

Licensläkemedel – Epoprostenol

LÄKEMEDELSINFORMATION

Läkemedelsnamn	Epoprostenol
Aktiv substans	epoprostenol
Beredningsform	Pulver till injektions-/infusionsvätska, lösning
Styrka	0,5 mg / vial
Förpackningsstorlek	1 x 10ml
Förvaring	Rumstemperatur

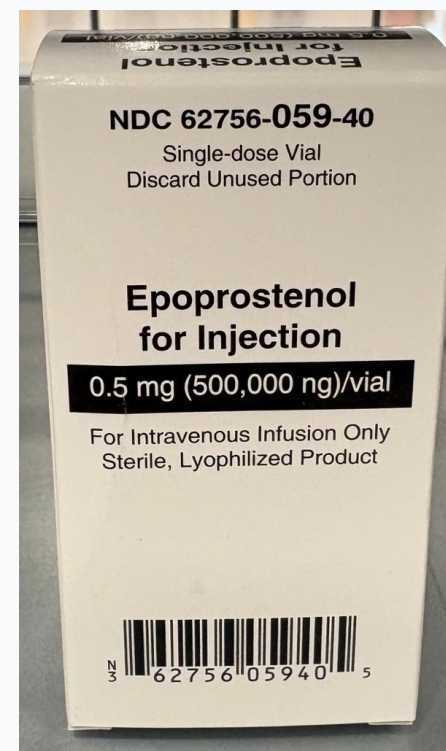
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FÖRPACKNINGSBILD



EPOPROSTENOL - epoprostenol injection, powder, lyophilized, for solution

Sun Pharmaceutical Industries, Inc.

HIGHLIGHTS OF PRESCRIBING INFORMATION

These highlights do not include all the information needed to use EPOPROSTENOL FOR INJECTION safely and effectively. See full prescribing information for EPOPROSTENOL FOR INJECTION.

EPOPROSTENOL for injection, for intravenous use Initial U.S. Approval: 1995

INDICATIONS AND USAGE

Epoprostenol sodium is a prostanoid vasodilator indicated for the treatment of pulmonary arterial hypertension (PAH) (WHO Group 1) to improve exercise capacity. Studies establishing effectiveness included predominantly patients with NYHA Functional Class III-IV symptoms and etiologies of idiopathic or heritable PAH or PAH associated with connective tissue diseases. (1)

DOSAGE AND ADMINISTRATION

- Dosage
 - Infusion of epoprostenol for injection should be initiated at 2 ng/kg/min and increased in increments of 2 ng/kg/min every 15 minutes or longer until dose-limiting pharmacologic effects are elicited or until a tolerance limit to the drug is established. (2.1)
 - If symptoms of pulmonary hypertension persist or recur after improving - the infusion should be increased by 1- to 2-ng/kg/min increments at intervals sufficient to allow assessment of clinical response; these intervals should be at least 15 minutes. (2.2)
- Administration
 - Epoprostenol for injection is administered by continuous intravenous infusion via a central venous catheter using an ambulatory infusion pump. (2.3)
 - Do not mix with any other parenteral medications or solutions prior to or during administration. (2.4)
- Reconstitution
 - Reconstituted in vial with only 5 mL of either Sterile Water for Injection or Sodium Chloride 0.9% Injection.
 - Epoprostenol for injection solution reconstituted and immediately diluted to the final concentration in the drug delivery reservoir can be administered per the conditions of use as outlined in Table 1. (2.4)
 - Solution for chronic delivery should be prepared in a drug delivery reservoir appropriate for the infusion pump. (2.4)

DOSAGE FORMS AND STRENGTHS

Injection: 10 mL single-dose vial with 0.5 mg (500,000 ng) or 1.5 mg (1,500,000 ng) epoprostenol. (3)

CONTRAINDICATIONS

- Congestive heart failure due to severe left ventricular systolic dysfunction (4)
- Pulmonary edema (4)
- Hypersensitivity to the drug or to structurally related compounds (4)

