

Australian PRODUCT INFORMATION

ITRANOX (Itraconazole) CAPSULES

1 NAME OF THE MEDICINE

Itraconazole.

2 QUALITATIVE AND QUANTITATIVE COMPOSITION

ITRANOX capsules contain itraconazole 100 mg.

Itraconazole is a synthetic triazole antifungal agent.

For the full list of excipients, see Section 6.1 List of excipients.

3 PHARMACEUTICAL FORM

ITRANOX is available as white opaque capsules printed with ITR on the cap and 100 on the body, containing 100 mg of itraconazole.

4 CLINICAL PARTICULARS

4.1 THERAPEUTIC INDICATIONS

ITRANOX is indicated for use in adults for the treatment of:

- Superficial dermatomycoses not responding to topical treatment.
- Fungal keratitis which has failed to respond to topical treatment or where the disease is either progressing rapidly or is immediately sight threatening.
- Pityriasis versicolor not responding to any other treatment.
- Vulvovaginal candidiasis not responding to topical treatment.
- Oral candidiasis in immunocompromised patients.
- Onychomycosis caused by dermatophytes.
- Systemic mycoses:
 - Systemic aspergillosis, histoplasmosis, sporotrichosis.
 - Treatment and maintenance therapy in AIDS patients with disseminated or chronic pulmonary histoplasmosis infection.
 - Treatment of oropharyngeal and/or oesophageal candidiasis when first line systemic antifungal therapy is inappropriate or has proven ineffective.
 - Treatment of non-invasive candidiasis in non-neutropenic patients when first-line systemic antifungal therapy is inappropriate or has proven ineffective. This may be due to underlying pathology, insensitivity of the pathogen or drug toxicity.

4.2 DOSE AND METHOD OF ADMINISTRATION

It is essential that ITRANOX capsules are taken immediately after a meal for maximal absorption. The capsules must be swallowed whole. Treatment schedules are as follows:

Superficial dermatomycoses:

- Tinea corporis, tinea cruris: 1 capsule (100 mg) daily for 2 weeks
- Tinea pedis, tinea manus: 1 capsule (100 mg) daily for 4 weeks

Fungal keratitis:

- 2 capsules (200 mg) once daily for 3 weeks

Pityriasis versicolor:

- 2 capsules (200 mg) once daily for 1 week

Vulvovaginal candidiasis:

- 2 capsules (200 mg) morning and evening for 1 day or 2 capsules (200 mg) once daily for 3 days

Oral candidiasis in immunocompromised patients:

- 1 capsule (100 mg) or 2 capsules (200 mg) daily for 4 weeks

Onychomycosis:

- 2 capsules (200 mg) once daily for 3 months OR
- Pulse therapy (see table below):
A pulse treatment consists of two capsules twice daily (200 mg b.i.d.) for one week. Two pulse treatments are recommended for fingernail infections, three pulse treatments for toenail infections. Pulse treatments are always separated by a 3-week drug-free interval. Clinical response will become evident as the nail regrows, following discontinuation of the treatment.

Site of Onychomycosis	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8	Week 9
Toenails with or without fingernail involvement	Pulse 1	Itraconazole free weeks			Pulse 2	Itraconazole free weeks			Pulse 3
Fingernails only	Pulse 1	Itraconazole free weeks			Pulse 2				

Systemic mycoses:

(Dosage recommendations vary according to the infection treated)

INDICATION	DOSE	USUAL DURATION	REMARKS
Aspergillosis	200 mg o.d.	2 - 5 months	Increase dose to 200 mg b.i.d. in cases of invasive or disseminated disease
Histoplasmosis	200 mg o.d. - 200 mg b.i.d.	8 months	Continue as necessary in AIDS patients. Maintenance therapy: 200 mg o.d.
Sporotrichosis	100 mg o.d.	3 months	Some patients may require 200 mg daily.
Candidiasis	100 - 200 mg o.d.	3 weeks - 7 months	-

Special Populations

Elderly

Clinical data on the use of Itraconazole capsules in elderly patients are limited. It is advised to use ITRANOX capsules in these patients only if it is determined that the potential benefit outweighs the potential risks. In general, it is recommended that the dose selection for an elderly patient should be taken into consideration, reflecting the greater frequency of decreased hepatic, renal, or cardiac function, and of concomitant disease or other drug therapy (See 4.4 Special warnings and precautions for use).

Hepatic Impairment

Limited data are available on the use of oral itraconazole in patients with hepatic impairment. Caution should be exercised when this drug is administered in this patient population. (See 4.4 Special warnings and precautions for use).

Renal Impairment

Limited data are available on the use of oral itraconazole in patients with renal insufficiency. The exposure of itraconazole may be lower in some patients with renal insufficiency. Caution should be exercised when this drug is administered in this patient population and adjusting the dose may be considered.

4.3 CONTRAINDICATIONS

Co-administration of a number of CYP3A4 substrates is contraindicated with SPORANOX Capsules. Increased plasma concentration of these drugs, caused by co-administration with itraconazole, may increase or prolong both therapeutic and adverse effect to such an extent that a potentially serious situation may occur. Increased plasma concentrations of some of these drugs can lead to QT prolongation. (see 4.5 Interactions with other medicines and other forms of interactions – Table 1 for specific examples)

Co-administration of the following drugs is contraindicated with Itraconazole capsule: terfenadine, astemizole, bepridil, felodipine, lercanidipine, domperidone, disopyramide, dronedarone, methadone, lurasidone, ticagrelor, halofantrine, isavuconazole, naloxegol, lomitapide, avanafil, dapoxetine, eliglustat, irinotecan, ivabradine, ranolazine, eplerenone, nisoldipine, mizolastine, cisapride, dofetilide, levacetylmethadol (levomethadyl), quinidine, pimozide, sertindole, CYP3A4-metabolised HMG-CoA reductase inhibitors such as simvastatin and lovastatin, oral midazolam, triazolam and ergot alkaloids such as dihydroergotamine, ergometrine (ergonovine), ergotamine and methylergometrine (methylergonovine), fesoterodine (in subjects with moderate to severe renal impairment, or moderate to severe hepatic impairment), colchicine (in subjects with renal or hepatic impairment), telithromycin (in subjects with severe renal impairment or severe hepatic impairment). (see 4.5 Interactions with other medicines and other forms of interactions – Table 1 for specific examples).

Serious cardiovascular adverse events, including death, ventricular tachycardia and torsades de pointes have been observed in patients taking itraconazole concomitantly with terfenadine, due to increased terfenadine concentrations induced by itraconazole.

Pharmacokinetic data indicates that another oral antifungal, ketoconazole, inhibits the metabolism of astemizole, resulting in elevated plasma levels of astemizole and its active metabolite desmethylastemizole, which may prolong QT intervals. *In vitro* data suggests that itraconazole, when compared to ketoconazole, has a less pronounced effect on the biotransformation system responsible for the metabolism of astemizole. Based on the chemical resemblance of itraconazole and ketoconazole, co-administration of astemizole with itraconazole is contraindicated.

Pharmacokinetic data indicates that oral ketoconazole potently inhibits the metabolism of cisapride resulting in an eight-fold increase in the mean AUC of cisapride. Data suggest that co-administration of oral ketoconazole and cisapride can result in prolongation of the QT interval on the ECG. *In vitro* data suggest that itraconazole also markedly inhibits the biotransformation system mainly responsible for the metabolism of cisapride; therefore concomitant administration of itraconazole with cisapride is contraindicated.

Co-administration of itraconazole with oral midazolam or triazolam has resulted in elevated plasma concentrations of the latter two drugs. This may potentiate and prolong hypnotic and sedative effects. These agents should not be used in patients treated with itraconazole. If

midazolam is administered parenterally, special precaution is required since the sedative effects may be prolonged.

Itraconazole capsules are contraindicated in patients with a known hypersensitivity to the drug or its excipients. There is no information regarding cross hypersensitivity between itraconazole and other azole antifungal agents. Caution should be used in prescribing itraconazole to patients with hypersensitivity to other azoles.

Itraconazole capsules should not be administered to patients with evidence of ventricular dysfunction such as congestive heart failure (CHF) or a history of CHF except for the treatment of life-threatening or other serious infections (see 4.4 Special warnings and precautions for use).

Itraconazole is contraindicated in pregnant women except for the treatment of life-threatening cases of systemic mycoses, where the potential benefits outweigh the potential harm to the foetus. Adequate contraceptive precautions should be taken by women of childbearing potential throughout itraconazole therapy, and continued until the next menstrual period following the completion of itraconazole therapy.

4.4 SPECIAL WARNINGS AND PRECAUTIONS FOR USE

Use with caution in the following circumstances

Peripheral neuropathy:

Isolated cases of peripheral neuropathy have also been reported, predominantly during long-term treatment with itraconazole. If neuropathy occurs that may be attributable to itraconazole, the treatment should be discontinued.

Decreased gastric acidity:

Absorption of itraconazole from itraconazole capsules is impaired when the gastric acidity is decreased. In patients also receiving acid neutralising medicines (e.g. aluminium hydroxide), these should be administered at least 2 hours after the intake of itraconazole. In patients with achlorhydria, such as certain AIDS patients and patients on acid secretion suppressors (e.g. H₂-antagonists, proton-pump inhibitors), it is advisable to administer itraconazole capsules with a cola beverage. (see 4.5 Interactions with other medicines and other forms of interactions)

Other azole antifungal agents:

There is limited information regarding cross hypersensitivity between itraconazole and other azole antifungal agents. Caution should be used in prescribing itraconazole capsules to patients with hypersensitivity to other azoles.

Use in patients with congestive heart failure

In a study with itraconazole IV in healthy volunteers a transient asymptomatic decrease of

the left ventricular ejection fraction, which resolved before the next infusion, was observed. The clinical relevance of these findings to the oral formulations is not known.

Itraconazole has been shown to have a negative inotropic effect. Itraconazole has been associated with reports of congestive heart failure. Heart failure was more frequently reported among spontaneous reports of 400 mg total daily dose than among those of lower total daily doses, suggesting that the risk of heart failure might increase with the total daily dose of itraconazole.

Itraconazole should not be used in patients with congestive heart failure or with a history of congestive heart failure unless the benefit clearly outweighs the risk. The risk benefit assessment should consider factors such as the severity of the indication, the dosing regimen (e.g. total daily dose) and individual risk factors for congestive heart failure. Risk factors include cardiac disease, such as ischaemic and valvular disease; significant pulmonary disease, such as chronic obstructive pulmonary disease; and renal failure and other oedematous disorders. Patients with these risk factors, who are being treated with itraconazole, should be informed of the signs and symptoms of congestive heart failure. Caution should be exercised and the patient monitored for the signs and symptoms of congestive heart failure. Itraconazole should be discontinued if such symptoms occur during treatment.

Calcium channel blockers can have negative inotropic effects which may be additive to those of itraconazole. In addition, itraconazole can inhibit the metabolism of calcium channel blockers. Therefore, caution should be used when co-administering itraconazole and calcium channel blockers due to an increased risk of CHF.

