

HIGHLIGHTS OF PRESCRIBING INFORMATION

These highlights do not include all the information needed to use PANTOPRAZOLE SODIUM FOR DELAYED-RELEASE ORAL SUSPENSION safely and effectively. See full prescribing information for PANTOPRAZOLE SODIUM FOR DELAYED-RELEASE ORAL SUSPENSION.

PANTOPRAZOLE SODIUM for delayed-release oral suspension Initial U.S. approval: 2000

----- RECENT MAJOR CHANGES Warnings and Precautions, Fundic Gland Polyps (5.9) 06/2018

----- INDICATIONS AND USAGE -----Pantoprazole sodium is a proton pump inhibitor (PPI) indicated for the

- · Short-Term Treatment of Erosive Esophagitis Associated with
- Gastroesophageal Reflux Disease (GERD) (1.1) Maintenance of Healing of Erosive Esophagitis (1.2)
- Pathological Hypersecretory Conditions Including Zollinger-Ellison (ZE)

Indication	Dose	Frequency		
Short-Term Treatment of Ero	sive Esop	phagitis Associated With GERD (2.1)		
Adults	40 mg	Once Daily for up to 8 wks		
Children (5 years and older) ≥ 40 kg	40 mg	Once Daily for up to 8 wks		
Maintenance of Healing of Erosive Esophagitis (2.1)				
Adults	40 mg	Once Daily*		
Pathological Hypersecretory Conditions Including Zollinger-Ellison Syndrome (2.1)				
Adults	40 mg	Twice Daily		

* Controlled studies did not extend beyond 12 months

See full prescribing information for administration instruct

---- DOSAGE FORMS AND STRENGTHS ---• For Delayed-Release Oral Suspension: 40 mg pantoprazole (3)

- ----- CONTRAINDICATIONS ------
- Patients with known hypersensitivity to any component of the formulation or to substituted benzimidazoles (4)
- Patients receiving rilpivirine-containing products (4,7)

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FULL PRESCRIBING INFORMATION

1 INDICATIONS AND USAGE

Pantoprazole sodium for delayed-release oral suspension is indicated for: 1.1 Short-Term Treatment of Erosive Esophagitis Associated With

Gastroesophageal Reflux Disease (GERD) Pantoprazole sodium for delayed-release oral suspension is indicated in adults and pediatric patients five years of age and older for the short-term treatment (up to 8 weeks) in the healing and symptomatic relief of erosive esophagitis (EE). For those adult patients who have not healed after 8 weeks of treatment, an additional 8-week course of pantoprazole sodium for delayed-release oral suspension may be considered. Safety of treatment beyond 8 weeks in pediatric patients has not been establish

1.2 Maintenance of Healing of Erosive Esophagitis

Pantoprazole sodium for delayed-release oral suspension is indicated for maintenance of healing of EE and reduction in relapse rates of daytime and nighttime heartburn symptoms in adult patients with GERD. Controlled studies did not extend beyond 12 months. 1.3 Pathological Hypersecretory Conditions Including Zollinger-Ellison

Pantoprazole sodium for delayed-release oral suspension is indicated for the

long-term treatment of pathological hypersecretory conditions, including Zollinger-Ellison (ZE) Syndrome

2 DOSAGE AND ADMINISTRATION

2.1 Recommended Dosing Schedule

Pantoprazole sodium is supplied as delayed-release granules in packets for preparation of oral suspensions. The recommended dosages are outlined in Table 1.

Table 1: Recommended Dosing Schedule for

Pantoprazole Sodium for Delayed-Release Oral Suspension				
Indication Dose Frequency				
Short-Term Treatment of Erosive Esophagitis Associated With GERD				
40 mg	Once daily for up to 8 weeks*			
40 mg	Once daily for up to 8 weeks			
Maintenance of Healing of Erosive Esophagitis				
40 mg	Once daily***			
Pathological Hypersecretory Conditions Including Zollinger-Ellison Syndrome				
40 mg	Twice daily**			
	Dose Dose 40 mg 40 mg 40 mg rosive Eso 40 mg			

- For adult patients who have not healed after 8 weeks of treatment, an additional 8-week course of pantoprazole sodium for delayed-release oral suspension may be considere Dosage regimens should be adjusted to individual patient needs and should continue for
- as long as clinically indicated. Doses up to 240 mg daily have been administered.
- *Controlled studies did not extend beyond 12 months 2.2 Administration Instructions

Directions for method of administration are presented in Table 2.

Table 2: Administration Instruction

Formulation	Route	Instructions*
For Delayed-Release Oral Suspension	Oral	Administered in 1 teaspoonful of applesauce or apple juice approximately 30 minutes prior to a meal
For Delayed-Release Oral Suspension	Nasogastric tube	See instructions below

* Do not split, chew, or crush Pantoprazole Sodium for Delayed-Release Oral Suspensio Take a missed dose as soon as possible. If it is almost time for the next dose, skip the missed dose and take the next dose at the regular scheduled time. Do not take 2 doses at the same time.

Administer pantoprazole sodium for delayed-release oral suspension approximately 30 minutes prior to a meal via oral administration in apple juice or applesauce or nasogastric tube in apple juice only. Because proper pH is necessary for stability, do not administer pantoprazole sodium for delayedrelease oral suspension in liquids other than apple juice, or foods other than

Do not divide the 40 mg pantoprazole sodium for delayed-release oral nsion packet to create a 20 mg dosage for pediatric patients who are unable to take the tablet formulation

Pantoprazole Sodium for Delayed-Release Oral Suspension - Oral

Administration in Applesauce

- Sprinkle granules on one teaspoonful of applesauce. DO NOT USE OTHER FOODS OR CRUSH OR CHEW THE GRANULES.
- Take within 10 minutes of preparation.
- . Take sips of water to make sure granules are washed down into the

stomach. Repeat water sips as necessary

Pantoprazole Sodium for Delayed-Release Oral Suspension - Oral Administration in Apple Juice

- · Open packet. Empty granules into a small cup or teaspoon containing one teaspoon of
- . Stir for 5 seconds (granules will not dissolve) and swallow immediately.
- . To make sure that the entire dose is taken, rinse the container once or twice with apple juice to remove any remaining granules. Swallow

--- WARNINGS AND PRECAUTIONS -----Gastric Malignancy: In adults, symptomatic response does not preclude presence of gastric malignancy. Consider additional follow-up and

- diagnostic testing. (5.1) Acute Interstitial Nephritis: Observed in patients taking PPIs. (5.2)
- Clostridium difficile-Associated Diarrhea: PPI therapy may be associated
- vith increased risk of *Clostridium difficile*-associated diarrhea. (5.3) Bone Fracture: Long-term and multiple daily dose PPI therapy may be associated with an increased risk for osteoporosis-related fractures of the hip, wrist or spine. (5.4)
- $\underline{\textit{Cutaneous and Systemic Lupus Erythematosus}}; \ \textit{Mostly cutaneous}; \ \textit{new}$ onset or exacerbation of existing disease; discontinue pantoprazole and
- refer to specialist for evaluation. (5.5) Cyanocobalamin (Vitamin B-12) Deficiency: Daily long-term use (e.g.,
- longer than 3 years) may lead to malabsorption or a deficiency of
- Hypomagnesemia: Reported rarely with prolonged treatment with PPIs. Fundic Gland Polyps: Risk increases with long-term use, especially

beyond one year. Use the shortest duration of therapy. (5.9)

- ----- ADVERSE REACTIONS ----Most common adverse reactions are:
- For adult use (>2%): headache, diarrhea, nausea, abdominal pain. vomiting, flatulence, dizziness, and arthralgia. (6.1)
- For pediatric use (>4%): URI, headache, fever, diarrhea, vomiting, rash, and abdominal pain, (6.1)

To report SUSPECTED ADVERSE REACTIONS, contact Sun Pharmaceutical Industries, Inc. at 1-800-818-4555 or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.

----- DRUG INTERACTIONS ------See full prescribing information for a list of clinically important drug

---- USE IN SPECIFIC POPULATIONS ----• Pregnancy: Based on animal data, may cause fetal harm. (8.1) See 17 for PATIENT COUNSELING INFORMATION and Medication Guide.

Revised: 02/2020

6.2 Postmarketing Experience

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* Sections or subsections omitted from the full prescribing information are

Pantoprazole Sodium for Delayed-Release Oral Suspension - Nasogastric (NG) Tube or Gastrostomy Tube Administration

- For patients who have a nasogastric tube or gastrostomy tube in place. pantoprazole sodium for delayed-release oral suspension can be given as follows: Remove the plunger from the barrel of a 2 ounce (60 mL) catheter-tip
- syringe. Discard the plunger. Connect the catheter tip of the syringe to a 16 French (or larger) tube. Hold the syringe attached to the tubing as high as possible while giving pantoprazole sodium for delayed-release oral suspension to prevent any bending of the tubing.
- Empty the contents of the packet into the barrel of the syringe. Add 10 mL (2 teaspoonfuls) of apple juice and gently tap and/or shake the barrel of the syringe to help rinse the syringe and tube. Repeat at least twice more using the same amount of apple juice (10 mL or 2

spoonfuls) each time. No granules should remain in the syringe. 3 DOSAGE FORMS AND STRENGTHS

For Delayed-Release Oral Suspension 40 mg pantoprazole, pale yellowish to dark brownish, enteric-coated granules in a unit-dose packet

CONTRAINDICATIONS

- Pantoprazole sodium for delayed-release oral suspension is contraindicated in patients with known hypersensitivity to any component of the formulation or any substituted benzimidazole. Hypersensitivity reactions may include anaphylaxis, anaphylactic shock, angioedema bronchospasm, acute interstitial nephritis, and urticaria [see Adverse Reactions (6)].
- Proton pump inhibitors (PPIs), including pantoprazole sodium for delayed-release oral suspension, are contraindicated with rilpivirinecontaining products [see Drug Interactions (7)]

5 WARNINGS AND PRECAUTIONS

5.1 Presence of Gastric Malignancy In adults, symptomatic response to therapy with pantoprazole sodium for delayed-release oral suspension does not preclude the presence of gastric malignancy. Consider additional follow-up and diagnostic testing in adult patients who have a suboptimal response or an early symptomatic relapse after completing treatment with a PPI. In older patients, also consider an endoscopy.