WARNINGS AND PRECAUTIONS

- Do not abruptly lower the dose or withdraw dosing. All dosing initiation and changes should be closely monitored.(5.2,5.3)

ADVERSE REACTIONS

- Most common adverse reactions during:
 - Dose Initiation and Escalation: Nausea, vomiting, headache, hypotension, flushing, chest pain, anxiety, dizziness, bradycardia, dyspnea, abdominal pain, musculoskeletal pain, and tachycardia (6.1)
 - Chronic Dosing: Headache, jaw pain, flushing, diarrhea, nausea and vomiting, flu-like symptoms, and anxiety/nervousness (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

- Diuretics, antihypertensive agents, or other vasodilators: reduction in blood pressure (7)
- Antiplatelet agents or anticoagulants: increase the risk of bleeding (7)
- Patients on digoxin: elevations of digoxin concentrations clinically significant in patients prone to digoxin toxicity (7)

See 17 for PATIENT COUNSELING INFORMATION.

Revised: 4/2025

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FULL PRESCRIBING INFORMATION

1 INDICATIONS AND USAGE

Epoprostenol for injection is indicated for the treatment of pulmonary arterial hypertension (PAH) (WHO Group 1) to improve exercise capacity. Studies establishing effectiveness included predominantly patients with NYHA Functional Class III-IV symptoms and etiologies of idiopathic or heritable PAH or PAH associated with connective tissue diseases.

2 DOSAGE AND ADMINISTRATION

Important Note:

Reconstitute epoprostenol for injection only as directed with Sterile Water for Injection, USP, or Sodium Chloride 0.9% Injection, USP. Do not dilute reconstituted solutions of epoprostenol for injection or administer it with other parenteral solutions or medications [see Dosage and Administration (2.4)] .

2.1 Dosage

Prepare continuous chronic infusion of epoprostenol for injection as directed, and administer through a central venous catheter. Temporary peripheral intravenous infusion may be used until central access is established. Initiate chronic infusion of epoprostenol for injection at 2 ng/kg/min and increase in increments of 2 ng/kg/min every 15 minutes or longer until a tolerance limit to the drug is established or further increases in the infusion rate are not clinically warranted. If dose-limiting pharmacologic effects occur, then decrease the infusion rate until epoprostenol for injection is tolerated. In clinical trials, the most common dose-limiting adverse events were nausea, vomiting, hypotension, sepsis, headache, abdominal pain, or respiratory disorder (most treatment-limiting adverse events were not serious). If the initial infusion rate of 2 ng/kg/min is not tolerated, use a lower dose.

In the controlled 12-week trial in PAH/SSD, for example, the dose increased from a mean starting dose of 2.2 ng/kg/min. During the first 7 days of treatment, the dose was increased daily to a mean dose of 4.1 ng/kg/min on day 7 of treatment. At the end of week 12, the mean dose was 11.2 ng/kg/min. The mean incremental increase was 2 to 3 ng/kg/min every 3 weeks.

2.2 Dosage Adjustments

Base changes in the chronic infusion rate on persistence, recurrence, or worsening of the patient's symptoms of pulmonary hypertension and the occurrence of adverse events due to excessive doses of epoprostenol for injection. In general, expect increases in dose from the initial chronic dose.

Consider increments in dose if symptoms of pulmonary hypertension persist or recur. Adjust the infusion by 1- to 2-ng/kg/min increments at intervals sufficient to allow assessment of clinical response; these intervals should be at least 15 minutes. In clinical trials, incremental increases in dose occurred at intervals of 24 to 48 hours or longer. Following establishment of new chronic infusion rate, observe the patient, and monitor standing and supine blood pressure and heart rate for several hours to ensure that the new dose is tolerated.

During chronic infusion, the occurrence of dose-limiting pharmacological events may necessitate a decrease in infusion rate, but the adverse event may occasionally resolve without dosage adjustment. Make dosage decreases gradually in 2-ng/kg/min decrements every 15 minutes or longer until the dose-limiting effects resolve [see *Adverse Reactions* (6.1 and 6.2)]. Avoid abrupt withdrawal of epoprostenol for injection or sudden large reductions in infusion rates. Except in life-threatening situations (e.g., unconsciousness, collapse, etc.), infusion rates of epoprostenol for injection should be adjusted only under the direction of a physician.