Immunocompromised patients

In some immunocompromised patients (e.g. neutropenic, AIDS or organ transplant patients) the oral bioavailability of itraconazole capsules may be decreased.

Patients with immediately life-threatening systemic fungal infections

Due to the pharmacokinetic properties itraconazole capsules are not recommended for initiation of treatment in patients with immediately life-threatening systemic fungal infections.

Patients with AIDS

In patients with AIDS having received treatment for a systemic fungal infection such as sporotrichosis, blastomycosis, histoplasmosis or cryptococcosis (meningeal and non-meningeal) and who are considered at risk for relapse, the treating physician should evaluate the need for a maintenance treatment.

Cystic fibrosis

In cystic fibrosis patients, variability in therapeutic levels of itraconazole was observed with steady state dosing of itraconazole oral solution using 2.5 mg/kg bid. Steady state

concentrations of > 250 ng/mL were achieved in approximately 50% of subjects greater than 16 years of age, but in none of the patients less than 16 years of age. If a patient does not respond to itraconazole capsules, consideration should be given to switching to alternative therapy.

Hearing loss

Transient or permanent hearing loss has been reported in patients receiving treatment with itraconazole. Several of these reports included concurrent administration of quinidine which is contraindicated (see 4.3 Contraindications and 4.5 Interactions with other medicines and other forms of interactions). The hearing loss usually resolves when treatment is stopped, but can persist in some patients.

Cross-resistance

In systemic candidosis, if fluconazole-resistant strains of *Candida* species are suspected, it cannot be assumed that these are sensitive to itraconazole, hence it is recommended to have their sensitivity tested before the start of itraconazole therapy.

Interchangeability

It is not recommended that itraconazole capsules and itraconazole oral solution* be used interchangeably. This is because drug exposure is greater with the oral solution than with the capsules when the same dose of the drug is given.

**itraconazole oral solution is unavailable in this brand however is available in other brands.*

Toxicology

(See 5.2 Pharmacokinetic properties – Toxicology section).

Use in hepatic impairment:

Itraconazole is predominantly metabolised in the liver. Patient with impaired hepatic function should be carefully monitored when taking itraconazole and when deciding to initiate therapy with other medications metabolised by CYP3A4. Dose adjustments may be considered in these patients. (See 5.2 Pharmacokinetic properties – special populations).

Patients with pre-existing abnormalities of hepatic function (raised liver enzymes, an active liver disease, or patients who have experienced liver toxicity with other drugs) who require itraconazole should be monitored, regardless of the duration of therapy.

Rare cases of cholestatic jaundice and very rare cases of hepatitis have been reported. Very rare cases of serious hepatotoxicity, including some cases of fatal acute liver failure, have occurred with the use of Itraconazole. Most of these cases involved patients who had pre-existing liver disease, were treated for systemic indications, had significant other medical conditions and/or were taking other hepatotoxic drugs. Some patients had no obvious risk

factors for liver disease. Some of these cases have been observed within the first month of treatment, including some within the first week. Liver function monitoring should be considered in patients receiving itraconazole treatment. Patients should be instructed to promptly report to their physician signs and symptoms suggestive of hepatitis such as anorexia, nausea, vomiting, fatigue, abdominal pain or dark urine. In these patients treatment should be stopped immediately and liver function testing should be conducted.

In patients with raised liver enzymes or active liver disease, or who have experienced liver toxicity with other drugs, treatment should not be started unless the expected benefit exceeds the risk of hepatic injury. In such cases liver enzyme monitoring is necessary.

Use in renal impairment:

Limited data are available on the use of oral itraconazole in patients with renal impairment. The exposure of itraconazole may be lower in some patients with renal insufficiency. Caution should be exercised when this drug is administered in this patient population and adjusting the dose may be considered.

Use in elderly:

Clinical data on the use of itraconazole capsules in elderly patients is limited. Use itraconazole capsules in these patients only if the potential benefits outweigh the potential risks. In general, it is recommended that the dose section for an elderly patient should be taken into consideration, reflecting the greater frequency of decreased hepatic, renal or cardiac function, and of concomitant disease or other therapy.

Paediatric Use:

The efficacy and safety of itraconazole have not been established in children. Since clinical data on the use of itraconazole in children is limited, itraconazole capsules should not be used in these patients unless the potential benefit outweighs the potential risks.

Toxicological studies have shown that itraconazole, when administered to rats, can produce bone toxicity. While such toxicity has not been reported in adult patients, the long-term effect of itraconazole in children is unknown (see 5.2 Pharmacokinetic properties – Toxicology).

Effects on laboratory tests:

No data available

4.5 INTERACTIONS WITH OTHER MEDICINES AND OTHER FORMS OF INTERACTIONS

Itraconazole is a drug with a high interaction potential. The various types of interaction and associated general recommendations are described below. In addition, a table is provided listing examples of drugs that may interact with itraconazole, organized per drug family for easy reference.

Other substances that either share this metabolic pathway or modify CYP3A4 activity may influence the pharmacokinetics of itraconazole. Coadministration of itraconazole with moderate or potent CYP3A4 inducers may decrease the bioavailability of itraconazole and hydroxy-itraconazole to such an extent that efficacy may be reduced.

Itraconazole and its major metabolite, hydroxy-itraconazole are potent CYP3A4 inhibitors. Itraconazole is an inhibitor of the drug transporters P-glycoprotein and breast cancer resistance protein (BCRP). Itraconazole can inhibit the metabolism of drugs metabolized by CYP3A4 and can inhibit the drug transport by P-glycoprotein and/or BCRP, which may result in increased plasma concentrations of these drugs and/or their active metabolite(s) when they are administered with itraconazole. These elevated plasma concentrations may increase or prolong both therapeutic and adverse effects of these drugs. For some drugs, coadministration with itraconazole may result in decreased plasma concentrations of the drug or of the active moiety of the drug. This may result in reduced efficacy of the drug.

Following cessation of medical treatment with itraconazole, plasma concentrations decrease below the detection limit within 7 to 14 days, depending on the dose and duration of treatment. In patients with hepatic cirrhosis or in subjects receiving CYP3A4 inhibitors the plasma concentrations decline slower. This is particularly important for consideration when initiating therapy with drugs whose metabolism is affected by itraconazole.

Other drugs that affect itraconazole

Demonstrated interactions

Itraconazole is mainly metabolised through CYP3A4. Potent inhibitors of this enzyme increase the bioavailability of itraconazole, which may result in increased or prolonged pharmacologic effects of Itraconazole. This has been demonstrated *in vivo* with clarithromycin, erythromycin and indinavir, and *in vitro* with ritonavir.

Rifampicin, phenytoin, rifabutin and isoniazid: These enzyme-inducing drugs significantly reduce the bioavailability and plasma concentrations of itraconazole to an extent that efficacy may be reduced. The combination of itraconazole with these potent enzyme inducers is not recommended.

Apixaban as an anticoagulant is also not recommended for co-administration with itraconazole.

Simeprevir and telaprevir as HCV protease inhibitors are not recommended for co-administration with itraconazole.

Certain antineoplastics, such as sunitinib is not recommended for co-administration with itraconazole.

Theoretical potential interactions

Other enzyme-inducing drugs capable of reducing the bioavailability of itraconazole include phenobarbital and carbamazepine. Similar effects on the efficacy of itraconazole, as demonstrated with other potent enzyme inducers, should be anticipated.

Effects of itraconazole on other drugs

Itraconazole can inhibit the metabolism of drugs metabolised by the cytochrome 3A family. This can result in an increase and/or a prolongation of their effects, including side effects. When using concomitant medication, the corresponding label should be consulted for information on the route of metabolism, interaction pathways, potential risks, and specific actions to be taken with regards to coadministration. After stopping treatment, the plasma levels of itraconazole decline gradually, depending on the dose and duration of treatment (see 5.2 Pharmacokinetic Properties). This should be taken into consideration when other drugs are co-administered.

In addition to possible pharmacokinetic interactions involving the drug metabolising enzyme CYP3A4, calcium channel blockers can have negative inotropic effects which may be additive to those of itraconazole. Itraconazole can inhibit the metabolism of calcium channel blockers. Caution should be used when co-administering itraconazole and calcium channel blockers due to an increased risk of CHF.

Demonstrated interactions

The following drugs are contraindicated with itraconazole:

- Astemizole, bepridil, cisapride, dofetilide, levacetylmethadol (levomethadyl), mizolastine, pimozone, quinidine, sertindole and terfenadine are contraindicated with Itraconazole oral solution* since co-administration may result in increased plasma concentrations of these substrates, which can lead to QT prolongation and rare occurrences of torsade de pointes.

**itraconazole oral solution is unavailable in this brand however is available in other brands.*

- CYP3A4 metabolized HMG-CoA reductase inhibitors such as lovastatin and simvastatin.
- Triazolam and oral midazolam.
- Ergot alkaloids such as dihydroergotamine, ergometrine (ergonovine), ergotamine and methylethergometrine (methylethergonovine).
- Nisoldipine

- Domperidone.
- Ticagrelor.
- Solifenacin in subjects with severe renal impairment or moderate to severe hepatic impairment.

Co-administration of terfenadine with itraconazole has led to elevated plasma concentrations of terfenadine, resulting in rare instances of life-threatening cardiac dysrhythmias and death.

The following drugs should be used with caution, and the plasma levels, effects or side effects of these drugs should be monitored. If co-administered with itraconazole, their dosage should be reduced if necessary:

- Midazolam I.V.: Special precaution is required since the sedative effect may be prolonged.
- Coumarin-like drugs (e.g. warfarin): It has been reported that itraconazole enhances the anticoagulant effect of coumarin-like drugs. Therefore, prothrombin time should be carefully monitored in patients receiving itraconazole and coumarin-like drugs simultaneously.
- HIV protease inhibitors such as indinavir, ritonavir and saquinavir. *In vitro* inhibition of the metabolism of saquinavir has been demonstrated. Inhibition of the metabolism of indinavir has been demonstrated *in vitro* and *in vivo*. The AUC for indinavir increased approximately 25% and C_{min} doubled when administered concomitantly with itraconazole (200 mg b.i.d.).
- Certain antineoplastic agents such as busulphan, docetaxel, trimetrexate and vinca alkaloids.
- CYP3A4-metabolised calcium channel blockers such as dihydropyridines (nifedipine, amlodipine besylate, felodipine and nimodipine) and verapamil. Oedema has been reported in patients concomitantly receiving Itraconazole and dihydropyridine calcium channel blockers. Patients should be monitored for adverse effects.
- Digoxin (via inhibition of P-glycoprotein): Co-administration of itraconazole and digoxin has led to increased plasma concentrations of digoxin. When digoxin is given concurrently with itraconazole, the physician is advised to monitor digoxin concentrations and reduce the dosage as needed.
- Certain immunosuppressive agents: cyclosporin, sirolimus and tacrolimus. Co-administration of itraconazole and cyclosporin has led to increased plasma concentrations of cyclosporin. Although no studies have been conducted, literature case reports suggest that the dose of cyclosporin should be reduced by 50% when itraconazole doses greater than 100 mg daily are given. Cyclosporin concentrations should be monitored frequently and the dose adjusted accordingly.
- Certain CYP3A4 metabolised HMG-CoA reductase inhibitors such as atorvastatin.
- Certain glucocorticosteroids such as budesonide, dexamethasone, fluticasone and methylprednisolone.
- Norethisterone: The bioavailability of norethisterone has been shown to increase by 40% with concomitantly administered itraconazole.
- Buspirone: Co-administration of buspirone (10 mg/day) and itraconazole (200 mg/day) resulted in marked increase in the C_{max} of buspirone (13 fold increase) and

AUC (19 fold increase) accompanied by sedative effects and psychomotor impairment. If the drugs are used concomitantly, a low dose of buspirone (2.5 mg b.i.d.) is initially recommended with subsequent adjustment based on clinical assessment.