5.2 Acute Interstitial Nephritis

Acute interstitial nephritis has been observed in patients taking PPIs including pantoprazole. Acute interstitial nephritis may occur at any point during PPI therapy and is generally attributed to an idiopathic hypersensitivity reaction nue pantoprazole sodium for delayed-release oral suspension if acute interstitial nephritis develops [see Contraindications (4)].

5.3 Clostridium difficile-Associated Diarrhea Published observational studies suggest that PPI therapy like pantoprazole may be associated with an increased risk of Clostridium difficile associated diarrhea, especially in hospitalized patients. This diagnosis should be considered for diarrhea that does not improve [see Adverse Reactions (6.2)]. Patients should use the lowest dose and shortest duration of PPI therapy

appropriate to the condition being treated. 5.4 Bone Fracture

Several published observational studies suggest that PPI therapy may be associated with an increased risk for osteoporosis-related fractures of the hip, wrist, or spine. The risk of fracture was increased in patients who received high-dose, defined as multiple daily doses, and long-term PPI therapy (a year or longer). Patients should use the lowest dose and shortest duration of PPI therapy appropriate to the condition being treated. Patients at risk for osteoporosis-related fractures should be managed according to established treatment guidelines [see Dosage and Administration (2), Adverse Reactions (6.2)1.

5.5 Cutaneous and Systemic Lupus Erythematosus

Cutaneous lupus erythematosus (CLE) and systemic lupus erythematosus (SLE) have been reported in patients taking PPIs, including pantoprazole sodium. These events have occurred as both new onset and an exacerbation of existing autoimmune disease. The majority of PPI-induced lupus erythematous cases were CLE.

The most common form of CLE reported in patients treated with PPIs was subacute CLE (SCLE) and occurred within weeks to years after continuous drug therapy in patients ranging from infants to the elderly. Generally, histological findings were observed without organ involvement.

Systemic lupus erythematosus (SLE) is less commonly reported than CLE in patients receiving PPIs. PPI associated SLE is usually milder than non-drug induced SLE. Onset of SLE typically occurred within days to years after initiating treatment primarily in patients ranging from young adults to the elderly. The majority of patients presented with rash; however, arthralgia and $\,$ cytopenia were also reported.

Avoid administration of PPIs for longer than medically indicated. If signs or symptoms consistent with CLE or SLE are noted in patients receiving pantoprazole, discontinue the drug and refer the patient to the appropriate specialist for evaluation. Most patients improve with discontinuation of the PPI alone in 4 to 12 weeks. Serological testing (e.g. ANA) may be positive and elevated serological test results may take longer to resolve than clinical

5.6 Cyanocobalamin (Vitamin B-12) Deficiency

Generally, daily treatment with any acid-suppressing medications over a long period of time (e.g., longer than 3 years) may lead to malabsorption of cyanocobalamin (Vitamin B-12) caused by hypo- or achlorhydria. Rare reports of cyanocobalamin deficiency occurring with acid-suppressing therapy have been reported in the literature. This diagnosis should be considered if clinical symptoms consistent with cyanocobalamin deficiency are observed.

Hypomagnesemia, symptomatic and asymptomatic, has been reported rarely in patients treated with PPIs for at least three months, and in most cases after a year of therapy. Serious adverse events include tetany, arrhythmias, and seizures. In most patients, treatment of hypomagnesemia required magnesium lacement and discontinuation of the PPI.

For patients expected to be on prolonged treatment or who take PPIs with medications such as digoxin or drugs that may cause hypomagnesemia (e.g., diuretics), health care professionals may consider monitoring magnesium levels prior to initiation of PPI treatment and periodically [see Adverse

5.8 Tumorigenicity

Due to the chronic nature of GERD, there may be a potential for prolonged administration of pantoprazole. In long-term rodent studies, pantoprazole was carcinogenic and caused rare types of gastrointestinal tumors. The relevance of these findings to tumor development in humans is unknown [see Nonclinical Toxicology (13.1)].

5.9 Fundic Gland Polyps

Pharmacology (12.2)].

PPI use is associated with an increased risk of fundic gland polyps that increases with long-term use, especially beyond one year. Most PPI users who developed fundic gland polyps were asymptomatic and fundic gland polyps were identified incidentally on endoscopy. Use the shortest duration of PPI

therapy appropriate to the condition being treated.

5.10 Interference with Investigations for Neuroendocrine Tumors Serum chromogranin A (CgA) levels increase secondary to drug-induced decreases in gastric acidity. The increased CgA level may cause false positive results in diagnostic investigations for neuroendocrine tumors. Healthcare providers should temporarily stop pantoprazole sodium for delayed-release oral suspension treatment at least 14 days before assessing CgA levels and consider repeating the test if initial CgA levels are high. If serial tests are performed (e.g. for monitoring), the same commercial laboratory should be used for testing, as reference ranges between tests may vary [see Clinical

5.11 Interference with Urine Screen for THC

There have been reports of false-positive urine screening tests for tetrahydrocannabinol (THC) in patients receiving PPIs, including pantoprazole [see Drug Interactions (7)]. 5.12Concomitant Use of Pantoprazole with Methotrexate

Literature suggests that concomitant use of PPIs with methotrexate (primarily at high dose; see methotrexate prescribing information) may elevate and prolong serum levels of methotrexate and/or its metabolite, possibly leading to methotrexate toxicities. In high-dose methotrexate administration, a temporary withdrawal of the PPI may be considered in some patients [see

6 ADVERSE REACTIONS

The following serious adverse reactions are described below and elsewhere in labeling:

- Acute Interstitial Nephritis (see Warnings and Precautions (5.2))
- Clostridium difficile-Associated Diarrhea [see Warnings and Precautions Bone Fracture [see Warnings and Precautions (5.4)]
- Cutaneous and Systemic Lupus Erythematosus [see Warnings and Precautions (5.5)]
- Cyanocobalamin (Vitamin B-12) Deficiency [see Warnings and Precautions (5.6)]
- Hypomagnesemia [see Warnings and Precautions (5.7)] • Fundic Gland Polyps [see Warnings and Precautions (5.9)]

6.1 Clinical Trials Experience The adverse reaction profiles for pantoprazole sodium for delayed-release oral

suspension and pantoprazole sodium delayed-release tablets are similar. Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in clinical practice.

Adults

Safety in nine randomized comparative US clinical trials in patients with GERD included 1,473 patients on oral pantoprazole (20 mg or 40 mg), 299 patients on an H2-receptor antagonist, 46 patients on another PPI, and 82 patients on placebo. The most frequently occurring adverse reactions are listed in Table 3.

Table 3: Adverse Reactions Reported in Clinical Trials of Adult Patients with GERD at a Frequency of > 2%

	Pantoprazole (n=1,473) %	Comparators (n=345) %	Placebo (n=82) %
Headache	12.2	12.8	8.5
Diarrhea	8.8	9.6	4.9
Nausea	7.0	5.2	9.8
Abdominal pain	6.2	4.1	6.1
Vomiting	4.3	3.5	2.4
Flatulence	3.9	2.9	3.7
Dizziness	3.0	2.9	1.2
Arthralgia	2.8	1.4	1.2

Additional adverse reactions that were reported for pantoprazole in clinica trials with a frequency of ≤ 2% are listed below by body system: Body as a Whole: allergic reaction, pyrexia, photosensitivity reaction, facial

Gastrointestinal: constipation, dry mouth, hepatitis

Hematologic: leukopenia, thrombocytopenia Metabolic/Nutritional: elevated CK (creatine kinase), generalized edema, elevated triglycerides, liver enzymes elevated Musculoskeletal: mvalgia

Nervous: depression, vertigo Skin and Appendages: urticaria, rash, pruritus

Special Senses: blurred vision Pediatric Patients Safety of pantoprazole in the treatment of EE associated with GERD was evaluated in pediatric patients ages 1 year through 16 years in three clinical trials. Safety trials involved pediatric patients with EE; however, as EE is uncommon in the pediatric population, 249 pediatric patients with endoscopically-proven or symptomatic GERD were also evaluated. All adult adverse reactions to pantoprazole are considered relevant to pediatric patients. In patients ages 1 year through 16 years, the most commonly reported (>4% adverse reactions include: URI, headache, fever, diarrhea, vomiting, rash, and

For safety information in patients less than 1 year of age see Use in Specific Populations (8.4).

Additional adverse reactions that were reported for pantoprazole in pediatric patients in clinical trials with a frequency of ≤ 4% are listed below by body Body as a Whole: allergic reaction, facial edema

Metabolic/Nutritional: elevated triglycerides, elevated liver enzymes, elevated

CK (creatine kinase) Musculoskeletal: arthralgia, myalgia Nervous: dizziness, vertigo

Skin and Appendages: urticaria

Gastrointestinal: constipation, flatulence, nausea

The following adverse reactions seen in adults in clinical trials were not reported in pediatric patients in clinical trials, but are considered relevant to pediatric patients; photosensitivity reaction, dry mouth, hepatitis, thrombocytopenia, generalized edema, depression, pruritus, leukopenia, and blurred vision.

Zollinger-Ellison (ZE) Syndrome In clinical studies of ZE Syndrome, adverse reactions reported in 35 patients

taking pantoprazole 80 mg/day to 240 mg/day for up to 2 years were similar to those reported in adult patients with GERD. 6.2 Postmarketing Experience The following adverse reactions have been identified during postapproval use

of pantoprazole. Because these reactions are reported voluntarily from a population of uncertain size, it is not always possible to reliably estimate their frequency or establish a causal relationship to drug exposure

These adverse reactions are listed below by body system: Gastrointestinal Disorders: fundic gland polyps

General Disorders and Administration Conditions: asthenia, fatique, malaise Hematologic: pancytopenia, agranulocytosis Hepatobiliary Disorders: hepatocellular damage leading to jaundice and hepatic

Immune System Disorders: anaphylaxis (including anaphylactic shock), systemic lupus erythematosus Infections and Infestations: Clostridium difficile associated diarrhea

Metabolism and Nutritional Disorders: hyponatremia, hypomagnesemia Musculoskeletal Disorders: rhabdomyolysis, bone fracture Nervous: ageusia, dysgeusia

Psychiatric Disorders: hallucination, confusion, insomnia, somnolence Renal and Urinary Disorders: interstitial nephritis Skin and Subcutaneous Tissue Disorders: severe dermatologic reactions (some fatal), including erythema multiforme, Stevens-Johnson syndrome,

toxic epidermal necrolysis (TEN, some fatal), angioedema (Quincke's edema)

and cutaneous lupus erythematosus 7 DRUG INTERACTIONS

Investigations: weight changes

Table 4 includes drugs with clinically important drug interactions and interaction with diagnostics when administered concomitantly with pantoprazole and instructions for preventing or managing them. Consult the labeling of concomitantly used drugs to obtain further information about interactions with PPIs.