In patients receiving lung transplants, doses of epoprostenol were tapered after the initiation of cardiopulmonary bypass.

2.3 Administration

Epoprostenol for injection, once prepared as directed [see *Dosage and Administration* (2.4)], is administered by continuous intravenous infusion via a central venous catheter using an ambulatory infusion pump. During initiation of treatment, epoprostenol for injection may be administered peripherally.

Infusion sets with an in-line 0.22 micron filter should be used.

The ambulatory infusion pump used to administer epoprostenol for injection should: (1) be small and lightweight, (2) be able to adjust infusion rates in 2-ng/kg/min increments, (3) have occlusion, end-of-infusion, and low-battery alarms, (4) be accurate to +6% of the programmed rate, and (5) be positive pressure-driven (continuous or pulsatile) with intervals between pulses not exceeding 3 minutes at infusion rates used to deliver epoprostenol for injection. The reservoir should be made of polyvinyl chloride, polypropylene, or glass. The infusion pump used in the most recent clinical trials was the CADD-1 HFX 5100 (SIMS Deltec). A 60-inch microbore non-DEHP extension set with proximal antisiphon valve, low priming volume (0.9 mL), and in-line 0.22 micron filter was used during clinical trials.

To avoid potential interruptions in drug delivery, the patient should have access to a backup infusion pump and intravenous infusion sets. Consider a multi-lumen catheter if other intravenous therapies are routinely administered.

2.4 Reconstitution

Epoprostenol for injection is stable only when reconstituted as directed using Sterile Water for Injection, USP, or Sodium Chloride 0.9% Injection, USP. Do not reconstitute or mix epoprostenol for injection with any other parenteral medications or solutions prior to or during administration. Each vial is for single-dose; discard any unused solution.

Use after reconstitution and immediate dilution to final concentration

Use at room temperature (77°F/25°C)

Epoprostenol for injection solution reconstituted with 5 mL of Sterile Water for Injection, USP or Sodium Chloride 0.9% Injection, and immediately diluted to the final concentration in the drug delivery reservoir can be administered at room temperature per the conditions of use as outlined in Table 1.

Table 1: Maximum Duration of Administration (hours) at Room Temperature (77°F/25°C) of Fully Diluted Solutions in the Drug Delivery Reservoir ^a

Final concentration range	Immediate administration	If stored for up to 8 days at 36° to 46°F (2° to 8°C)
0.5 mg vial		
≥3,000 ng/mL and <15,000 ng/mL	48 hours	24 hours
1.5 mg vial		
≥15,000 ng/mL and <60,000 ng/mL	48 hours	48 hours
≥60,000 ng/mL	72 hours	48 hours

^a Short excursions at 104°F (40°C) are permitted for up to:

2 hours for concentrations below 15,000 ng/mL

4 hours for concentrations between 15,000 ng/mL and 60,000 ng/mL

8 hours for concentrations above 60,000 ng/mL

Use at higher temperatures >77°F up to 104°F (>25° to 40°C)

Temperatures greater than 77°F and up to 86 °F (>25 °C to 30°C): A single reservoir of fully diluted solution of 60,000 ng/mL or above of epoprostenol for injection prepared as directed can be administered (either immediately or after up to 8 days storage at 36° to 46°F (2° to 8°C)) for up to 48 hours. For diluted solutions of less than 60,000 ng/mL, pump reservoirs should be changed every 24 hours.

Temperatures up to 104°F (40°C): Fully diluted solutions of 60,000 ng/mL or above of epoprostenol for injection, prepared as directed, can be immediately administered for periods up to 24 hours.

Do not expose this solution to direct sunlight.