- Others: alfentanil, alprazolam, bosentan, brotizolam, carbamazepine, cilostazol, disopyramide, ebastine, eletriptan, gefitinib, imatinib, fentanyl, halofantrine, oxybutynin, reboxetine, repaglinide, rufabutin, riociguat, Sildenafil, for the treatment of erectile dysfunction.
- Certain antineoplastics such as axitinib, dabrafenib and ibrutinib are not recommended for co-administration with itraconazole.
- Sildenafil, for the treatment of pulmonary hypertension is not recommended for co-administration with itraconazole.
- Certain urological drugs, such as darifenacin is not recommended for co-administration with itraconazole.
- Tolvaptan is not recommended for co-administration with itraconazole.

The following general recommendations apply, unless stated differently in table.

- ‘Contraindicated’: Under no circumstances is the drug to be coadministered with itraconazole. This applies to:
 - o CYP3A4 substrates for which increased plasma concentrations may increase or prolong therapeutic and/or adverse effects to such an extent that a potentially serious situation may occur. (see 4.3 *Contraindications*)
- ‘Not recommended’: It is recommended that the use of the drug be avoided, unless the benefits outweigh the potentially increased risks. If coadministration cannot be avoided, clinical monitoring is recommended, and the dosage of itraconazole and/or the coadministered drug adapted as deemed necessary. When appropriate, it is recommended that plasma concentrations be measured. This applies to:
 - o Moderate or potent CYP3A4 inducers: not recommended from 2 weeks before and during treatment with itraconazole
 - o CYP3A4/P-gp/BCRP substrates for which increased or decreased plasma concentrations result in significant risk: not recommended during and up to 2 weeks after treatment with itraconazole.
- ‘Use with caution’: Careful monitoring is recommended when the drug is coadministered with itraconazole. Upon coadministration, it is recommended that patients be monitored closely and the dosage of itraconazole and/or the coadministered drug adapted as deemed necessary. When appropriate, it is recommended that plasma concentrations be measured. This applies to:
 - o Drugs that reduce gastric acidity (itra caps only)
 - o Moderate or potent inhibitors of CYP3A4
 - o CYP3A4/P-gp/BCRP substrates for which increased or decreased plasma concentrations result in a clinically relevant risk

Examples of interacting drugs are listed in the table below. The drugs listed in this table are based on either drug interaction studies or case reports, or potential interactions based on the mechanism of interaction.

Table 1

Medicinal products within class	Expected/Potential effect on drug levels (see footnotes for additional info)	Clinical comment (see codes above for additional info)
Alpha Blockers		
Alfuzosin Silodosin Tamsulosin	Alfuzosin C _{max} (↑↑), AUC (↑↑) ^a Silodosin C _{max} (↑↑), AUC (↑↑) ^a Tamsulosin C _{max} (↑↑), AUC (↑↑) ^a	Not recommended during and for 2 weeks after treatment with itraconazole. Increased risk of alfuzosin/silodosin/tamsulosin-related adverse reactions ^c .
Analgesics		
Alfentanil Buprenorphine (IV and sublingual) Oxycodone Sufentanil	Alfentanil AUC (↑↑ to ↑↑↑↑) ^a Buprenorphine C _{max} (↑↑), AUC (↑↑) ^a Oxycodone C _{max} ↑, AUC ↑↑ Sufentanil conc increase (extent unknown) ^{a,b}	Use with caution, monitor for adverse reactions related to the analgesic ^c , dose reduction of alfentanil/buprenorphine/oxycodone/sufentanil may be necessary.
Fentanyl	Fentanyl IV AUC (↑↑) ^a Fentanyl other form. conc increase (extent unknown) ^{a,b}	Not recommended during and for 2 weeks after treatment with itraconazole. Increased risk of fentanyl-related adverse reactions ^c .
Levacetylmethadol (levomethadyl)	Levacetylmethadol C _{max} (↑↑), AUC (↑↑↑) ^a	Contraindicated during and for 2 weeks after treatment with itraconazole. Increased risk of levacetylmethadol-related adverse reactions, such as QT prolongation and TdP.
Methadone	(R)-methadone C _{max} (↑), AUC (↑) ^a	Contraindicated during and for 2 weeks after treatment with itraconazole. Increased risk of methadone-related adverse reactions, such as potentially life-threatening respiratory depression, QT prolongation and TdP.
Antiarrhythmics		

Digoxin	Digoxin C _{max} ↑, AUC ↑	Use with caution, monitor for digoxin adverse reactions, dose reduction of digoxin may be necessary ^c .
Disopyramide	Disopyramide conc increase (↑↑) ^{a,b}	Contraindicated during and for 2 weeks after treatment with itraconazole. Increased risk of disopyramide-related adverse reactions, such as serious arrhythmias including TdP.
Dofetilide	Dofetilide C _{max} (↑), AUC (↑) ^a	Contraindicated during and for 2 weeks after treatment with itraconazole. Increased risk of dofetilide-related adverse reactions, such as serious ventricular arrhythmias including TdP.
Dronedarone	Dronedarone C _{max} (↑↑↑), AUC (↑↑↑↑) ^a	Contraindicated during and for 2 weeks after treatment with itraconazole. Increased risk of dronedarone-related adverse reactions, such as QT prolongation and cardiovascular death.
Quinidine	Quinidine C _{max} ↑, AUC ↑↑	Contraindicated during and for 2 weeks after treatment with itraconazole. Increased risk of quinidine-related adverse reactions, such as QT prolongation, TdP, hypotension, confusion and delirium.
Antibacterials		
Bedaquiline	Bedaquiline C _{max} (↔), AUC (↑) during 2 weeks of bedaquiline q.d. dosing ^a	Not recommended, coadministration for more than 2 weeks at any time during bedaquiline dosing is not recommended: increased risk of bedaquiline-related adverse reactions ^c .
Ciprofloxacin Erythromycin	Itraconazole C _{max} ↑, AUC ↑	Use with caution, monitor for itraconazole adverse reactions, dose reduction of itraconazole may be necessary.
Clarithromycin	Clarithromycin conc increase (extent unknown) ^{a,b} Itraconazole C _{max} ↑, AUC ↑;	Use with caution, monitor for adverse reactions related to itraconazole and/or clarithromycin ^c , dose reduction of itraconazole and/or clarithromycin may be necessary.
Delamanid Trimetrexate	Delamanid conc. increase (extent unknown) ^{a,b}	Use with caution, monitor for delamanid/trimetrexate adverse reactions,
	Trimetrexate conc increase (extent unknown) ^{a,b}	dose reduction of delamanid/trimetrexate may be necessary ^c .
Isoniazid Rifampicin	Isoniazid: itraconazole conc. (↓↓↓) ^{a,b}	Not recommended from 2 weeks before and during treatment with itraconazole,

	Rifampicin: itraconazole AUC ↓↓↓	Itraconazole efficacy may be reduced .
Rifabutin	Rifabutin conc. increase (extent unknown) ^{a,b} Itraconazole: C _{max} ↓↓, AUC ↓↓	Not recommended from 2 weeks before, during and for 2 weeks after treatment with itraconazole. Itraconazole efficacy may be reduced and increased risk of rifabutin-related adverse reactions ^c .
Telithromycin	In healthy subjects: telithromycin C _{max} ↑, AUC ↑ In severe renal impairment: telithromycin AUC (↑↑) ^a In severe hepatic impairment: telithromycin conc. increase (extent unknown) ^{a,b}	Contraindicated in patients with severe renal or hepatic impairment during and for 2 weeks after treatment with itraconazole, Increased risk of telithromycin-related adverse reactions, such as hepatotoxicity, QT prolongation and TdPs. Use with caution in other patients:, monitor for telithromycin adverse reactions, dose reduction of telithromycin may be necessary ^c .
Anticoagulants and Antiplatelet Drugs		
Apixaban Rivaroxaban Vorapaxar	Apixaban C _{max} (↑), AUC (↑) ^a Rivaroxaban C _{max} (↑), AUC (↑ to ↑↑) ^a Vorapaxar C _{max} (↑), AUC (↑) ^a	Not recommended during and for 2 weeks after treatment with itraconazole. Increased risk of apixaban/rivaroxaban/vorapaxar-related adverse reactions ^c .
Coumarins (eg, warfarin) Cilostazol	Coumarins (eg, warfarin) conc increase (extent unknown) ^{a,b} Cilostazol C _{max} (↑), AUC (↑↑) ^a	Use with caution, monitor for coumarins/cilostazol adverse reactions, dose reduction of coumarins/cilostazol may be necessary ^c .
Dabigatran	Dabigatran C _{max} (↑↑), AUC (↑↑) ^a	Use with caution, monitor for dabigatran adverse reactions, dose reduction of dabigatran may be necessary ^c .
Ticagrelor	Ticagrelor C _{max} (↑↑), AUC (↑↑↑) ^a	Contraindicated during and for 2 weeks after treatment with itraconazole. Increased risk of ticagrelor-related adverse reactions, such as bleeding.
Anticonvulsants		

Carbamazepine	Carbamazepine conc. (↑) ^{a,b} Itraconazole conc. (↓↓) ^{a,b}	Not recommended from 2 weeks before, during and for 2 weeks after treatment with itraconazole. Itraconazole efficacy may be reduced and increased risk for carbamazepine-related adverse reactions ^c .
Phenobarbital Phenytoin	Phenobarbital: itraconazole conc. (↓↓↓) ^{a,b} Phenytoin: itraconazole AUC ↓↓↓	Not recommended from 2 weeks before and during treatment with itraconazole. Itraconazole efficacy may be reduced.
Antidiabetics		
Repaglinide Saxagliptin	Repaglinide C _{max} ↑, AUC ↑ Saxagliptin C _{max} (↑↑), AUC (↑↑) ^a	Use with caution, monitor for repaglinide/saxagliptin adverse reactions, dose reduction of repaglinide/saxagliptin may be necessary ^c .
Antihelminthics, antifungals and antiprotozoals		
Artemether- lumefantrine Quinine	Artemether C _{max} (↑↑), AUC (↑↑) ^a Lumefantrine C _{max} (↑), AUC (↑) ^a Quinine C _{max} ↔, AUC ↑	Use with caution, monitor for artemetherlumefantrine/quinine adverse reactions ^c . Refer to the label for specific actions to be taken.
Halofantrine	Halofantrine conc increase (extent unknown) ^{a,b}	Contraindicated during and for 2 weeks after treatment with itraconazole. Increased risk of halofantrine-related adverse reactions, such as QT prolongation and fatal arrhythmias.
Isavuconazole	Isavuconazole C _{max} (↔), AUC (↑↑↑) ^a	Contraindicated during and for 2 weeks after treatment with itraconazole. Increased risk of isavuconazole-related adverse reactions, such as hepatic adverse reactions, hypersensitivity reactions and embryo-fetal toxicity.
Praziquantel	Praziquantel C _{max} (↑↑), AUC (↑) ^a	Use with caution, monitor for praziquantel adverse reactions, dose reduction of praziquantel may be necessary ^c .
Antihistamines		
Astemizole	Astemizole C _{max} (↑), AUC (↑↑) ^a	Contraindicated during and for 2 weeks after treatment with itraconazole. Increased risk of astemizole-related adverse reactions, such as QT prolongation, TdP and other ventricular arrhythmias.