Table 4: Clinically Relevant Interactions Affecting Drugs

Coadministered with Pantoprazole and Interactions with Diagnostics Antiretrovirals The effect of PPIs on antiretroviral drugs is variable. The clinical importance and the mechanisms behind these interactions are not always known. Decreased exposure of some antiretroviral drugs (e.g

rilpivirine atazanavir, and nelfinavir) when use concomitantly with pantoprazole may reduce antivira effect and promote the development of drug resistance Increased exposure of other antiretroviral drugs (e.g. saguinavir) when used concomitantly with pantoprazo

may increase toxicity of the antiretroviral drugs. There are other antiretroviral drugs which do not result in clinically relevant interactions with pantoprazole. Rilpivirine-containing products: Concomitant use with pantoprazole is contraindicated [see Contraindication

Atazanavir: See prescribing information for atazanavir fo dosing information. Nelfinavir: Avoid concomitant use with pantoprazole. See prescribing information for nelfinavir

Saquinavir: See the prescribing information for saquin and monitor for notential saguinavir toxicities Other antiretrovirals: See prescribing information

(4)]. See prescribing information.

Warfarin Clinical Impact: Increased INR and prothrombin time in patients receiving PPIs, including pantoprazole, and warfarin con Increases in INR and prothrombin time may lead abnormal bleeding and even death. Monitor INR and prothrombin time. Dose adjustm warfarin may be needed to maintain target INR range. See

Concomitant administration of pantoprazole an clopidogrel in healthy subjects had no clinically importan effect on exposure to the active metabolite of clopidogre or clopidogrel-induced platelet inhibition [see Clinica Pharmacology (12.3)].

sodium for delayed-release oral suspension Methotrexate Clinical Impact: Concomitant use of PPIs with methotrexate (primar at high dose) may elevate and prolong serur concentrations of methotrexate and/or its metabolit hydroxymethotrexate, possibly leading to methotrexat toxicities. No formal drug interaction studies of high-dose methotrexate with PPIs have been conducted [see

administered with an approved dose of pantoprazo

Warnings and Precautions (5.12)]. A temporary withdrawal of pantoprazole may be conside in some patients receiving high-dose methotrexate Drugs Dependent on Gastric pH for Absorption (e.g., iron salts, erlotinil

Clinical Impact: | Pantoprazole can reduce the absorption of other drug

lasatinib, nilotinib, mycophenolate mofetil, ketoconazole/itrac

due to its effect on reducing intragastric acidity. Mycophenolate mofetil (MMF): Coadministration pantoprazole sodium in healthy subjects and in transplai patients receiving MMF has been reported to reduce the exposure to the active metabolite, mycophenolic acid (MPA), possibly due to a decrease in MMF solubility at a increased gastric pH [see Clinical Pharmacology (12.3)] The clinical relevance of reduced MPA exposure on organ rejection has not been established in transplant patien receiving pantoprazole and MMF. Use pantoprazole with caution in transplant patients receiving MMF. See the prescribing information for other drug

dependent on gastric pH for absorption. nteractions with Investigations of Neuroendocrine Tumors Clinical Impact: | CgA levels increase secondary to PPI-induced decrease in gastric acidity. The increased CgA level may cause false positive results in diagnostic investigations for

(5.10), Clinical Pharmacology (12.2)].

neuroendocrine tumors [see Warnings and Precautio

Temporarily stop pantoprazole treatment at least 14 day

before assessing CqA levels and consider repeating th

test if initial CgA levels are high. If serial tests are performed (e.g. for monitoring), the same commercia aboratory should be used for testing, as reference ranges between tests may vary. False Positive Urine Tests for THC Clinical Impact: There have been reports of false positive urine screen tests for tetrahydrocannabinol (THC) in patients receivi

PPIs [see Warnings and Precautions (5.11)].

An alternative confirmatory method should be considere

to verify positive results. **USE IN SPECIFIC POPULATIONS**

8.1 Pregnancy

Risk Summary Available data from published observational studies did not demonstrate an association of major malformations or other adverse pregnancy outcomes with pantoprazole.

In animal reproduction studies, no evidence of adverse development outcomes

was observed with pantoprazole. Reproduction studies have been performed

in rats at oral doses up to 450 mg/kg/day (about 88 times the recommended human dose) and rabbits at oral doses up to 40 mg/kg/day (about 16 times the recommended human dose) with administration of pantoprazole during organogenesis in pregnant animals and have revealed no evidence of harm to the fetus due to pantoprazole in this study (see Data). A pre-and postnatal development toxicity study in rats with additional endpoints to evaluate the effect on bone development was performed with pantoprazole sodium. Oral pantoprazole doses of 5, 15, and 30 mg/kg/day (approximately 1, 3, and 6 times the human dose of 40 mg/day) were administered to pregnant females from gestation day (GD) 6 through lactation

as by oral dosing from postnatal day (PND) 4 through PND 21 [see Use in Specific Populations (8.4)]. There were no drug-related findings in maternal animals. Advise pregnant women of the potential risk of fetal harm. The estimated background risk of major birth defects and miscarriage for the indicated population is unknown. All pregnancies have a background risk of birth defect, loss or other adverse outcomes. In the U.S. general population the estimated background risk of major birth defects and miscarriage in the

day (LD) 21. Changes in bone morphology were observed in pups exposed to pantoprazole in utero and through milk during the period of lactation as well

clinically recognized pregnancies is 2 to 4% and 15 to 20%, respectively Human Data

Available data from published observational studies failed to demonstrate an association of adverse pregnancy-related outcomes and pantoprazole use. Methodological limitations of these observational studies cannot definitely establish or exclude any drug-associated risk during pregnancy. In a prospective study by the European Network of Teratology Information Services, outcomes from a group of 53 pregnant women administered median daily doses of 40 mg pantoprazole were compared to a control group of 868 pregnant women who did not take any proton pump inhibitors (PPIs). There was no difference in the rate of major malformations between women exposed to PPIs and the control group, corresponding to a Relative Risk (RR)=0.55, [95% Confidence Interval (Cl) 0.08-3.95]. In a population-based retrospective cohort study covering all live births in Denmark from 1996 to 2008, there was no significant increase in major birth defects during analysis of first trimester exposure to pantoprazole in 549 live births. A meta-analysis that compared 1,530 pregnant women exposed to PPIs in at least the first trimester with 133,410 unexposed pregnant women showed no significant increases in risk for congenital malformations or spontaneous abortion with exposure to PPIs (for major malformations OR=1.12 ([95% CI 0.86-1.45] and for spontaneous abortions OR=1.29 [95% CI 0.84-1.97]).

Animal Data Reproduction studies have been performed in rats at oral pantoprazole doses up to 450 mg/kg/day (about 88 times the recommended human dose based on body surface area) and in rabbits at oral doses up to 40 mg/kg/day (about 16 times the recommended human dose based on body surface area) with nistration of pantoprazole sodium during organogenesis in pregnant animals. The studies have revealed no evidence of impaired fertility or harm to the fetus due to pantoprazole.

A pre-and postnatal development toxicity study in rats with additional endpoints to evaluate the effect on bone development was performed with pantoprazole sodium. Oral pantoprazole doses of 5, 15, and 30 mg/kg/day (approximately 1 3, and 6 times the human dose of 40 mg/day on a body surface area basis) were administered to pregnant females from gestation day (GD) 6 through lactation day (LD) 21. On postnatal day (PND 4) through PND 21, the pups were administered oral doses at 5, 15, and 30 mg/kg/day (approximately 1, 2.3, and 3.2 times the exposure (AUC) in humans at a dose of 40 mg). There were no drug-related findings in maternal animals. During the preweaning dosing phase (PND 4 to 21) of the pups, there were increased mortality and/or moribundity and decreased body weight and body weight gain at 5 mg/kg/day (approximately equal exposures (AUC) in humans receiving the 40 mg dose) and higher doses. On PND 21, decreased mean femur length and weight and changes in femur bone mass and geometry were observed in the offspring at 5 mg/kg/day (approximately equal exposures (AUC) in humans at the 40 mg dose) and higher doses. The femur findings included lower total area, bone nineral content and density, periosteal and endosteal circumference, and cross sectional moment of inertia. There were no microscopic changes in the distal femur, proximal tibia, or stifle joints. Changes in bone parameters were partially reversible following a recovery period, with findings on PND 70 limited to lower mur metaphysis cortical/subcortical bone mineral density in female pups at 5 mg/kg/day (approximately equal exposures (AUC) in humans at the 40 mg

8.2 Lactation

Risk Summary Pantoprazole has been detected in breast milk of a nursing mother after a single 40 mg oral dose of pantoprazole. There were no effects on the breastfed fant (see Data). There are no data on pantoprazole effects on milk production The developmental and health benefits of breastfeeding should be considered along with the mother's clinical need for pantoprazole and any potential adverse effects on the breastfed child from pantoprazole or from the underlying maternal condition.

The breast milk of a 42-year-old woman receiving 40 mg of oral pantoprazole, at 10 months postpartum, was studied for 24 hours, to demonstrate low levels of pantoprazole present in the breast milk. Pantoprazole was detectable in milk only 2 and 4 hours after the dose with milk levels of approximately 36 mcg/L and 24 mcg/L, respectively. A milk-to-plasma ratio of 0.022 was observed at 2 hours after drug administration. Pantoprazole was not detectable (<10 $\,$ mcg/L) in milk at 6, 8 and 24 hours after the dose. The relative dose to the infant was estimated to be 7.3 mcg of pantoprazole, which is equivalent to 0.14% of the weight-adjusted maternal dose. No adverse events in the infant were reported by the mother.

