. Further information is available on request to A. Menarini Farmaceutica Internazionale SRL, or may be found in the SmPC.
Prescribing Information prepared: November 2021.
Prepared: January 2022. PP-ORB-UK-0011.

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A. MENARINI FARMACEUTICA INTERNAZIONALE SRL

PROVIDING SOLUTIONS FOR RESISTANT AND LIFE THREATENING BACTERIAL INFECTIONS

Antibiotic portfolio

To find out more about our antibiotic portfolio and to contact a company representative please email **antibiotics@menariniuk.com.**
UK healthcare professionals can also visit our website **www.menarinipro.co.uk**

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References: 1. TENKASI 400 mg powder for concentrate for solution for infusion SmPC. 2. Brade KD *et al. Infect Dis Ther* 2016; 5: 1–15. 3. QUOFENIX 300 mg powder for concentrate for solution for infusion SmPC. 4. QUOFENIX 450 mg tablets SmPC. 5. Giordano PA *et al. Clin Infect Dis* 2019; 68(Suppl 3): S223–S232. 6. VABOREM 1 g/1 g powder for concentrate for solution for infusion SmPC. 7. Hecker SJ *et al. J Med Chem* 2015; 58: 3682–3692. 8. Dhillon S. *Drugs* 2018; 78: 1259–1270. 9. Toussaint KA *et al. Ann Pharmacother* 2015; 49: 86–98. 10. Pogue JM *et al. Clin Infect Dis* 2019; 68: 519–524. 11. Corey GR *et al. N Engl J Med* 2014; 370: 2180–2190; 12. Corey GR *et al. Clin Infec Dis* 2015; 60: 254–262. 13. Tirupathi R *et al. J Community Hosp Intern Med Perspect* 2019; 9: 310–313. 14. Mogle BT *et al. J Antimicrob Chemother* 2018; 73: 1439–1451. 15. Jorgensen SCJ *et al. Infect Dis Ther* 2018; 7: 197–217. 16. Pfaller MA *et al. Antimicrob Agents Chemother* 2017; 61: e02609–02616. 17. Litwin JS *et al. Antimicrob Agents Chemother* 2015; 59: 3469–3473. 18. Dawe RS *et al. Photochem Photobiol Sci* 2018; 17: 773–780. 19. Dryden M *et al. J Antimicrob Chemother* 2012; 67: 2289–2296. 20. Petty, LA *et al. Infection and Drug Resistance* 2018; 11: 1461–1472. 21. Ackley R *et al. Antimicrob Agents Chemother* 2020; 64: e02313–19. 22. Novelli A *et al. Expert Rev Anti Infect Ther* 2020; 18: 643–655. 23. Wunderink RG *et al. Infect Dis Ther* 2018; 7: 439–455. 24. Meini S *et al. Infection* 2021; 49: 411–421. 25. Biagi M *et al. Antimicrob Agents Chemother* 2019; 63: e01426–19. 26. Maraki S *et al. Eur J Clin Microbiol Infect Dis* 2021; 40: 1755–1759.

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