Bilastine Ebastine Rupatadine	Bilastine C _{max} (↑↑), AUC (↑) ^a Ebastine C _{max} ↑↑, AUC ↑↑↑ Rupatadine conc increase (↑↑↑↑) ^{a,b}	Use with caution, monitor for bilastine/ebastine/rupatadine adverse reactions ^c , dose reduction of bilastine/ebastine/rupatadine may be necessary.
Mizolastine	Mizolastine C _{max} (↑), AUC (↑) ^a	Contraindicated during and for 2 weeks after treatment with itraconazole. Increased risk of mizolastine-related adverse reactions, such as QT prolongation.
Terfenadine	Terfenadine conc increase (extent unknown) ^b	Contraindicated during and for 2 weeks after treatment with itraconazole. Increased risk of terfenadine-related adverse reactions, such as QT prolongation, TdP and other ventricular arrhythmias.
Antimigraine Drugs		
Eletriptan	Eletriptan C _{max} (↑↑), AUC (↑↑↑) ^a	Use with caution, monitor for eletriptan adverse reactions ^c , dose reduction of eletriptan may be necessary.
Ergot alkaloids (such as dihydroergotamine, ergometrine, ergotamine, methylergometrine)	Ergot alkaloids conc increase (extent unknown) ^{a,b}	Contraindicated during and for 2 weeks after treatment with itraconazole. Increased risk of ergot alkaloid-related adverse reactions, such as ergotism.
Antineoplastics		
Bortezomib Brentuximab vedotin Busulfan Erlotinib Gefitinib Imatinib Ixabepilone Nintedanib Panobinostat Ponatinib Ruxolitinib Sonidegib Vandetanib	Bortezomib AUC (↑) ^a Brentuximab vedotin AUC (↑) ^a Busulfan C _{max} ↑, AUC ↑ Erlotinib C _{max} (↑↑), AUC (↑) ^a Gefitinib C _{max} ↑, AUC ↑ Imatinib C _{max} (↑), AUC (↑) ^a Ixabepilone C _{max} (↔), AUC (↑) ^a Nintedanib C _{max} (↑), AUC (↑) ^a	Use with caution, monitor for adverse reactions related to the antineoplastic drug ^c , dose reduction of the antineoplastic drug may be necessary.

	Panobinostat C _{max} (↑), AUC (↑) ^a Ponatinib C _{max} (↑), AUC (↑) ^a Ruxolitinib C _{max} (↑), AUC (↑) ^a Sonidegib C _{max} (↑), AUC (↑↑) ^a Vandetanib C _{max} ↔, AUC ↑	
Idelalisib	Idelalisib C _{max} (↑), AUC (↑) ^a Itraconazole serum conc. increase (extent unknown) ^{a,b}	Use with caution, monitor for adverse reactions related to itraconazole and/or idelalisib ^c , dose reduction of itraconazole and/or idelalisib may be necessary.
Axitinib Bosutinib Cabazitaxel Cabozantinib Ceritinib Cobimetinib Crizotinib Dabrafenib	Axitinib C _{max} (↑), AUC (↑↑) ^a Bosutinib C _{max} (↑↑↑), AUC (↑↑↑) ^a Cabazitaxel C _{max} (↔), AUC (↔) ^a Cabozantinib C _{max} (↔), AUC (↑) ^a Ceritinib C _{max} (↑), AUC (↑↑) ^a Cobimetinib C _{max} ↑↑, AUC ↑↑↑ Crizotinib C _{max} (↑), AUC (↑↑) ^a Dabrafenib AUC (↑) ^a	Not recommended during and for 2 weeks after treatment with itraconazole. Increased risk of adverse reactions related to the antineoplastic drug ^c . Additionally: For cabazitaxel, even though the change in pharmacokinetic parameters did not reach statistical significance in a low-dose drug
Dasatinib Docetaxel Ibrutinib Lapatinib Nilotinib Olaparib Pazopanib Sunitinib Trabectedin Trastuzumab emtansine	Dasatinib C _{max} (↑↑), AUC (↑↑) ^a Docetaxel AUC (↔ to ↑↑) ^a Ibrutinib C _{max} (↑↑↑↑), AUC (↑↑↑↑) ^a Lapatinib C _{max} (↑↑), AUC (↑↑) ^a Nilotinib C _{max} (↑), AUC (↑↑) ^a	interaction study with ketoconazole, a high variability in the results was observed. For ibrutinib, refer to the label for specific actions to be taken.

Vinca alkaloids	<p>Olaparib C_{max} ↑, AUC ↑↑</p> <p>Pazopanib C_{max} (↑), AUC (↑)^a</p> <p>Sunitinib C_{max} (↑), AUC (↑)^a</p> <p>Trabectedin C_{max} (↑), AUC (↑)^a</p> <p>Trastuzumab emtastine conc increase (extent unknown)^{a,b}</p> <p>Vinca alkaloid conc increase (extent unknown)^{a,b}</p>	
Regorafenib	Regorafenib AUC (↓↓ by estimation of active moiety) ^a	Not recommended during and for 2 weeks after treatment with itraconazole. Regorafenib efficacy may be reduced.
Irinotecan	Irinotecan and its active metabolite conc increase (extent unknown) ^{a,b}	Contraindicated during and for 2 weeks after treatment with itraconazole. Increased risk of irinotecan-related adverse reactions, such as potentially life-threatening myelosuppression and diarrhea.
Antipsychotics, Anxiolytics and Hypnotics		
<p>Alprazolam</p> <p>Aripiprazole</p> <p>Brotizolam</p> <p>Buspirone</p> <p>Haloperidol</p> <p>Midazolam (iv)</p> <p>Perospirone</p> <p>Quetiapine</p> <p>Ramelteon</p> <p>Risperidone</p> <p>Suvorexant</p> <p>Zopiclone</p>	<p>Alprazolam C_{max} ↔, AUC ↑↑</p> <p>Aripiprazole C_{max} ↑, AUC ↑</p> <p>Brotizolam C_{max} ↔, AUC ↑↑</p> <p>Buspirone C_{max} ↑↑↑↑, AUC ↑↑↑↑</p> <p>Ramelteon C_{max} ↑, AUC ↑</p> <p>Midazolam (iv) conc increase ↑↑^b</p> <p>Perospirone C_{max} ↑↑↑, AUC ↑↑↑</p> <p>Quetiapine C_{max} (↑↑), AUC (↑↑↑)^a</p> <p>Risperidone C_{max} (↑), AUC (↑)^a</p>	Use with caution, monitor for adverse reactions related to the antipsychotic, anxiolytic or hypnotic drug ^c , dose reduction of these drugs may be necessary.

	Risperidone conc increase \uparrow^b Suvorexant C_{\max} (\uparrow), AUC ($\uparrow\uparrow$) ^a Zopiclone C_{\max} \uparrow , AUC \uparrow	
Lurasidone	Lurasidone C_{\max} ($\uparrow\uparrow\uparrow$), AUC ($\uparrow\uparrow\uparrow$) ^a	Contraindicated during and for 2 weeks after treatment with itraconazole. Increased risk of lurasidone-related adverse reactions, such as hypotension, circulatory collapse, severe extrapyramidal symptoms, seizures.
Midazolam (oral)	Midazolam (oral) C_{\max} \uparrow to $\uparrow\uparrow$, AUC $\uparrow\uparrow$ to $\uparrow\uparrow\uparrow\uparrow$	Contraindicated during and for 2 weeks after treatment with itraconazole. Increased risk of midazolam-related adverse reactions, such as respiratory depression, cardiac arrest, prolonged sedation and coma.
Pimozide	Pimozide C_{\max} (\uparrow), AUC ($\uparrow\uparrow$) ^a	Contraindicated during and for 2 weeks after treatment with itraconazole. Increased risk of pimozide-related adverse reactions, such as cardiac arrhythmias, possibly associated with QT prolongation and TdP.
Sertindole	Sertindole conc increase (extent unknown) ^{a,b}	Contraindicated during and for 2 weeks after treatment with itraconazole. Increased risk of sertindole-related adverse reactions, such as QT prolongation and TdP.
Triazolam	Triazolam C_{\max} \uparrow to $\uparrow\uparrow$, AUC $\uparrow\uparrow$ to $\uparrow\uparrow\uparrow\uparrow$	Contraindicated during and for 2 weeks after treatment with itraconazole. Increased risk of triazolam-related adverse reactions, such as seizures, respiratory depression, angioedema, apnea and coma.
Antivirals		
Asunaprevir (boosted) Tenofovir disoproxil fumarate (TDF)	Asunaprevir C_{\max} ($\uparrow\uparrow\uparrow$), AUC ($\uparrow\uparrow\uparrow$) ^a Tenofovir conc increase (extent unknown) ^{a,b}	Use with caution, however, refer to the label of the antiviral drug for specific actions to be taken.