8.4 Pediatric Use The safety and effectiveness of pantoprazole for short-term treatment (up to eight weeks) of EE associated with GERD have been established in pediatric patients 1 year through 16 years of age. Effectiveness for EE has not been demonstrated in patients less than 1 year of age. In addition, for patients less than 5 years of age, there is no appropriate dosage strength in an age-appropriate formulation available. Therefore, pantoprazole is indicated for the short-term treatment of EE associated with GERD for patients 5 years and older. The safety and effectiveness of pantoprazole for pediatric uses other

than EE have not been established.

1 year through 16 years of age Use of pantoprazole in pediatric patients 1 year through 16 years of age for short-term treatment (up to eight weeks) of EE associated with GERD is supported by: a) extrapolation of results from adequate and well-controlled studies that supported the approval of pantoprazole for treatment of EE associated with GERD in adults, and b) safety, effectiveness, and pharmacokinetic studies performed in pediatric patients [see Clinical Studies

(14.1), Clinical Pharmacology (12.3)]. Safety of pantoprazole in the treatment of EE associated with GERD in pediatric patients 1 through 16 years of age was evaluated in three multicenter randomized, double-blind, parallel-treatment studies, involving 249 pediatric patients, including 8 with EE (4 patients ages 1 year to 5 years and 4 patients 5 years to 11 years). The children ages 1 year to 5 years with endoscopically diagnosed EE (defined as an endoscopic Hetzel-Dent score ≥ 2) were treated once daily for 8 weeks with one of two dose levels of nantonrazole (approximating 0.6 mg/kg or 1.2 mg/kg). All 4 of these patients with EE were healed (Hetzel-Dent score of 0 or 1) at 8 weeks. Because EE is uncommon in the pediatric population, predominantly pediatric patients with endoscopicallyproven or symptomatic GERD were also included in these studies. Patients were treated with a range of doses of pantoprazole once daily for 8 weeks. For safety findings see Adverse Reactions (6.1). Because these pediatric trials had no placebo, active comparator, or evidence of a dose response, the trials were nconclusive regarding the clinical benefit of pantoprazole for symptomatic GERD in the pediatric population. The effectiveness of pantoprazole for treating

symptomatic GERD in pediatric patients has not been established. Although the data from the clinical trials support use of pantoprazole for the short-term treatment of EE associated with GERD in pediatric patients 1 year through 5 years, there is no commercially available dosage formulation appropriate for patients less than 5 years of age [see Dosage and Administration (2)].

In a population pharmacokinetic analysis, clearance values in the children 1 to 5 years old with endoscopically proven GERD had a median value of 2.4 L/h. Following a 1.2 mg/kg equivalent dose (15 mg for \leq 12.5 kg and 20 mg for > 12.5 to < 25 kg), the plasma concentrations of pantoprazole were highly variable and the median time to peak plasma concentration was 3 to 6 hours The estimated AUC for patients 1 to 5 years old was 37% higher than for adults receiving a single 40 mg tablet, with a geometric mean AUC value of $6.8\,$

mcg•hr/mL.

Neonates to less than one year of age Pantoprazole was not found to be effective in a multicenter, randomized double-blind, placebo-controlled, treatment-withdrawal study of 129 pediatric patients 1 through 11 months of age. Patients were enrolled if they had symptomatic GERD based on medical history and had not responded to nonpharmacologic interventions for GERD for two weeks. Patients received pantoprazole daily for four weeks in an open-label phase, then patients were andomized in equal proportion to receive pantoprazole treatment or placebo for the subsequent four weeks in a double-blind manner. Efficacy was assessed by observing the time from randomization to study discontinuation due to $% \left(1\right) =\left(1\right) \left(1\right) \left$ symptom worsening during the four-week treatment-withdrawal phase. There was no statistically significant difference between pantoprazole and placebo in the rate of discontinuation.

In this trial, the adverse reactions that were reported more commonly

In a population pharmacokinetic analysis, the systemic exposure was higher

population were elevated CK, otitis media, rhinitis, and laryngitis.

difference of \geq 4%) in the treated population compared to the placebo

in patients less than 1 year of age with GERD compared to adults who received a single 40 mg dose (geometric mean AUC was 103% higher in preterm infants and neonates receiving single dose of 2.5 mg of pantoprazole, and 23% higher in infants 1 through 11 months of age receiving a single dose of approximately 1.2 mg/kg). In these patients, the apparent clearance (CL/F) increased with age (median clearance: 0.6 L/hr, range: 0.03 to 3.2 L/hr). These doses resulted in pharmacodynamic effects on gastric but not esophageal pH. Following once daily dosing of 2.5 mg of pantoprazole in preterm infants and neonates, there was an increase in the mean gastric pH from 4.3 at baseline to 5.2 at steady-state) and in the mean % time that gastric

pH was > 4 (from 60% at baseline to 80% at steady-state). Following once

daily dosing of approximately 1.2 mg/kg of pantoprazole in infants 1 through

11 months of age, there was an increase in the mean gastric pH (from 3.1 at

paseline to 4.2 at steady-state) and in the mean % time that gastric pH was >

4 (from 32% at baseline to 60% at steady-state). However, no significant changes were observed in mean intraesophageal pH or % time that esophageal pH was < 4 in either age group. Because pantoprazole was not shown to be effective in the randomized, placebo-controlled study in this age group, the use of pantoprazole for

treatment of symptomatic GERD in infants less than 1 year of age is not

Animal Toxicity Data

In a pre- and post-natal development study in rats, the pups were administe oral doses of pantoprazole at 5, 15, and 30 mg/kg/day (approximately 1, 2.3, and 3.2 times the exposure (AUC) in children aged 6 to 11 years at a dose of 40 mg) on postnatal day (PND 4) through PND 21, in addition to lactational exposure through milk. On PND 21, decreased mean femur length and weight and changes in femur bone mass and geometry were observed in the offsprin at 5 mg/kg/day (approximately equal exposures (AUC) in children aged 6 to 11 years at the 40 mg dose) and higher doses. Changes in bone parameters were partially reversible following a recovery period.

In neonatal/juvenile animals (rats and dogs) toxicities were similar to those

observed in adult animals, including gastric alterations, decreases in red cell

nass, increases in lipids, enzyme induction and hepatocellular hypertrophy

An increased incidence of eosinophilic chief cells in adult and neonatal/juvenile rats, and atrophy of chief cells in adult rats and in neonatal/juvenile dogs, was observed in the fundic mucosa of stomachs in repeated-dose studies. Full to artial recovery of these effects were noted in animals of both age groups following a recovery period. 8.5 Geriatric Use In short-term US clinical trials, EE healing rates in the 107 elderly patients (\geq 65 years old) treated with pantoprazole were similar to those found in patients under the age of 65. The incidence rates of adverse reactions and laboratory

240 mg) is limited. Spontaneous postmarketing reports of overdose are generally within the known safety profile of pantoprazole. Pantoprazole is not removed by hemodialysis. In case of overdosage treatment should be symptomatic and supportive Single oral doses of pantoprazole at 709 mg/kg, 798 mg/kg, and 887 mg/kg

were lethal to mice, rats, and dogs, respectively. The symptoms of acute

toxicity were hypoactivity, ataxia, hunched sitting, limb-splay, lateral position,

Experience in patients taking very high doses of pantoprazole (greater than

abnormalities in patients aged 65 years and older were similar to those

associated with patients younger than 65 years of age.

segregation, absence of ear reflex, and tremor.

If overexposure to pantoprazole occurs, call your Poison Control Center at 1-800-222-1222 for current information on the management of poisoning or

432.4. The structural formula is:

10 OVERDOSAGE

11 DESCRIPTION The active ingredient in pantoprazole sodium for delayed-release oral suspension, a PPI, is a substituted benzimidazole, sodium 5oromethoxy)-2-[[(3,4-dimethoxy-2-pyridinyl)methyl]sulfinyl]-1*H*-benzimi dazole sesquihydrate, a compound that inhibits gastric acid secretion. Its molecular formula is C₁₆H₁₄F₂N₃NaO₄S x 1.5 H₂O, with a molecular weight of

Pantoprazole sodium USP, (sesquihydrate) is a white to off-white crystalline powder and is racemic. Pantoprazole has weakly basic and acidic properties Pantoprazole sodium sesquihydrate is freely soluble in water, very slightly soluble in phosphate buffer at pH 7.4, and practically insoluble in n-hexane. The stability of the compound in aqueous solution is pH-dependent. The rate of degradation increases with decreasing pH. At ambient temperature, the degradation half-life is approximately 2.8 hours at pH 5 and approximately 220

SAP CODE: 5208261 ITF CODE: 05208261

Track: A09/03/2020, A13/03/2020,

A19/03/2020, A20/03/2020, A21/03/2020

Pack Insert Flat Size : 360 x 480 mm Folded Size: 45 x 60 mm

Color: Black

Pantoprazole sodium for delayed-release oral suspension is supplied as a for delayed-release oral suspension in unit-dose packets available in one strength 40 mg pantoprazole, (equivalent to 45.1 mg of pantoprazole sodium), conta the following inactive ingredients: calcium stearate, crospovidone, ferric oxide yellow, hydroxypropyl cellulose, hypromellose, methacrylic acid copolymer, microcrystalline cellulose, polysorbate 80, povidone, sodium carbonate, sodium lauryl sulfate, talc, titanium dioxide, and triethyl citrate.

12 CLINICAL PHARMACOLOGY

12.1 Mechanism of Action

Pantoprazole is a PPI that suppresses the final step in gastric acid production by covalently binding to the (H+, K+)-ATPase enzyme system at the secretory surface of the gastric parietal cell. This effect leads to inhibition of both basal and stimulated gastric acid secretion, irrespective of the stimulus. The binding to the (H+, K+)-ATPase results in a duration of antisecretory effect that persists longer than 24 hours for all doses tested (20 mg to 120 mg).

12.2 Pharmacodynamics

Pantoprazole sodium for delayed-release oral suspension, 40 mg has been shown to be comparable to pantoprazole sodium delayed-release tablets in suppressing pentagastrin-stimulated MAO in patients (n=49) with GERD and a history of EE. In this multicenter, pharmacodynamic crossover study, a 40 mg oral dose of pantoprazole sodium for delayed-release oral suspension administered in a teaspoonful of applesauce was compared with a 40 mg oral dose of pantoprazole sodium delayed-release tablets after administration of each formulation once daily for 7 days. Both medications were administered thirty minutes before breakfast. Pentagastrin-stimulated (MAO) was assessed from hour 23 to 24 at steady state.