Boceprevir	Boceprevir C_{\max} (\uparrow), AUC ($\uparrow\uparrow$) ^a Itraconazole conc increase (extent unknown) ^{a,b}	Use with caution, monitor for adverse reactions related to itraconazole and/or boceprevir ^c , dose reduction of itraconazole may be necessary. Refer to the boceprevir label for specific actions to be taken.
Cobicistat	Cobicistat conc increase (extent unknown) ^{a,b} Itraconazole conc increase (extent unknown) ^{a,b}	Use with caution, monitor for adverse reactions related to itraconazole, dose reduction of itraconazole may be necessary.
Daclatasvir Vaniprevir	Daclatasvir C_{\max} (\uparrow), AUC ($\uparrow\uparrow$) ^a Vaniprevir C_{\max} ($\uparrow\uparrow\uparrow$), AUC ($\uparrow\uparrow\uparrow$) ^a	Use with caution, monitor for daclatasvir/vaniprevir adverse reactions ^c , dose reduction of daclatasvir/vaniprevir may be necessary.
Darunavir (boosted) Fosamprenavir (ritonavirboosted) Telaprevir	Ritonavir-boosted darunavir: itraconazole C_{\max} ($\uparrow\uparrow$), AUC ($\uparrow\uparrow$) ^a Ritonavir-boosted fosamprenavir: itraconazole C_{\max} (\uparrow), AUC ($\uparrow\uparrow$) ^a Telaprevir: itraconazole C_{\max} (\uparrow), AUC ($\uparrow\uparrow$) ^a	Use with caution, monitor for itraconazole adverse reactions, dose reduction of itraconazole may be necessary.
Elvitegravir (boosted)	Elvitegravir C_{\max} (\uparrow), AUC (\uparrow) ^a Itraconazole conc increase (extent unknown) ^{a,b}	Use with caution, monitor for adverse reactions related to itraconazole and/or elvitegravir (ritonavir-boosted) ^c . Dose reduction of itraconazole may be necessary; refer to the elvitegravir label for specific actions to be taken.
Efavirenz Nevirapine	Efavirenz: itraconazole C_{\max} \downarrow , AUC \downarrow Nevirapine: itraconazole C_{\max} \downarrow , AUC $\downarrow\downarrow$	Not recommended from 2 weeks before and during treatment with itraconazole. Itraconazole efficacy may be reduced.
Indinavir	Itraconazole conc. \uparrow ^b Indinavir C_{\max} \leftrightarrow , AUC \uparrow	Use with caution, monitor for adverse reactions related to itraconazole and/or indinavir ^c , dose reduction of itraconazole and/or indinavir may be necessary.
Maraviroc	Maraviroc C_{\max} ($\uparrow\uparrow$), AUC ($\uparrow\uparrow\uparrow$) ^a	Use with caution monitor for adverse reactions ^c . Dose reduction of maraviroc may be necessary.

Ritonavir	Itraconazole C _{max} (↑), AUC (↑↑) ^a Ritonavir C _{max} (↔), AUC (↑) ^a	Use with caution, monitor for adverse reactions related to itraconazole and/or ritonavir ^c , Dose reduction of itraconazole may be necessary; refer to the ritonavir label for specific actions to be taken.
Saquinavir	Saquinavir (unboosted) C _{max} ↑↑, AUC ↑↑↑ Itraconazole (with boosted saquinavir) C _{max} (↑), AUC (↑↑) ^a	Use with caution, monitor for adverse reactions related to itraconazole and/or saquinavir ^c , Dose reduction of itraconazole may be necessary; refer to the saquinavir label for specific actions to be taken.
Simeprevir	Simeprevir C _{max} (↑↑), AUC (↑↑↑) ^a	Not recommended during and for 2 weeks after treatment with itraconazole.
Beta Blockers		
Nadolol	Nadolol C _{max} ↑↑, AUC ↑↑	Use with caution, monitor for nadolol adverse reactions ^c . Dose reduction of nadolol may be necessary.
Calcium Channel Blockers		
Bepridil	Bepridil conc increase (extent unknown) ^{a,b}	Contraindicated during and for 2 weeks after treatment with itraconazole. Increased risk of bepridil-related adverse reactions, such as
		new arrhythmias and TdP type ventricular tachycardia.
Diltiazem	Diltiazem & Itraconazole conc increase (extent unknown) ^{a,b}	Use with caution, monitor for adverse reactions related to itraconazole and/or diltiazem ^c , dose reduction of itraconazole and/or diltiazem may be necessary.
Felodipine Lercanidipine Nisoldipine	Felodipine C _{max} ↑↑↑, AUC ↑↑↑ Lercanidipine AUC (↑↑↑↑) ^a Nisoldipine C _{max} (↑↑↑↑), AUC (↑↑↑↑) ^a	Contraindicated during and for 2 weeks after treatment with itraconazole. Increased risk of dihydropyridine-related adverse reactions, such as hypotension and peripheral edema.
Other dihydropyridines Verapamil	Dihydropyridine conc increase (extent unknown) ^{a,b} Verapamil conc increase (extent unknown) ^{a,b}	Use with caution, monitor for dihydropyridine/verapamil adverse reactions ^c , dose reduction of dihydropyridine/verapamil may be necessary.
Cardiovascular Drugs, Misc		

Aliskiren Riociguat Sildenafil (pulmonary hypertension) Tadalafil (pulmonary hypertension)	Aliskiren C _{max} ↑↑↑, AUC ↑↑↑ Riociguat C _{max} (↑), AUC (↑↑) ^a Sildenafil/Tadalafil conc increase (extent unknown but effect may be greater than reported under Urological Drugs) ^{a,b}	Not recommended during and for 2 weeks after treatment with itraconazole ^c . Increased risk of adverse reactions related to the cardiovascular drug.
Bosentan Guanfacine	Bosentan C _{max} (↑↑), AUC (↑↑) ^a Guanfacine C _{max} (↑), AUC (↑↑) ^a	Use with caution, monitor for bosentan/guanfacine adverse reactions ^c , dose reduction of bosentan/guanfacine may be necessary.
Ivabradine	Ivabradine C _{max} (↑↑), AUC (↑↑↑) ^a	Contraindicated during and for 2 weeks after treatment with itraconazole. Increased risk of ivabradine-related adverse reactions, such as atrial fibrillation, bradycardia, sinus arrest and heart block.
Ranolazine	Ranolazine C _{max} (↑↑), AUC (↑↑) ^a	Contraindicated during and for 2 weeks after treatment with itraconazole. Increased risk of ranolazine-related adverse reactions, such as QT prolongation and renal failure.
Contraceptives		
Dienogest Ulipristal	Dienogest C _{max} (↑), AUC (↑↑) ^a Ulipristal C _{max} (↑↑), AUC (↑↑↑) ^a	Use with caution, monitor for contraceptive adverse reactions ^c , refer to the dienogest/ulipristal label for specific actions to be taken.
Diuretics		
Eplerenone	Eplerenone C _{max} (↑), AUC (↑↑↑) ^a	Contraindicated during and for 2 weeks after treatment with itraconazole. Increased risk of eplerenone-related adverse reactions, such as hyperkalemia and hypotension.
Gastrointestinal Drugs		
Aprepitant Loperamide Netupitant	Aprepitant AUC (↑↑↑) ^a Loperamide C _{max} ↑↑, AUC ↑↑ Netupitant C _{max} (↑), AUC (↑↑) ^a	Use with caution, monitor for aprepitant/loperamide/netupitant adverse reactions ^c , Dose reduction of aprepitant/loperamide/ may be necessary. Refer to the netupitant label for specific actions to be taken.

Cisapride	Cisapride conc increase (extent unknown) ^{a,b}	Contraindicated during and for 2 weeks after treatment with itraconazole. Increased risk of cisapride-related adverse reactions, such as serious cardiovascular events including QT prolongation, serious ventricular arrhythmias and TdP.
Domperidone	Domperidone C _{max} ↑↑, AUC ↑↑	Contraindicated during and for 2 weeks after treatment with itraconazole. Increased risk of domperidone-related adverse reactions, such as serious ventricular arrhythmias and sudden cardiac death.
Drugs that reduce gastric acidity	Itraconazole: C _{max} ↓↓, AUC ↓↓	Use with caution: Drugs that reduce gastric acidity: e.g. acid neutralizing medicines such as aluminum hydroxide, or acid secretion suppressors such as H ₂ - receptor antagonists and proton pump inhibitors. When co-treatment with acid neutralizing medicines (e.g. aluminum hydroxide) these should be administered at least 2 hours before or 2 hours after the intake of Sporanox capsules. (See 4.4 Special precautions and warnings for use.)
Naloxegol	Naloxegol C _{max} (↑↑↑), AUC (↑↑↑↑) ^a	Contraindicated during and for 2 weeks after treatment with itraconazole. Increased risk of naloxegol-related adverse reactions, such as opioid withdrawal symptoms.
Saccharomyces boulardii	<i>S. boulardii</i> colonization decrease (extent unknown)	Not recommended during and for 2 weeks after treatment with itraconazole. <i>S. boulardii</i> efficacy may be reduced.
Immunosuppressants		

Budesonide	Budesonide (inhalation) C_{max} ↑, AUC ↑↑; Budesonide (other form.) conc increase (extent unknown) ^{a,b}	Use with caution monitor for immunosuppressant adverse reactions ^c , Dose reduction of the immunosuppressant drug may be necessary
Ciclesonide	Ciclesonide (inhalation) C_{max} (↑↑), AUC (↑↑) ^a	
Cyclosporine	Cyclosporine (iv) conc increase ↔ to ↑ ^b	
Dexamethasone	Cyclosporine (other form.) conc increase (extent unknown) ^{a,b}	
Fluticasone	Dexamethasone C_{max} ↔ (iv) ↑ (oral), AUC ↑↑ (iv, oral)	
Methylprednisolone	Fluticasone (inhalation) conc increase ↑↑ ^b	
Tacrolimus	Fluticasone (nasal) conc increase (↑) ^{a,b}	
Temsirolimus	Methylprednisolone (oral) C_{max} ↑ to ↑↑, AUC ↑↑ Methylprednisolone (iv) AUC ↑↑ Tacrolimus (iv) conc increase ↑ ^b Tacrolimus (oral) C_{max} (↑↑), AUC (↑↑) ^a Temsirolimus (iv) C_{max} (↑↑), AUC (↑↑) ^a	
Everolimus Sirolimus (rapamycin)	Everolimus C_{max} (↑↑), AUC (↑↑↑↑) ^a Sirolimus C_{max} (↑↑), AUC (↑↑↑↑) ^a	Not recommended during and for 2 weeks after treatment with itraconazole ^c . Increased risk of everolimus/ sirolimus-related adverse reactions.
Lipid Regulating Drugs		

Atorvastatin	Atorvastatin C _{max} ↔ to ↑↑, AUC ↑ to ↑↑	Use with caution, monitor for atorvastatin adverse reactions ^c , Dose reduction of atorvastatin may be necessary.
Lomitapide	Lomitapide C _{max} (↑↑↑↑), AUC (↑↑↑↑) ^a	Contraindicated during and for 2 weeks after treatment with itraconazole. Increased risk of lomitapide-related adverse reactions, such as hepatotoxicity and severe gastrointestinal reactions.
Lovastatin Simvastatin	Lovastatin C _{max} ↑↑↑↑, AUC ↑↑↑↑ Simvastatin C _{max} ↑↑↑↑, AUC ↑↑↑↑	Contraindicated during and for 2 weeks after treatment with itraconazole. Increased risk of lovastatin/ simvastatin-related adverse reactions, such as myopathy, rhabdomyolysis and liver enzyme abnormalities.
Nonsteroidal Anti-Inflammatory Drugs		
Meloxicam	Meloxicam C _{max} ↓↓, AUC ↓	Use with caution, monitor for reduced efficacy of meloxicam, dose adaption of meloxicam may be necessary.
Respiratory Drugs		
Salmeterol	Salmeterol C _{max} (↑), AUC (↑↑↑↑) ^a	Not recommended during and for 2 weeks after treatment with itraconazole. Increased risk of salmeterol-related adverse reactions ^c .
SSRIs, Tricyclics and Related Antidepressants		
Reboxetine Venlafaxine	Reboxetine C _{max} (↔), AUC (↑) ^a Venlafaxine C _{max} (↑), AUC (↑) ^a	Use with caution, monitor for reboxetine/venlafaxine adverse reactions ^c , dose reduction of reboxetine/venlafaxine may be necessary.
Urologic Drugs		
Avanafil	Avanafil C _{max} (↑↑), AUC (↑↑↑↑) ^a	Contraindicated during and for 2 weeks after treatment with itraconazole. Increased risk avanafil-related adverse reactions, such as priapism, visual problems and sudden loss of hearing.
Dapoxetine	Dapoxetine C _{max} (↑), AUC (↑) ^a	Contraindicated during and for 2 weeks after treatment with itraconazole. Increased risk for dapoxetine-related adverse reactions, such as orthostatic hypotension and ocular effects.

Darifenacin Vardenafil	Darifenacin C _{max} (↑↑↑), AUC (↑↑↑ to ↑↑↑↑) ^a Vardenafil C _{max} (↑↑), AUC (↑↑↑↑) ^a	Not recommended during and for 2 weeks after treatment with itraconazole. Increased risk of darifenacin/vardenafil-related adverse reactions ^c .
Dutasteride Imidafenacin Oxybutynin Sildenafil (erectile dysfunction) Tadalafil (erectile dysfunction and benign prostatic hyperplasia) Tolterodine Udenafil	Dutasteride conc increase (extent unknown) ^{a,b} Imidafenacin C _{max} ↑, AUC ↑ Oxybutynin conc increase ↑ ^b Sildenafil C _{max} (↑↑), AUC (↑↑ to ↑↑↑↑) ^a Tadalafil C _{max} (↑), AUC (↑↑) ^a Tolterodine C _{max} (↑ to ↑↑), AUC (↑↑) ^a in poor metabolizers of CYP2D6 Udenafil C _{max} (↑), AUC (↑↑) ^a	Use with caution, monitor for urologic drug adverse reactions ^c , dose reduction of the urologic drug may be necessary; refer to the dutasteride label for specific actions to be taken. (For sildenafil and tadalafil, see also <i>Cardiovascular Drugs, Miscellaneous Drugs and other substances</i> .)
Fesoterodine	Fesoterodine C _{max} (↑↑), AUC (↑↑) ^a	Contraindicated in patients with moderate to severe renal or hepatic impairment, during and for 2 weeks after treatment with itraconazole. Increased risk of fesoterodine-related adverse reactions, such as severe anticholinergic effects. Use with caution in other patients: monitor for fesoterodine adverse reactions ^c , dose reduction of fesoterodine may be necessary.
Solifenacin	Solifenacin C _{max} (↑), AUC (↑↑) ^a	Contraindicated in patients with severe renal or moderate to severe hepatic impairment, during and for 2 weeks after treatment with itraconazole. Increased risk of solifenacin-related adverse reactions, such as anticholinergic effects and QT prolongation. Use with caution in other patients, monitor for solifenacin drug adverse reactions ^c , dose reduction of solifenacin may be necessary.

Miscellaneous Drugs and Other Substances		
Alitretinoin (oral) Cabergoline	Alitretinoin C _{max} (↑), AUC (↑) ^a Cabergoline C _{max} (↑↑), AUC (↑↑) ^a	Use with caution, monitor for alitretinoin/ cabergoline/cannabinoids/cinacalcet drug
Cannabinoids Cinacalcet	Cannabinoids conc increase, extent unknown but likely (↑↑) ^a Cinacalcet C _{max} (↑↑), AUC (↑↑) ^a	adverse reactions, dose reduction of alitretinoin/ cabergoline/cannabinoids/cinacalcet may be necessary ^c .
Colchicine	Colchicine C _{max} (↑), AUC (↑↑) ^a	Contraindicated in patients with renal or hepatic impairment, during and for 2 weeks after treatment with itraconazole. Increased risk of colchicine-related adverse reactions, such as decreased cardiac output, cardiac arrhythmias, respiratory distress and bone marrow depression. Not recommended in other patients, during and for 2 weeks after treatment with itraconazole. Increased risk of colchicinereLATED adverse reactions ^c .
Eliglustat	CYP2D6 EMs: Eliglustat C _{max} (↑↑), AUC (↑↑) ^a Higher increases are expected in CYP2D6 IMs/PMs and upon coadministration with a CYP2D6 inhibitor.	Contraindicated in CYP2D6 EMs taking a strong or moderate CYP2D6 inhibitor / CYP2D6 IMs and PMs, during and for 2 weeks after treatment with itraconazole. Increased risk of eliglustat-related AEs such as prolongation of the PR, QTc, and/or QRS cardiac interval, and cardiac arrhythmias. Use with caution in CYP2D6 EMs, monitor for eliglustat adverse reactions ^c , dose reduction of eliglustat may be necessary.
Ergot alkaloids	Ergot alkaloids conc increase (extent unknown) ^{a,b}	Contraindicated during and for 2 weeks after treatment with itraconazole. Increased risk of ergot alkaloid-related adverse reactions, such as ergotism. (see also <i>Antimigraine Drugs</i>)
Ivacaftor	Ivacaftor C _{max} (↑↑), AUC (↑↑↑) ^a	Use with caution, monitor for ivacaftor adverse reactions ^c , dose reduction of ivacaftor may be necessary.

Lumacaftor/Ivacaftor	Ivacaftor C _{max} (↑↑), AUC (↑↑) ^a Lumacaftor C _{max} (↔), AUC (↔) ^a Itraconazole conc decrease, extent unknown but likely ↓↓↓	Not recommended from 2 weeks before, during and for 2 weeks after treatment with itraconazole. Itraconazole efficacy may be reduced and increased risk of ivacaftor-related adverse reactions ^c .
Vasopressin Receptor Antagonists		
Conivaptan Tolvaptan	Conivaptan C _{max} (↑↑), AUC (↑↑↑↑) ^a Tolvaptan C _{max} (↑↑), AUC (↑↑↑) ^a	Not recommended during and for 2 weeks after treatment with itraconazole. Increased risk of conivaptan/ tolvaptan-related adverse reactions ^c .
Mozavaptan	Mozavaptan C _{max} ↑, AUC ↑↑	Use with caution, monitor for mozavaptan adverse reactions ^c , dose reduction of mozavaptan may be necessary.

EMs: extensive metabolizers; IMs: intermediate metabolizers, PMs: poor metabolizers; TdP: Torsade de Pointes Note:

Average increase:

↑: <100% (i.e. <2-fold);

↑↑: 100-400% (i.e. ≥2-fold to <5-fold);

↑↑↑: 400-900% (i.e. ≥5-fold and <10-fold);

↑↑↑↑: ≥10-fold;

Average decrease:

↓: <40%;

↓↓: 40-80%;

↓↓↓: >80%;

No effect: ↔;

Medicinal products within class	Expected/Potential effect on drug levels (see footnotes for additional info)	Clinical comment (see codes above for additional info)
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For the effect (middle column) the name of the parent drug is stated, even when the effect is related to the active moiety or the active metabolite of a prodrug.

^a For drugs with arrows between brackets, the assessment was based on the mechanism of interaction and clinical drug interaction information with ketoconazole or other strong CYP3A4 inhibitors and/or inhibitors of P-glycoprotein or BCRP, modelling techniques, case reports and/or in vitro data. For the other drugs listed, the assessment was based on clinical drug interaction information with itraconazole.

^b Pharmacokinetic parameters were not available. ^c Please consult the corresponding label for information on drug-related adverse events

Theoretical potential interactions

- Phenytoin: Although no studies have been conducted, concomitant administration of itraconazole and phenytoin may alter the metabolism of phenytoin; therefore, plasma concentrations of phenytoin should be monitored when it is given concurrently with itraconazole.
- Oral hypoglycaemic agents: Severe hypoglycaemia has been reported in patients concomitantly receiving azole fungal agents and oral hypoglycaemic agents. Blood glucose concentrations should be carefully monitored when itraconazole and oral hypoglycaemic agents are co-administered.

Potential interactions that have been excluded

In vitro studies have shown that there are no interactions on the plasma protein binding between itraconazole and imipramine, propranolol, diazepam, cimetidine, indomethacin, tolbutamide and sulfamethazine.

No interaction of itraconazole with AZT (zidovudine) and fluvastatin has been observed.

The results from a study in which eight HIV-infected individuals were treated with zidovudine, 8 ± 0.4 mg/kg/day, with or without itraconazole, 100 mg b.i.d., showed that the pharmacokinetics of zidovudine are not significantly affected during concomitant administration of itraconazole.

No inducing effects of itraconazole on the metabolism of ethinylestradiol and norethisterone were observed.

Instructions to the patient

Patients should be instructed to take itraconazole capsules with food. The capsules must be swallowed whole.

Patients should be instructed to report any signs and symptoms that may suggest liver dysfunction so that the appropriate laboratory testing can be done. Such signs and symptoms may include unusual fatigue, anorexia, nausea and/or vomiting, jaundice, dark urine or pale stool.

4.6 FERTILITY, PREGNANCY AND LACTATION

Effects on fertility

Itraconazole did not affect the fertility of male or female rats treated orally with dosage levels of up to 40 mg/kg/day even though parental toxicity was present at this dosage level.

Use in pregnancy (Category D)

(Category B3)

Teratogenic effects: Itraconazole was found to cause a dosage related increase in maternal

toxicity, embryotoxicity and teratogenicity in rats at dosage levels of approximately 40-160 mg/kg/day and in mice at dosage levels of approximately 80 mg/kg/day. In rats, the teratogenicity consisted of major skeletal defects and in mice it consisted of encephaloceles and/or macroglossia.

Itraconazole capsules are contraindicated in pregnancy except in life-threatening cases where the potential benefit to the mother outweighs the potential harm to the foetus (see 4.3 Contraindications).

There is limited information on the use of itraconazole during pregnancy. During post-marketing experience, cases of congenital abnormalities have been reported. These cases included skeletal, genitourinary tract, cardiovascular and ophthalmic malformations as well as chromosomal and multiple malformations. A causal relationship with itraconazole has not been established.

Epidemiological data on exposure to itraconazole during the first trimester of pregnancy (mostly in patients receiving short-term treatment for vulvovaginal candidiasis) did not show an increased risk of malformations as compared to control subjects not exposed to any known teratogens. Itraconazole has been shown to cross the placenta in a rat model.