Antisecretory Activity

Under maximal acid stimulatory conditions using pentagastrin, a dosedependent decrease in gastric acid output occurs after a single dose of oral (20 mg to 80 mg) or a single dose of intravenous (20 mg to 120 mg) pantoprazole in healthy subjects. Pantoprazole given once daily results in increasing inhibition of gastric acid secretion. Following the initial oral dose of 40 mg pantoprazole, a 51% mean inhibition was achieved by 2.5 hours. With once-a-day dosing for 7 days, the mean inhibition was increased to 85% Pantoprazole suppressed acid secretion in excess of 95% in half of the subjects. Acid secretion had returned to normal within a week after the last

dose of pantoprazole; there was no evidence of rebound hypersecretion. In a series of dose-response studies, pantoprazole, at oral doses ranging from 20 to 120 mg, caused dose-related increases in median basal gastric pH and in the percent of time gastric pH was >3 and >4. Treatment with 40 mg of pantoprazole produced significantly greater increases in gastric pH than the 20 mg dose. Doses higher than 40 mg (60, 80, 120 mg) did not result in further significant increases in median gastric pH. The effects of pantoprazole on median pH from one double-blind crossover study are shown in Table 5.

Table 5: Effect of Single Daily Doses of

orar ramoprazoro on maagadaro pri				
Time	Median pH on day 7			
	Placebo	20 mg	40 mg	80 mg
8 a.m. to 8 a.m. (24 hours)	1.3	2.9*	3.8*#	3.9*#
8 a.m. to 10 p.m. (Daytime)	1.6	3.2*	4.4*#	4.8*#
10 p.m. to 8 a.m. (Nighttime)	1.2	2.1*	3.0*	2.6*

Significantly different from placebo F Significantly different from 20 mg

clinical trials.

after 4 years.

Serum Gastrin Effects Fasting serum gastrin levels were assessed in two double-blind studies of the acute healing of EE in which 682 patients with gastroesophageal reflux disease (GERD) received 10, 20, or 40 mg of pantoprazole for up to 8 weeks. At 4 weeks of treatment there was an increase in mean gastrin levels of 7%, 35%, and 72% over pretreatment values in the 10, 20, and 40 mg treatment grou respectively. A similar increase in serum gastrin levels was noted at the 8week visit with mean increases of 3%, 26%, and 84% for the three pantoprazole dose groups. Median serum gastrin levels remained within normal limits during maintenance therapy with pantoprazole sodium delayedrelease tablets.

In long-term international studies involving over 800 patients, a 2- to 3-fold mean increase from the pretreatment fasting serum gastrin level was observed in the initial months of treatment with pantoprazole at doses of 40 mg per day during GERD maintenance studies and 40 mg or higher per day in patients with refractory GERD. Fasting serum gastrin levels generally remained at approximately 2 to 3 times baseline for up to 4 years of periodic follow-up in

Following short-term treatment with pantoprazole, elevated gastrin levels return to normal by at least 3 months

Enterochromaffin-Like (ECL) Cell Effects In 39 patients treated with oral pantoprazole 40 mg to 240 mg daily (majority receiving 40 mg to 80 mg) for up to 5 years, there was a moderate increase in $\hbox{ECL-cell density, starting after the first year of use, which appeared to plateau } \\$

In a nonclinical study in Sprague-Dawley rats, lifetime exposure (24 months) to pantoprazole at doses of 0.5 to 200 mg/kg/day resulted in dose-related increases in gastric ECL-cell proliferation and gastric neuroendocrine (NE)cell tumors. Gastric NE-cell tumors in rats may result from chronic elevation of serum gastrin concentrations. The high density of ECL cells in the rat stomach makes this species highly susceptible to the proliferative effects of elevated gastrin concentrations produced by PPIs. However, there were no observed elevations in serum gastrin following the administration of pantoprazole at a dose of 0.5 mg/kg/day. In a separate study, a gastric NE-cell tumor without concomitant ECL-cell proliferative changes was observed in 1 female rat following 12 months of dosing with pantoprazole at 5 mg/kg/day and a 9 month off-dose recovery [see Nonclinical Toxicology (13.1)].

Endocrine Effects In a clinical pharmacology study, pantoprazole 40 mg given once daily for 2 weeks had no effect on the levels of the following hormones: cortisol, $\,$ testosterone, triiodothyronine (T₃), thyroxine (T₄), thyroid-stimulating hormone (TSH), thyronine-binding protein, parathyroid hormone, insulin, glucagon, renin, aldosterone, follicle-stimulating hormone, luteinizing hormone, prolactin, and growth hormone.

In a 1-year study of GERD patients treated with pantoprazole 40 mg or 20 mg, there were no changes from baseline in overall levels of T3, T4, and TSH. 12.3 Pharmacokinetics

Pantoprazole sodium delayed-release tablets are prepared as enteric-coated tablets so that absorption of pantoprazole begins only after the tablet leaves the stomach. Peak serum concentration (Cmax) and area under the serum n a manner proportional to oral and intravenous doses from 10 mg to 80 mg. Pantoprazole does not accumulate. and its pharmacokinetics are unaltered with multiple daily dosing. Following oral or intravenous administration, the serum concentration of pantoprazole declines biexponentially, with a terminal elimination half-life of approximately one hour.

In extensive metabolizers with normal liver function receiving an oral dose of the enteric-coated 40 mg pantoprazole tablet, the peak concentration (C_{max}) is 2.5 mcg/mL; the time to reach the peak concentration (t_{max}) is 2.5 h, and the mean total area under the plasma concentration versus time curve (AUC) is $4.8\ \text{mcg-h/mL}\ (\text{range }1.4\ \text{to }13.3\ \text{mcg-h/mL}).\ \text{Following intravenous administration of pantoprazole to extensive metabolizers, its total clearance is}$ 7.6 to 14.0 L/h, and its apparent volume of distribution is 11.0 to 23.6 L.

A single oral dose of pantoprazole sodium for delayed-release oral suspension 40 mg, was shown to be bioequivalent when administered to healthy subjects (N = 22) as granules sprinkled over a teaspoonful of applesauce, as granules mixed with apple juice, or mixed with apple juice followed by administration through a nasogastric tube. The plasma pharmacokinetic parameters from a crossover study in healthy subjects are summarized in Table 6.

Table 6: Pharmacokinetics Parameters (mean ± SD) of

Failtoprazole Souluili for Delayeu-Nelease Oral Suspelision at 40 mg				
Pharmacokinetic Parameters	Granules in Applesauce	Granules in Apple Juice	Granules in Nasogastric Tube	
AUC (mcg•hr/mL)	4.0 ± 1.5	4.0 ± 1.5	4.1 ± 1.7	
C _{max} (mcg/mL)	2.0 ± 0.7	1.9 ± 0.5	2.2 ± 0.7	
T (hr)a	2.0	2.5	2.0	

a Median values are reported for Tmax Absorption

After administration of a single or multiple oral 40 mg doses of pantoprazole sodium delayed-release tablets, the peak plasma concentration of pantoprazole was achieved in approximately 2.5 hours, and C_{max} was 2.5 mcg/mL. Pantoprazole undergoes little first-pass metabolism, resulting in an absolute bioavailability of approximately 77%. Pantoprazole absorption is not affected by concomitant administration of antacids.

Administration of pantoprazole sodium delayed-release tablets with food may delay its absorption up to 2 hours or longer; however, the Cmax and the extent of pantoprazole absorption (AUC) are not altered. Thus, pantoprazole sodium delayed-release tablets may be taken without regard to timing of meals.

Administration of pantoprazole granules, 40 mg, with a high-fat meal delayed median time to peak plasma concentration by 2 hours. With a concomitant high-fat meal, the C_{max} and AUC of pantoprazole granules, 40 mg, sprinkled on applesauce decreased by 51% and 29%, respectively. Thus, pantoprazole sodium for delayed-release oral suspension should be taken approximately 30 minutes before a meal.

Distribution

The apparent volume of distribution of pantoprazole is approximately 11 to 23.6 L. distributing mainly in extracellular fluid. The serum protein binding of pantoprazole is about 98%, primarily to albumin.

Elimination Metabolism

Pantoprazole is extensively metabolized in the liver through the cytochrom P450 (CYP) system. Pantoprazole metabolism is independent of the route of administration (intravenous or oral). The main metabolic pathway is demethylation, by CYP2C19, with subsequent sulfation; other metabolic pathways include oxidation by CYP3A4. There is no evidence that any of the pantoprazole metabolites have significant pharmacologic activity.

Excretion After a single oral or intravenous dose of ¹⁴C-labeled pantoprazole to healthy, normal metabolizer subjects, approximately 71% of the dose was excreted in the urine, with 18% excreted in the feces through biliary excretion. There was no renal excretion of unchanged pantoprazole

Geriatric Patients

Only slight to moderate increases in the AUC (43%) and C_{max} (26%) of pantoprazole were found in elderly subjects (64 to 76 years of age) after repeated oral administration, compared with younger subjects [see Use in Specific Populations (8.5)].

Pediatric Patients The pharmacokinetics of pantoprazole were studied in children less than 16 years of age in four randomized, open-label clinical trials in pediatric patients with presumed/proven GERD. A pediatric granule formulation was studied in children through 5 years of age, and pantoprazole sodium delayed-release tablets were studied in children older than 5 years.

In a population PK analysis, total clearance increased with increasing bodyweight in a non-linear fashion. The total clearance also increased with

increasing age only in children under 3 years of age. Neonate through 5 Years of Age [see Use in Specific Populations (8.4)]

Children and Adolescents 6 through 16 Years of Age The pharmacokinetics of pantoprazole sodium delayed-release tablets were valuated in children ages 6 through 16 years with a clinical diagnosis of GERD. The PK parameters following a single oral dose of 20 mg or 40 mg of pantoprazole sodium delayed-release tablets in children ages 6 through 16 years were highly variable (%CV ranges 40 to 80%). The geometric mean AUC estimated from population PK analysis after a 40 mg pantoprazole sodium delayed-release tablets in pediatric patients was about 39% and 10% higher spectively in 6 to 11 and 12 to 16 year-old children, compared to that of adults (Table 7).