Women of childbearing potential taking itraconazole oral solution should use contraceptive precautions. Effective contraception should be continued until the menstrual period following the end of itraconazole therapy.

Use in lactation.

Based on the determination of itraconazole concentration in the breast milk of lactating mothers who received a single daily dose of 400 mg itraconazole (200 mg b.i.d.), it was calculated that the exposure in the infant to itraconazole would be around 450 times lower than in the mother. The expected benefits of itraconazole capsules therapy should therefore be weighed against the potential risk of breast-feeding. In case of doubt, the patient should not breast-feed.

4.7 EFFECTS ON ABILITY TO DRIVE AND USE MACHINES

No studies on the effects on the ability to drive or use machines have been performed. When driving vehicles and operating machinery the possibility of adverse reactions such as dizziness, visual disturbances and hearing loss, which may occur in some instances, must be taken into account. See 4.8 Adverse effects (Undesirable effects) section.

4.8 ADVERSE EFFECTS (UNDESIRABLE EFFECTS)

In clinical studies involving short periods of treatment with itraconazole the overall incidence of adverse experiences is about 7%. In patients receiving prolonged (approximately 1 month) continuous treatment especially, the incidence of adverse experiences was higher (about 15%).

Common (>1%)

Body as a whole	dizziness, headache
Liver	reversible increases in hepatic enzymes
Gastrointestinal	nausea, vomiting, diarrhoea, abdominal pain, constipation, dyspepsia

Uncommon (<1%)

Infections and Infestations	Sinusitis, upper respiratory tract infection, rhinitis
Gastrointestinal disorders	flatulence
Hepatobiliary disorders	hepatic function abnormal
Renal and urinary disorders	pollakiuria
Reproductive System and breast disorders	erectile dysfunction

Rare (<0.1%)

Body as a whole	allergic reactions such as pruritus, rash, urticaria and angio-oedema
Endocrine	menstrual disorder

Very rare (<0.01%)

Liver	hepatitis (especially during prolonged treatment)
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The following is a list of additional adverse effects associated with itraconazole.

Blood and Lymphatic System Disorders	Granulocytopenia, Thrombocytopenia
Immune System Disorders	Anaphylactoid reaction
Metabolism and Nutrition Disorders	Hyperglycemia, Hyperkalemia, Hypokalemia, Hypomagnesemia
Psychiatric Disorders	Confusional state
Nervous System Disorders	Neuropathy peripheral, Dizziness, Somnolence
Cardiac Disorders	Cardiac failure, Left ventricular failure, Tachycardia

Vascular Disorders	Hypertension, Hypotension
Respiratory, Thoracic and Mediastinal Disorders	Pulmonary edema, Dysphonia, Cough
Gastrointestinal Disorders	Gastrointestinal disorder
Hepatobiliary Disorders	Hepatic failure, Hepatitis, Jaundice
Skin and Subcutaneous Tissue Disorders	Rash erythematous, Hyperhidrosis
Musculoskeletal and Connective Tissue Disorders	Myalgia, Arthralgia
Renal and Urinary Disorders	Renal impairment, Urinary incontinence
General Disorders and Administration Site Conditions	Generalized edema, Face edema, Chest pain, Pyrexia, Pain, Fatigue, Chills
Investigations	Alanine aminotransferase increased, Aspartate aminotransferase increased, Blood alkaline phosphatase increased, Blood lactate dehydrogenase increased, Blood urea increased, Gamma-glutamyltransferase increased, Hepatic enzyme increased, Urine analysis abnormal

Postmarketing data

Adverse drug reactions from spontaneous reports during the worldwide postmarketing experience with itraconazole (all formulations) that meet threshold criteria are included in the table below. The adverse drug reactions are ranked by frequency, using the following convention: Very common ($\geq 1/10$); Common ($\geq 1/100$ and $< 1/10$); Uncommon ($\geq 1/1,000$ and $< 1/100$); Rare ($\geq 1/10,000$ and $< 1/1,000$); Very rare ($< 1/10,000$), including isolated reports.

The frequencies below reflect reporting rates for adverse drug reactions from spontaneous reports, and do not represent more precise estimates of incidence that might be obtained in clinical or epidemiological studies.

Blood and Lymphatic System Disorders	Very rare: leucopenia and neutropenia, thrombocytopenia
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Immune system disorders	Very rare: Serum sickness, angioneurotic oedema, anaphylactic, anaphylactoid and allergic reactions
Metabolism and Nutrition Disorders	Very rare: Hypertriglyceridemia, hypokalaemia
Nervous System Disorders	Very rare: Peripheral neuropathy, paraesthesia, hypoaesthesia, headache, dizziness, tremor
Eye Disorders	Very rare: Visual disturbances, including vision blurred and diplopia
Ear and Labyrinth Disorder	Very rare: Tinnitus, transient or permanent hearing loss
Cardiac Disorders	Very rare: Congestive heart failure
Respiratory, Thoracic and Mediastinal Disorders	Very rare: Pulmonary oedema, dyspnoea
Gastrointestinal Disorders	Very rare: Pancreatitis, abdominal pain, vomiting, dyspepsia, nausea, diarrhoea, constipation, dysgeusia
Hepato-biliary disorders	Very rare: Serious hepatotoxicity (including some cases of fatal acute liver failure), hepatitis, reversible increases in hepatic enzymes
Skin and Subcutaneous Tissue Disorders	Very rare: Toxic epidermal necrolysis, Stevens-Johnson syndrome, acute generalized exanthematous pustulosis, erythema multiforme, exfoliative dermatitis, leukocytoclastic vasculitis, urticaria, alopecia, photosensitivity, rash, pruritus
Musculoskeletal and connective tissue disorders	Very rare: Myalgia, arthralgia
Renal and Urinary Disorders	Very rare: Pollakiuria, urinary incontinence
Reproductive System and Breast Disorders	Very rare: Menstrual disorders, erectile dysfunction
General Disorders and Administration Site Conditions	Very rare: Oedema, pyrexia
Investigations	Very rare: Blood creatine phosphokinase increased

Reporting Suspected adverse effects:

Reporting suspected adverse reactions after registration of this medicinal product is important. It allows continued monitoring of the benefit-risk balance of this medicinal product. Healthcare professionals are asked to report any suspected adverse reactions at <https://www.tga.gov.au/reporting-problems>.

4.9 OVERDOSE

Itraconazole is not removed by dialysis. In the event of accidental overdosage, supportive measures should be employed.

For information on the management of overdose, contact the poisons information centre on 131126 (Australia).

5 PHARMACOLOGICAL PROPERTIES

5.1 PHARMACODYNAMIC PROPERTIES

Mechanism of action

In vitro studies have demonstrated that itraconazole inhibits the cytochrome P450-dependent synthesis of ergosterol, which is a vital component of fungal cell membranes.

Clinical trials

Histoplasmosis: In five open-label, non-comparative studies in patients (n = 136) with histoplasmosis exposed to treatment and maintenance therapy with itraconazole: sixty-one patients (45%) were HIV infected and 8 patients (6%) had other causes of immunosuppression. Ninety-eight patients (72%) had disseminated disease and 42 patients (31%) had other forms of histoplasmosis. Overall, 135 of the 136 patients (approx. 100%) responded. Five patients (4%) relapsed while on treatment. Efficacy was demonstrated for the oral treatment and maintenance therapy of histoplasmosis, both in immunocompromised and non-immunocompromised patients at the recommended dose of 200 - 400 mg/day for 8 months.

Onychomycosis: In three double-blind, placebo-controlled studies (n = 214 total), conducted in the US, patients with onychomycosis of the toenails received 200 mg once daily for 12 consecutive weeks. Results of these studies demonstrated mycological cure in 54% of patients, defined as simultaneous occurrence of negative KOH plus negative culture. Thirty-five (35) percent of patients were considered an overall success (mycological cure plus clear or minimal nail involvement with significantly decreased signs); 14% of patients demonstrated mycological cure plus clinical cure (clearance of all signs, with or without residual nail deformity). The mean time to overall success was approximately 10 months. Twenty-one (21) percent of the overall success group has a relapse (worsening of the global score or conversion of KOH or culture from negative to positive).

Intermittent (pulse) treatment of onychomycosis: *Onychomycosis of the toe nail:* In a double-blind study (n= 129 total) there was no significant difference in clinical and mycological success and overall response between itraconazole 200 mg b.i.d. one week per month (pulse) for 3 months and continuous treatment of itraconazole 200 mg o.d. for 3 months. In an open study (n = 50 total) there was no significant difference in clinical and mycological success and overall response between a 3 pulse and 4 pulse regimen.

Onychomycosis of the fingernail: In a double-blind, placebo controlled study (n = 71 total) a treatment of itraconazole 200 mg b.i.d. one week per month was more effective than placebo. The clinical and mycological success for itraconazole pulse treatment in compliant patients was 77% and 73% respectively and for placebo was nil and 12%. In an open study 84% of patients receiving 2 pulse treatments (n = 48) and 91% receiving 3 pulse treatments (n = 68) showed a clinical success and 77% and 85% respectively showed a mycological cure at endpoint.

Aspergillosis: In nine open-label studies of patients (n = 719) with systemic aspergillosis and treated with itraconazole, an overall response rate of 63% was observed. This varied according to the clinical syndrome, e.g. pulmonary aspergilloma (60%), bronchopulmonary (78%), invasive (62%) and extra-pulmonary (62%). In eight patients with cerebral aspergillosis the response rate was 13%. In a randomised, double-blind, comparator trial against amphotericin B in patients with proven or highly suspected aspergillosis, 6 of 8 patients receiving itraconazole responded and 2 of 5 patients responded on amphotericin B. The numbers are too small to assert any difference between treatments. The recommended dose for systemic aspergillosis is 200 mg/day for 2 - 5 months, with a dose of 200 mg twice daily for invasive or disseminated disease.

Sporotrichosis: In four open-label, non-comparative studies of patients (n = 124) with sporotrichosis, 115 of 124 patients (93%) treated with itraconazole demonstrated a complete or marked remission rate. The recommended dosage is 100 - 200 mg/day for 3 months. Treatment duration may be longer in patients with lymphatic/lymphocutaneous and extracutaneous sporotrichosis.

Candidiasis: In three open-label studies of patients (n = 143) with systemic candidiasis and treated with itraconazole, patients with urinary and pulmonary candidiasis responded with high efficacy, although the numbers with these conditions were small. An 85% response rate was observed in patients with oral and oesophageal candidiasis who had underlying cancer and were receiving chemotherapy and/or antibiotics or who had HIV/AIDS. In non-neutropenic patients with non-invasive candidiasis the response rate was 76%. The recommended dose is 100 - 200 mg/day for 3 weeks to 7 months.