Table 7: PK Parameters in Children and Adolescents 6 through 16 years with GERD receiving 40 mg Pantoprazole Sodium Delayed-Release Tablets

Dolayea Helease Fablets			
6 to 11 years (n=12)	12 to 16 years (n=11)		
1.8	1.8		
2.0	2.0		
6.9	5.5		
6.6	6.8		
	6 to 11 years (n=12) 1.8 2.0 6.9		

b Median values

Male and Female Patients

There is a modest increase in pantoprazole AUC and C_{max} in women compared to men. However, weight-normalized clearance values are similar in women

In pediatric patients ages 1 through 16 years there were no clinically relevant effects of gender on clearance of pantoprazole, as shown by population pharmacokinetic analysis. Patients with Renal Impairment

In patients with severe renal impairment, pharmacokinetic parameters for pantoprazole were similar to those of healthy subjects.

Patients with Hepatic Impairment In patients with mild to severe hepatic impairment (Child-Pugh A to C cirrhosis), maximum pantoprazole concentrations increased only slightly (1.5fold) relative to healthy subjects. Although serum half-life values increased to 7 to 9 hours and AUC values increased by 5- to 7-fold in hepatic-impaired atients, these increases were no greater than those observed in CYP2C19 poor metabolizers, where no dosage adjustment is warranted. These pharmacokinetic changes in hepatic-impaired patients result in minimal drug accumulation following once-daily, multiple-dose administration. Doses higher than 40 mg/day have not been studied in hepatically impaired patients

Drug Interaction Studies Effect of Other Drugs on Pantoprazolo

Pantoprazole is metabolized mainly by CYP2C19 and to minor extents by CYPs 3A4, 2D6, and 2C9. In *in vivo* drug-drug interaction studies with CYP2C19 substrates (diazepam [also a CYP3A4 substrate] and phenytoin [also a CYP3A4 inducer] and clopidogrel), nifedipine, midazolam, and clarithromycin (CYP3A4 substrates), metoprolol (a CYP2D6 substrate), diclofenac, naproxen and piroxicam (CYP2C9 substrates), and theophylline (a CYP1A2 substrate) in healthy subjects, the pharmacokinetics of pantoprazole were not significantly

Effect of Pantoprazole on Other Drugs

Clopidogrel Clopidogrel is metabolized to its active metabolite in part by CYP2C19. In a crossover clinical study, 66 healthy subjects were administered clopidogrel (300 mg loading dose followed by 75 mg per day) alone and with pantoprazole (80 mg at the same time as clopidogrel) for 5 days. On Day 5, the mean AUC of the active metabolite of clopidogrel was reduced by approximately 14% (geometric mean ratio was 86%, with 90% CI of 79 to 93%) when pantoprazole was coadministered with clopidogrel as compared to clopidogrel administered alone. Pharmacodynamic parameters were also measured and strated that the change in inhibition of platelet aggregation (induced by $5 \,\mu\text{M}$ ADP) was correlated with the change in the exposure to clopidogrel active metabolite. The clinical significance of this finding is not clear

Mycophenolate Mofetil (MMF) Administration of pantoprazole 40 mg twice daily for 4 days and a single 1,000 mg dose of MMF approximately one hour after the last dose of pantoprazole to 12 healthy subjects in a cross-over study resulted in a 57% reduction in the C_{max} and 27% reduction in the AUC of MPA. Transplant patients receiving approximately 2,000 mg per day of MMF (n=12) were compared to transplant patients receiving approximately the same dose of MMF and pantoprazole 40 mg per day (n=21). There was a 78% reduction in the C_{max} and a 45%

[see Drug Interactions (7)].

n vivo studies also suggest that pantoprazole does not significantly affect the kinetics of the following drugs (cisapride, theophylline, diazepam [and its active netabolite, desmethyldiazepam], phenytoin, metoprolol, nifedipine, carbamazepine, midazolam, clarithromycin, diclofenac, naproxen, piroxicam, d oral contraceptives [levonorgestrel/ethinyl estradiol]). In other *in viv*e studies, digoxin, ethanol, glyburide, antipyrine, caffeine, metronidazole, and amoxicillin had no clinically relevant interactions with pantoprazole.

reduction in the AUC of MPA in patients receiving both pantoprazole and MMF

Ithough no significant drug-drug interactions have been observed in clinical studies, the potential for significant drug-drug interactions with more than once-daily dosing with high doses of pantoprazole has not been studied in poor metabolizers or individuals who are hepatically impaired. Antacids

There was also no interaction with concomitantly administered antacids. 12.5 Pharmacogenomics

CYP2C19 displays a known genetic polymorphism due to its deficiency in some subpopulations (e.g., approximately 3% of Caucasians and African-Americans and 17% to 23% of Asians are poor metabolizers). Although these subpopulations of pantoprazole poor metabolizers have elimination half-life values of 3.5 to 10 hours in adults, they still have minimal accumulation (23% or less) with once-daily dosing. For adult patients who are CYP2C19 poor metabolizers, no dosage adjustment is needed.

Similar to adults, pediatric patients who have the poor metabolizer genotype of CYP2C19 (CYP2C19 *2/*2) exhibited greater than a 6-fold increase in AUC compared to pediatric extensive (CYP2C19 *1/*1) and intermediate (CYP2C19 *1/*x) metabolizers. Poor metabolizers exhibited approximately 10-fold lower apparent oral clearance compared to extensive metabolizers.

For known pediatric poor metabolizers, a dose reduction should be considered. 13 NONCLINICAL TOXICOLOGY

13.1 Carcinogenesis, Mutagenesis, Impairment of Fertility

In a 24-month carcinogenicity study, Sprague-Dawley rats were treated orally with pantoprazole doses of 0.5 to 200 mg/kg/day, about 0.1 to 40 times the exposure on a body surface area basis of a 50 kg person dosed with 40 mg/day. In the gastric fundus, treatment with 0.5 to 200 mg/kg/day produced enterochromaffin-like (ECL) cell hyperplasia and benign and malignant neuroendocrine cell tumors in a dose-related manner. In the forestomach treatment with 50 and 200 mg/kg/day (about 10 and 40 times the recommended human dose on a body surface area basis) produced benign squamous cell papillomas and malignant squamous cell carcinomas. Rare nastrointestinal tumors associated with nantonrazole treatment included an adenocarcinoma of the duodenum with 50 mg/kg/day and benign polyps and adenocarcinomas of the gastric fundus with 200 mg/kg/day. In the liver, treatment with 0.5 to 200 mg/kg/day produced dose-related increases in the incidences of hepatocellular adenomas and carcinomas. In the thyroid gland, treatment with 200 mg/kg/day produced increased incidences of follicular cell adenomas and carcinomas for both male and female rats.

In a 24-month carcinogenicity study, Fischer 344 rats were treated orally with doses of 5 to 50 mg/kg/day of pantoprazole, approximately 1 to 10 times the recommended human dose based on body surface area. In the gastric fundus treatment with 5 to 50 mg/kg/day produced enterochromaffin-like (ECL) cell hyperplasia and benign and malignant neuroendocrine cell tumors. Dose selection for this study may not have been adequate to comprehensively

evaluate the carcinogenic potential of pantoprazole. In a 24-month carcinogenicity study, B6C3F1 mice were treated orally with doses of 5 to 150 mg/kg/day of pantoprazole, 0.5 to 15 times the recommended human dose based on body surface area. In the liver, treatment with 150 mg/kg/day produced increased incidences of hepatocellula adenomas and carcinomas in female mice. Treatment with 5 to 150 mg/kg/day also produced gastric-fundic ECL cell hyperplasia.

A 26-week p53 +/- transgenic mouse carcinogenicity study was not positive. Pantoprazole was positive in the in vitro human lymphocyte chromosomal aberration assays, in one of two mouse micronucleus tests for clastogenic effects, and in the in vitro Chinese hamster ovarian cell/HGPRT forward mutation assay for mutagenic effects. Equivocal results were observed in the in vivo rat liver DNA covalent binding assay. Pantoprazole was negative in the in vitro Ames mutation assay, the in vitro unscheduled DNA synthesis (UDS) assay with rat hepatocytes, the in vitro AS52/GPT mammalian cell-forward gene mutation assay, the in vitro thymidine kinase mutation test with mouse ymphoma L5178Y cells, and the *in vivo* rat bone marrow cell chromosoma aberration assav.

There were no effects on fertility or reproductive performance when pantoprazole was given at oral doses up to 500 mg/kg/day in male rats (98 times the recommended human dose based on body surface area) and 450 mg/kg/day in female rats (88 times the recommended human dose based on

14 CLINICAL STUDIES

body surface area).

Pantoprazole sodium delayed-release tablets were used in the following clinical

14.1 Erosive Esophagitis (EE) Associated with Gastroesophageal Reflux Disease (GERD)

Adult Patients A US multicenter, double-blind, placebo-controlled study of pantoprazole sodium delayed-release tablets 10 mg, 20 mg, or 40 mg once daily was conducted in 603 patients with reflux symptoms and endoscopically diagnosed EE of grade 2 or above (Hetzel-Dent scale). In this study, approximately 25%of enrolled patients had severe EE of grade 3, and 10% had grade 4. The percentages of patients healed (per protocol, n = 541) in this study are shown in Table 8.

Table 6. Libsive Esophagitis Healing Hates (1 et 1 1010col)					
	Pantoprazole Sodium Delayed-Release Tablets				
11/2 - 1	10 mg daily	20 mg daily	40 mg daily	Placebo	
Week	(n = 153)	(n = 158)	(n = 162)	(n = 68)	
4	45.6%+	58.4%+#	75.0%+*	14.3%	
8	66.0%+	83.5%+#	92.6%+*	39.7%	

(p < 0.05) versus 10 mg or 20 mg pantoprazole sodium delayed-release tablet

(p < 0.05) versus 10 mg pantoprazole sodium delayed-release tablets In this study, all pantoprazole sodium delayed-release tablets treatment groups

had significantly greater healing rates than the placebo group. This was true regardless of *H. pylori* status for the 40 mg and 20 mg pantoprazole sodium delayed-release tablets treatment groups. The 40 mg dose of pantopraz sodium delayed-release tablets resulted in healing rates significantly greater than those found with either the 20 mg or 10 mg dose

A significantly greater proportion of patients taking pantoprazole sodium delayed-release tablets 40 mg experienced complete relief of daytime and nighttime heartburn and the absence of regurgitation, starting from the first day of treatment, compared with placebo. Patients taking pantoprazole sodium delayed-release tablets consumed significantly fewer antacid tablets per day than those taking placebo.

Pantoprazole sodium delayed-release tablets 40 mg and 20 mg once daily were also compared with nizatidine 150 mg twice daily in a US multicenter, double blind study of 243 patients with reflux symptoms and endoscopically diagnosed EE of grade 2 or above. The percentages of patients healed (per protocol, n = 212) are shown in Table 9.

Table 9: Erosive Esophagitis Healing Rates (Per Protocol)

Week	Pantoprazole Sodium Delayed-Release Tablets		Nizatidine
	20 mg daily	mg daily 40 mg daily	
	(n = 72)	(n = 70)	(n = 70)
4	61.4%+	64.0%+	22.2%
8	79.2%+	82.9%+	41.4%

(p < 0.001) pantoprazole sodium delayed-release tablets versus nizatidin

Once-daily treatment with pantoprazole sodium delayed-release tablets 40 mg or 20 mg resulted in significantly superior rates of healing at both 4 and 8 $\,$ weeks compared with twice-daily treatment with 150 mg of nizatidine. For the $40\ mg$ treatment group, significantly greater healing rates compared to nizatidine were achieved regardless of the H. pylori status

A significantly greater proportion of the patients in the pantoprazole sodium delayed-release tablets treatment groups experienced complete relief of nighttime heartburn and regurgitation, starting on the first day and of daytime heartburn on the second day, compared with those taking nizatidine 150 mg twice daily. Patients taking pantoprazole sodium delayed-release tablets consumed significantly fewer antacid tablets per day than those taking

Pediatric Patients Ages 5 Years through 16 Years

of EE associated with GERD in pediatric patients ages 5 years through 16 years is extrapolated from adequate and well-conducted trials in adults, as the pathophysiology is thought to be the same. Four pediatric patients with endoscopically diagnosed EE were studied in multicenter, randomized, double blind, parallel-treatment trials. Children with endoscopically diagnosed EE (defined as an endoscopic Hetzel-Dent score \geq 2) were treated once daily for 8 weeks with one of two dose levels of pantoprazole sodium delayed-release tablets (20 mg or 40 mg). All 4 patients with EE were healed (Hetzel-Dent score of 0 or 1) at 8 weeks.

14.2 Long-Term Maintenance of Healing of Erosive Esophagitis

Two independent, multicenter, randomized, double-blind, comparator controlled trials of identical design were conducted in adult GERD patients with endoscopically confirmed healed EE to demonstrate efficacy of pantoprazole sodium delayed-release tablets in long-term maintenance of healing. The two US studies enrolled 386 and 404 patients, respectively, to receive either 10 mg, 20 mg, or 40 mg of pantoprazole sodium delayed-release tablets once daily or 150 mg of ranitidine twice daily. As demonstrated in Table 10. pantoprazole sodium delayed-release tablets 40 mg and 20 mg were significantly superior to ranitidine at every timepoint with respect to the tenance of healing. In addition, pantoprazole sodium delayed-release tablet 40 mg was superior to all other treatments studied.

Table 10: Long-Term Maintenance of Healing of Erosive Gastroesophageal Reflux Disease (GERD Maintenance): Percentage of Patients Who Remained Healed

Delayed-Release Tablets	Dalamad Dalaman Tablata	
	Delayed-Release Tablets	150 mg
20 mg daily	40 mg daily	twice daily
n = 75	n = 74	n = 75
91*	99 [*]	68
82*	93*#	54
76*	90*#	44
70*	86*#	35
n = 74	n = 88	n = 84
89*	92*#	62
78*	91*#	47
72*	88*#	39
72 [*]	83 [*]	37
	n = 75 91' 82' 76' 70' n = 74 89' 78' 72'	n = 75

(n < 0.05 vs. nantonrazole sodium dela elease tablets 20 mg Note: Pantoprazole sodium delayed-release tablets 10 mg was superior (p < 0.05) to ranitidine in Study 2, but not Study 1.

Pantoprazole sodium delayed-release tablet 40 mg was superior to ranitidine in reducing the number of daytime and nighttime heartburn episodes from the first through the twelfth month of treatment. Pantoprazole sodium delayed-release tablets 20 mg, administered once daily, was also effective in reducing episodes of daytime and nighttime heartburn in one trial, as presented in Table 11.

Table 11: Number of Episodes of Heartburn (mean ± SD)				
	Pantoprazole Sodium Delayed-Release Tablets 40 mg daily		Ranitidine 150 mg twice daily	
Month 1	Daytime	5.1 ± 1.6*	18.3 ± 1.6	
	Nighttime	3.9 ± 1.1*	11.9 ± 1.1	
Month 12	Daytime	2.9 ± 1.5*	17.5 ± 1.5	
	A11 1 111	0 5 4 0 5	10.0 1.0	

2.5 ± 1.2* 13.8 ± 1.3 Nighttime (p < 0.001 vs. ranitidine, combined data from the two US studies)

14.3 Pathological Hypersecretory Conditions Including Zollinger-Ellison

In a multicenter, open-label trial of 35 patients with pathological hypersecretory conditions, such as Zollinger-Ellison Syndrome, with or without multiple endocrine neoplasia-type I, pantoprazole sodium delayed-release tablets successfully controlled gastric acid secretion. Doses ranging from 80 mg daily to 240 mg daily maintained gastric acid output below 10 mEg/h in patients without prior acid-reducing surgery and below 5 mEq/h in patients with prior acid-reducing surgery.

Doses were initially titrated to the individual patient needs, and adjusted in some patients based on the clinical response with time [see Dosage and Administration (2)]. Pantoprazole sodium delayed-release tablet was well tolerated at these dose levels for prolonged periods (greater than 2 years in some patients).

16 HOW SUPPLIED/STORAGE AND HANDLING **How Supplied**

Pantoprazole sodium for delayed-release oral suspension is supplied as pale yellowish to dark brownish, enteric-coated granules containing 40 mg pantoprazole in a unit-dose packet. Pantoprazole sodium for delayed-release oral suspension is supplied as child-resistant sachets as follows:

NDC 62756-071-64, unit-dose carton of 30.

Store at 20° to 25°C (68° to 77°F); excursions permitted between 15° and 30°C (59° and 86°F) [see USP Controlled Room Temperature].

17 PATIENT COUNSELING INFORMATION Advise the patient to read the FDA-approved patient labeling (Medication Guide

Gastric Malignancy Advise patients to return to their healthcare provider if they have a subontimal response or an early symptomatic relapse [see Warnings and Precautions

Acute Interstitial Nephritis Advise patients to call their healthcare provider immediately if they experience signs and/or symptoms associated with acute interstitial nephritis [see

Warnings and Precautions (5.2)].

Clostridium difficile-Associated Diarrhea Advise patients to immediately call their healthcare provider if they experience

Bone Fracture Advise patients to report any fractures, especially of the hip, wrist or spine, to

diarrhea that does not improve [see Warnings and Precautions (5.3)].

their healthcare provider [see Warnings and Precautions (5.4)]

Cutaneous and Systemic Lupus Erythematosus Advise patients to immediately call their healthcare provider for any new or worsening of symptoms associated with cutaneous or systemic lupus erythematosus [see Warnings and Precautions (5.5)].

Cyanocobalamin (Vitamin B-12) Deficiency Advise patients to report any clinical symptoms that may be associated with cyancobalamin deficiency to their healthcare provider if they have been eceiving pantoprazole sodium for delayed-release oral suspension for longer than 3 years [see Warnings and Precautions (5.6)].

Hypomagnesemia Advise patients to report any clinical symptoms that may be associated with

hypomagnesemia to their healthcare provider, if they have been receiving pantoprazole sodium for delayed-release oral suspension for at least 3 months [see Warnings and Precautions (5.7)]. **Drug Interactions**

Instruct patients to inform their healthcare provider of any other medications they are currently taking, including rilpivirine-containing products [see Contraindications (4)] digoxin [see Warnings and Precautions (5.7)] and high dose methotrexate [see Warnings and Precautions (5.12)]. Pregnancy

Advise a pregnant woman of the potential risk to a fetus. Advise females of reproductive potential to inform their healthcare provider of a known or suspected pregnancy [see Use in Specific Populations (8.1)].

- Do not split, crush, or chew pantoprazole sodium for delayed-release oral
- Pantonrazole sodium for delayed-release oral suspension packet is a fixed dose and cannot be divided to make a smaller dose
- Take pantoprazole sodium for delayed-release oral suspens approximately 30 minutes before a meal.
- Administer pantoprazole sodium for delayed-release oral suspension in apple juice or applesauce, as described in the Instructions for Use. Do not administer in water, other liquids, or foods.
- For patients with a nasogastric (NG) or gastrostomy tube, pantoprazole sodium for delayed-release oral suspension can be administered with
- apple juice, as described in the Instructions for Use. Take a missed dose as soon as possible. If it is almost time for the next dose, skip the missed dose and take the next dose at the regular

MEDICATION GUIDE Pantoprazole Sodium (pan-TOE-pra-zole SOE-dee-um)

scheduled time. Do not take 2 doses at the same time.

for Delayed-Release Oral Suspensi What is the most important information I should know about pantoprazo odium for delayed-release oral suspension?