5.2 PHARMACOKINETIC PROPERTIES

Absorption

The oral bioavailability of itraconazole capsules is maximal and appears to be more consistent when they are taken immediately after a meal. However, there is a marked intersubject variability. The observed absolute oral bioavailability of itraconazole was 55%. If

administered in the fasting state, C_{max} and AUC are about 30-40% lower than after a meal. Peak plasma levels are reached 3 to 5 hours following an oral dose. Elimination from plasma is biphasic with a terminal half-life of 1.5 to 2 days. During chronic administration, steady state is reached after 10-14 days. Mean steady state plasma concentrations of itraconazole 3-4 hours after drug intake are 0.4 microgram/mL (100 mg o.d.), 1.1 micrograms/mL (200 mg o.d.) and 2.0 micrograms/mL (200 mg b.i.d.).

Distribution

The plasma protein binding of itraconazole is 99.8%. Concentrations of itraconazole in whole blood are 60% of those in plasma. Steady state itraconazole levels in the skin vary according to the distribution of sebaceous glands, ranging from one third of plasma levels in the skin of the palms to double plasma levels in the skin of the back. Itraconazole is eliminated from keratinous tissues by the shedding of cells during normal regeneration. Itraconazole is undetectable in the plasma within 7 days of stopping therapy, but levels at or above the MIC_{90} for dermatophytes persist in the skin for one or two weeks after discontinuation of a 4-week treatment. Itraconazole is present at high concentrations in sebum but levels in sweat are negligible.

Itraconazole is extensively distributed into most tissues that are prone to fungal invasion but only minimally into CSF or ocular fluid. Concentrations in lung, kidney, liver, bone, stomach, spleen and muscle were found to be two to three times higher than the corresponding plasma concentration.

Metabolism

Itraconazole is extensively metabolised by the liver into a large number of metabolites. One of the metabolites is hydroxy-itraconazole, which has a comparable antifungal activity *in vitro* to itraconazole. Serum antifungal drug levels measured by bioassay were about 3 times those of itraconazole assayed by high performance liquid chromatograph.

Excretion

Faecal excretion of the parent drug varies between 3-18% of the dose. Renal excretion of the parent drug is less than 0.03% of the dose. About 35% of a dose is excreted as metabolites in the urine within 1 week.

Special population

Hepatic Impairment

A pharmacokinetic study using a single 100mg dose of itraconazole (one 100mg capsule) was conducted in 6 healthy and 12 cirrhotic subjects. No statistically significant differences in AUC were seen between these two groups. A statistically significant reduction in mean C_{max} (47%) and a twofold increase in the elimination half-life (37 ± 17 hours) of itraconazole were noted in cirrhotic subjects compared with healthy subjects. Patients with impaired hepatic functions should be carefully monitored when taking itraconazole. The prolonged elimination half-life of itraconazole observed in hepatic impairment patients (37.2 ± 17 h) should be considered

when deciding to initiate therapy with other medications metabolised by CYP3A4. (See 4.5 Interactions with other medicines and other forms of interactions).

Renal Impairment

A pharmacokinetic study using a single 200mg dose of itraconazole (four 50mg capsules) was conducted in three groups of patients with renal impairment (uremic: n=7; hemodialysis: n=7, and continuous ambulatory peritoneal dialysis: n=5). In uremic/hemodialysis and continuous ambulatory peritoneal dialysis subjects, C_{max} were reduced compared with normal population parameters and listed below.

- C_{max} 132-417 (normal) / 50.9-505 ng.h/mL (uremic)
- C_{max} 18.2-341 (hemodialysis / 51.7-111 ng.h/mL (continuous ambulatory peritoneal dialysis)

Plasma concentration-versus-time profiles showed wide inter-subject variation in all three groups.

Microbiology

In vitro Susceptibility Tests, Dilution or diffusion techniques:

Either quantitative (MIC) or breakpoint, should be used following a regulatory updated, recognised and standardised method (eg, Clinical and Laboratory Standard Institute [CLSI formerly NCCLS]). Standardised susceptibility test procedures require the use of laboratory control microorganisms to control the technical aspects of the laboratory procedures.

For itraconazole, breakpoints have only been established for *Candida* spp. from superficial mycotic infections (CLSI M27-A2, using laboratory controlled *Candida parapsilosis* ATCC 22019, *Candida krusei* ATCC 6258). The proposed MIC breakpoints are as follows:

- Susceptible: A report of “Susceptible” indicates that the pathogen is likely to be inhibited if the antifungal compound in the blood reaches the concentrations usually achievable.
- Susceptibility that is “dose- or delivery-dependent” (S-DD): This category implies possible clinical applicability in body sites where the medicine is physiologically concentrated or in situations where high dosage of medicine can be used.
 - Note that itraconazole MIC values for *Candida* species; *Cryptococcus neoformans*; *Blastomyces dermatidis*; *Coccidioides immitis*; *Histoplasma capsulatum*; and *Geotrichum* species were reported as ≤ 1 µg/mL.
 - Itraconazole MIC values for *Aspergillus flavus*, *Aspergillus fumigatus* *Trichosporon* species, *Fonsecaea pedrosoi*, and *Trichophyton* species were reported as ≤ 1 µg/mL, although interpretive breakpoints have not been established for the filamentous fungi.
- Resistant: A report of “Resistant” indicates that the pathogen is not likely to be inhibited if the antifungal compound in the blood reaches the concentrations usually achievable; other therapy should be select.
 - *Candida krusei*, *Candida glabrata* and *Candida tropicalis* are generally the least

susceptible *Candida* species, with some isolates showing unequivocal resistance to itraconazole *in vitro*.

- The principal fungus types that are not inhibited by itraconazole are: *Zygomycetes* (e.g. *Rhizopus* spp., *Rhizomucor* spp., *Mucor* spp. and *Absidia* spp.), *Fusarium* spp., *Scedosporium* spp. and *Scopulariopsis* spp.
- Azole resistance appears to develop slowly and is often the result of several genetic mutations. Mechanisms that have been described are overexpression of ERG11, which encodes the target enzyme 14 α -demethylase, point mutations in ERG11 that lead to decreased target affinity and/or transporter overexpression resulting in increased efflux. Cross-resistance between members of the azole class has been observed within *Candida* spp., although resistance to one member of the class does not necessarily confer resistance to other azoles. Itraconazole-resistant strains of *Aspergillus fumigatus* have been reported.

Correlation between *in vitro* MIC results and clinical outcomes:

Susceptibility of a microorganism *in vitro* does not predict successful therapy. Host factors are often more important than susceptibility test results in determining clinical outcomes, and resistance *in vitro* should often predict therapeutic failure. Correlation between minimum inhibitory concentration (MIC) results *in vitro* and clinical outcome has yet to be established for azole antifungal agents.

Toxicology

In three toxicology studies using rats, itraconazole induced bone defects at dosage levels as low as 20 mg/kg/day. The induced defects included reduced bone plate activity, thinning of the zona compacta of the large bones and increased bone fragility. At a dosage level of 80 mg/kg/day over one year or 160 mg/kg/day for six months, itraconazole induced small tooth pulp with hypocellular appearance in some rats.

Increased relative adrenal weights and swollen adrenals (reversible) were seen in rats and dogs where plasma levels were comparable to those of human therapeutic doses. Adrenocortical function was not affected in studies in humans after the recommended daily doses; with higher doses (600 mg/day for 3 months), adrenal cortex response to ACTH stimulation was reduced in 1 of 8 patients, but returned to normal when the dosage was reduced.

5.3 PRECLINICAL SAFETY DATA

Genotoxicity – Itraconazole produced no mutagenic effects when assayed in appropriate bacterial, non-mammalian and mammalian test systems.

Carcinogenicity – Itraconazole showed no evidence of carcinogenicity potential in mice treated orally for 23 months at dosage levels of up to 80 mg/kg/day. Male rats treated with 25 mg/kg/day had a slightly increased incidence of soft tissue sarcoma. These sarcomas may have been a consequence of hypercholesterolaemia, which is a response of rats, but not dogs

or humans to chronic itraconazole administration.

Female rats treated with 50 mg/kg/day had an increased incidence of squamous cell carcinoma of the lung (2/50) as compared to the untreated group. Although the occurrence of squamous cell carcinoma in the lung is extremely uncommon in untreated rats, the increase in this study was not statistically significant.

6 PHARMACEUTICAL PARTICULARS

6.1 LIST OF EXCIPIENTS

Hypromellose, macrogol 20,000, sucrose, maize starch in a hard gelatin capsule. The capsules are printed with TekPrint SW-9008 Black Ink.

6.2 Incompatibilities

Incompatibilities were either not assessed or not identified as part of the registration of this medicine.

6.3 SHELF LIFE

In Australia, information on the shelf-life can be found on the public summary of the Australian Register of Therapeutic Goods (ARTG). The expiry date can be found on the packaging.

6.4 SPECIAL PRECAUTIONS FOR STORAGE

Store below 25°C. Protect from light and moisture.

6.5 NATURE AND CONTENTS OF CONTAINER

They are supplied in PVC/PE/PVDC/Al blister packs of 4*, 6*, 15*, 28* and 60* capsules.

*Not all pack sizes may be marketed.

6.6 SPECIAL PRECAUTIONS FOR DISPOSAL

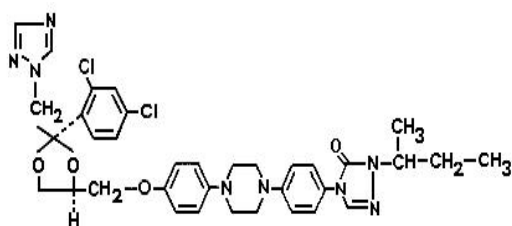
In Australia, any unused medicine or waste material should be disposed of by taking to your local pharmacy.

6.7 PHYSICOCHEMICAL PROPERTIES

Chemical structure

(±)-cis-4-[4-[4-[4-[[2-(2,4-dichlorophenyl)-2-(1H-1,2,4-triazol-1-ylmethyl)-1,3-dioxolan-4-yl]methoxy]phenyl]-1-piperazinyl]phenyl]-2,4-dihydro-2-(1-methylpropyl)-3H-1,2,4-triazol-3-one.

Itraconazole has three chiral centres and is a 1:1:1:1 racemic mixture of four diastereomers (two enantiomeric pairs).



CAS Number: 84625-61-6

Itraconazole is a white to slightly yellowish powder, insoluble in water at pH 1-12, very slightly soluble in alcohol and freely soluble in dichloromethane.

Molecular weight: 705.64

Molecular formula: C₃₅H₃₈Cl₂N₈O₄

7 MEDICINE SCHEDULE (POISONS STANDARD)

S4 – Prescription only medicine

8 SPONSOR

Arrow Pharma Pty Ltd
15 – 17 Chapel street
Cremorne, VIC 3121
www.arrowpharma.com.au

9 DATE OF FIRST APPROVAL

9/08/2016

10 DATE OF REVISION

05 December 2018

SUMMARY TABLE OF CHANGES

Section Changed	Summary of new information
	Reformatted
4.3	Contraindications updated
4.5	Interactions with other medicines and other forms of interactions updated
4.8	Adverse effects updated
8	Sponsor details updated