You should take pantoprazole sodium for delayed-release suspension exactly as prescribed, at the lowest dose possible and for the antoprazole sodium for delayed-release oral suspension may help you

acid-related symptoms, but you could still have serious stomach

Pantoprazole sodium for delayed-release oral suspen erious side effects, including: A type of kidney problem (acute interstitial nephritis). Some peop who take proton pump inhibitor (PPI) medicines, including panto

sodium for delayed-release oral suspension, may develop a kidner problem called acute interstitial nephritis that can happen at any time during treatment with pantoprazole sodium for delayed-release ora suspension. Call your doctor right away if you have a decrease in the amount that you urinate or if you have blood in your urine. Diarrhea caused by an infection (Clostridium difficile) in you intestines. Call your doctor right away if you have watery stools of

stomach pain that does not go away. You may or may not have a fever

Bone fractures (hip, wrist, or spine). Bone fractures in the hip, wrist, or spine may happen in people who take multiple daily doses of PP medicines and for a long period of time (a year or longer). Tell your docto if you have a bone fracture, especially in the hip, wrist, or spine Certain types of lupus erythematosus. Lupus erythematosus is autoimmune disorder (the body's immune cells attack other cells o organs in the body). Some people who take PPI medicines, includin pantoprazole sodium for delayed-release oral suspension, may develo

already have. Call your doctor right away if you have new or worseni joint pain or a rash on your cheeks or arms that gets worse in the sun Talk to your doctor about your risk of these serious side effects. Pantoprazole sodium for delayed-release oral suspension can have other

certain types of lupus erythematosus or have worsening of the lupus the

erious side effects. See "What are the possible side effects of pantoprazole sodium for delayed-release oral suspension?" What is pantoprazole sodium for delayed-release oral suspension

A prescription medicine called a proton pump inhibitor (PPI) used to reduc he amount of acid in your stomach. n adults, pantoprazole sodium for delayed-release oral suspension is us

up to 8 weeks for the healing and symptom relief of acid-related dama to the lining of the esophagus (called erosive esophagitis or EE). You doctor may prescribe another 8 weeks of pantoprazole sodium for delayed-release oral suspension in patients whose EE does not heal

maintaining healing of EE and to help prevent the return of heartbu symptoms caused by GERD. It is not known if pantoprazole sodium fo delayed-release oral suspension is safe and effective when used for longe than 12 months for this purpose. the long-term treatment of conditions where your stomach makes to

much acid. This includes a rare condition called Zollinger-Ellison

In children 5 years of age and older, pantoprazole sodium for delayed elease oral suspension is used for

up to 8 weeks for the healing and symptom relief of EE t is not known if pantoprazole sodium for delayed-release oral suspens

is safe if used longer than 8 weeks in children. Pantoprazole sodium for delayed-release oral suspension is not for use in children under 5 years of age. It is not known if pantoprazole sodium for delayed-release oral suspension is safe and effective in children fo

Do not take pantoprazole sodium for delayed-release oral suspension you are:

allergic to pantoprazole sodium, any other PPI medicine, or any of the ingredients in pantoprazole sodium for delayed-release oral suspension See the end of this Medication Guide for a complete list of ingredients. taking a medicine that contains rilpivirine (EDURANT*, COMPLERA* ODEFSEY*, JULUCA*) used to treat HIV-1 (Human Immunodeficience Virus).

Before taking pantoprazole sodium for delayed-release oral suspension

tell your doctor about all of your medical conditions, including if you: have low magnesium levels in your blood.

are pregnant or plan to become pregnant. Pantoprazole sodium for delayed-release oral suspension may harm your unborn baby. Tell you doctor if you become pregnant or think you may be pregnant durin treatment with pantoprazole sodium for delayed-release oral suspension are breastfeeding or plan to breastfeed. Pantoprazole sodium for delayedrelease oral suspension can pass into your breast milk. Talk with you

doctor about the best way to feed your baby if you take pantoprazol sodium for delayed-release oral suspension Tell your doctor about all the medicines you take, including prescription and over-the-counter medicines, vitamins and herbal supplem Especially tell your doctor if you take methotrexate (Otrexup*, Rasuvo Trexall*, XATMEP*), digoxin (LANOXIN*), or a water pill (diuretic).

How should I take pantoprazole sodium for delayed-release oral Take pantoprazole sodium for delayed-release oral suspension exactly as

prescribed by your doctor.

Do not split, chew, or crush pantoprazole sodium for delayed release oral suspension

Take pantoprazole sodium for delayed-release oral suspension about 30 minutes before a meal. Pantoprazole sodium for delayed-release oral suspension should only be given by mouth mixed in apple juice or applesauce or through a nasogastric (NG) tube or gastrostomy tube mixed in apple juice. Do

not mix pantoprazole sodium for delayed-release oral suspension i liquids other than apple juice or foods other than applesauce. Do not divide a packet of pantoprazole sodium for delayed-rele

oral suspension to make a smaller dose. See the "Instructions for Use" at the end of this Medication Guide fo instructions on how to mix and take pantoprazole sodium for delayedrelease oral suspension by mouth in applesauce or apple juice or how to mix and give the suspension through an NG tube or gastrostor

If you miss a dose of pantoprazole sodium for delayed-release oral suspension, take it as soon as possible. If it is almost time for your next dose, do not take the missed dose. Take the next dose at your regula time. Do not take 2 doses at the same time.

tube mixed in apple juice.

If you take too much pantoprazole sodium for delayed-release ora suspension, call your doctor or your poison control center at 1-800-222 1222 right away or go to the nearest emergency room

What are the possible side effects of pantoprazole sodium for delayedrelease oral suspension? Pantoprazole sodium for delayed-release oral suspension can cause

erious side effects, including: See "What is the most important information I should know about

pantoprazole sodium for delayed-release oral suspension? Low vitamin B-12 levels in your body can happen in people who have taken pantoprazole sodium for delayed-release oral suspension for a long time (more than 3 years). Tell your doctor if you have symptoms of low $\,$ vitamin B-12 levels, including shortness of breath, lightheadedness rregular heartbeat, muscle weakness, pale skin, feeling tired, moo

changes, and tingling or numbness in the arms and legs Low magnesium levels in your body can happen in people who hav taken pantoprazole sodium for delayed-release oral suspension for at least 3 months. Tell your doctor if you have symptoms of low magnesium

aches or weakness, and spasms of hands, feet or voice. Stomach growths (fundic gland polyps). People who take PPI medicine stomach growths called fundic gland polyps, especially after taking PP

The most common side effects of pantoprazole sodium for delayed release oral suspension in adults include: headache, diarrhea, nause omach-area (abdominal) pain, vomiting, gas, dizziness, and joint pain The most common side effects of pantoprazole sodium for delayed release oral suspension in children include: upper respiratory infection neadache, fever, diarrhea, vomiting, rash, and stomach-area (abdominal pain. These are not all the possible side effects of pantoprazole sodium for delayed-release oral suspension. Call your doctor for medical advice about side effects. You may report side effects to FDA at 1-800-FDA-1088.

Pantoprazole sodium for delayed-release oral suspension comes in a child

emperature between 68°F to 77°F (20°C to 25°C).

General information about the safe and effective use of pantoprazole

What are the ingredients in pantoprazole sodium for delayed-release oral

Inactive ingredients: calcium stearate, crospovidone, ferric oxide vellow

hydroxypropyl cellulose, hypromellose, methacrylic acid copolyme

Instructions for Use Pantoprazole Sodium

oral suspension Take pantoprazole sodium for delayed-release oral suspension about 30

nacket should not be divided to make a smaller dose.

Taking pantoprazole sodium for delayed-release oral suspension with

2. Sprinkle all of the granules in the packet on 1 teaspoon of applesauce 3. Swallow the granules and applesauce within 10 minutes of putting the granules on the teaspoon of applesauce.

Taking pantoprazole sodium for delayed-release oral suspension with apple

3. Stir the granules-apple juice mixture for 5 seconds. The granules will not

stir and swallow the apple juice right away

5. To make sure that the entire dose is taken, add more apple juice to the cup,

through an NG tube or gastrostomy tube smaller than size 16 French. Mix pantoprazole sodium for delayed-release oral suspension only in apple

juice when giving through an NG tube or gastrostomy tube. 1. Remove the plunger from a 60 mL (2 ounce) catheter-tip syringe Throw away the plunger.

3. Hold the syringe attached to the NG tube or gastrostomy tube as high as possible while giving pantoprazole sodium for delayed-release oral suspension to prevent the tubing from bending. 4. Open the packet of pantoprazole sodium for delayed-release oral

5. Empty all the granules in the packet into the catheter-tip syringe.

and gently tap or shake the syringe to help empty the syringe. 7. Repeat step 6 at least 2 more times until there are no granules left in

Pantoprazole sodium for delayed-release oral suspension comes in a childresistant package.

Store pantoprazole sodium for delayed-release oral suspension at room mperature between 68°F to 77°F (20°C to 25°C).

This Medication Guide and Instructions for Use has been approved by the U.S. Food and Drug Administration

Distributed by: Sun Pharmaceutical Industries, Inc. Cranbury, NJ 08512

Manufactured by: Sun Pharmaceutical Industries Ltd.

ISS. 02/2020

evels, including seizures, dizziness, irregular heartbeat, jitteriness, muscl

How should I store pantoprazole sodium for delayed-release oral

resistant package. Store pantoprazole sodium for delayed-release oral suspension at roor

Keep pantoprazole sodium for delayed-release oral suspension and all nedicines out of the reach of children.

sodium for delayed-release oral suspensior

Medicines are sometimes prescribed for purposes other than those lists in a Medication Guide. Do not use pantoprazole sodium for delayed-releas oral suspension for a condition for which it was not prescribed. Do not give pantoprazole sodium for delayed-release oral suspension to other people even if they have the same symptoms that you have. It may harm them. You can ask your doctor or pharmacist for information about pantoprazole sodium for delayed-release oral suspension that is written for health

Active ingredient: pantoprazole sodium sesquihydrate

microcrystalline cellulose, polysorbate 80, povidone, sodium carbonate,

(pan-TOE-pra-zole SOE-dee-um) for Delayed-Release Oral Suspension

Important information • Do not split, chew, or crush pantoprazole sodium for delayed-release

minutes before a meal. · Pantoprazole sodium for delayed-release oral suspension o should only be taken with applesauce or apple juice. should not be mixed in water or other liquids, or other foods.

 $1. \ \, \text{Open the packet of pantoprazole sodium for delayed-release oral}$

 $\ensuremath{\mathsf{4}}.$ Take sips of water to make sure the granules are washed down into the stomach. Take more sips of water as needed.

1. Open the packet of pantoprazole sodium for delayed-release ora 2. Empty all of the granules in the packet into a small cup that contains 1

break up. 4. Swallow the mixture right away.

6. Repeat step 5 if there are granules left in the cur Giving pantoprazole sodium for delayed-release oral suspension through a nasogastric (NG) tube or gastrostomy tube: Pantoprazole sodium for delayed-release oral suspension may be given through an NG tube or gastrostomy tube that is size 16 French or larger.

Do not give pantoprazole sodium for delayed-release oral suspension

2. Connect the tip of the catheter-tip syringe to the NG tube or gastrostomy tube.

the catheter-tip syringe. How should I store pantoprazole sodium for delayed-release oral

Keep pantoprazole sodium for delayed-release oral suspension and all medicines out of the reach of children.

* All trademark names are the property of their respective owners