A concentration for the solution of epoprostenol for injection should be selected that is compatible with the infusion pump being used with respect to minimum and maximum flow rates, reservoir capacity, and the infusion pump criteria listed above. Epoprostenol for injection, when administered chronically, should be prepared in a drug delivery reservoir appropriate for the infusion pump. Outlined in Table 2 are directions for preparing different concentrations of epoprostenol for injection. Each vial is for single-dose; discard any unused solution.

Table 2: Reconstitution and Dilution Instructions

To make 100 mL of solution with Final Concentration (ng/mL) of:	Directions:
Using the 0.5 mg vial	
3,000 ng/ml	Dissolve contents of one 0.5 mg vial with 5 mL of Sterile Water for Injection, USP or Sodium Chloride 0.9% Injection, USP. Withdraw 3 mL of the vial contents and add to a sufficient volume of the identical diluent to make a total of 100 mL.
5,000 ng/mL	Dissolve contents of one 0.5 mg vial with 5 mL of Sterile Water for Injection, USP, or Sodium Chloride 0.9% Injection, USP. Withdraw entire vial contents and add to a sufficient volume of the identical diluent to make a total of 100 mL.
10,000 ng/ml	Dissolve contents of two 0.5 mg vials each with 5 mL of Sterile Water for Injection, USP, or Sodium Chloride 0.9% Injection, USP. Withdraw entire vial contents and add to a sufficient volume of the identical diluent to make a total of 100 mL.
Using the 1.5 mg vial	
15,000 ng/mL ^a	Dissolve contents of one 1.5 mg vial with 5 mL of Sterile Water for Injection, USP, or Sodium Chloride 0.9% Injection, USP. Withdraw entire vial contents and add to a sufficient volume of the identical diluent to make a total of 100 mL.
30,000 ng/mL ^a	Dissolve contents of two 1.5 mg vials each with 5 mL of Sterile Water for Injection, USP, or Sodium Chloride 0.9% Injection, USP. Withdraw entire vial contents and add to a sufficient volume of the identical diluent to make a total of 100 mL.

^a Higher concentrations may be prepared for patients who receive epoprostenol for

injection long-term.

Infusion rates may be calculated using the following formula:

$$\text{Infusion Rate (mL/hr)} = \frac{[\text{Dose (ng/kg/min)} \times \text{Weight (kg)} \times 60 \text{ min/hr}]}{\text{Final Concentration (ng/mL)}}$$

Tables 3 to 7 provide infusion delivery rates for doses up to 16 ng/kg/min based upon patient weight, drug delivery rate, and concentration of the solution of epoprostenol for injection to be used. These tables may be used to select the most appropriate concentration of epoprostenol for injection that will result in an infusion rate between the minimum and maximum flow rates of the infusion pump and that will allow the desired duration of infusion from a given reservoir volume. For infusion/dose rates lower than those listed in Tables 3 to 7, it is recommended that the pump rate be set by a healthcare professional such that steady state is achieved in the patient, keeping in mind the half-life of epoprostenol is no more than six minutes. Higher infusion rates, and therefore, more concentrated solutions may be necessary with long-term administration of epoprostenol for injection.

Table 3: Infusion Rates for Epoprostenol for Injection at a Concentration of 3,000 ng/mL

Patient weight (kg)	Dose or Drug Delivery Rate (ng/kg/min)			
	2	3	4	5
	Infusion Delivery Rate (mL/hr)			
20	--	1.2	1.6	2.0
30	1.2	1.8	2.4	3.0
40	1.6	2.4	3.2	4.0
50	2.0	3.0	4.0	---
60	2.4	3.6	---	---
70	2.8	---	---	---
80	3.2	---	---	---
90	3.6	---	---	---
100	4.0	---	---	---

Table 4: Infusion Rates for Epoprostenol for Injection at a Concentration of 5,000 ng/mL

Patient weight (kg)	Dose or Drug Delivery Rate (ng/kg/min)						
	2	4	6	8	10	12	14
	Infusion Delivery Rate (mL/hr)						
20	---	1.0	1.4	1.9	2.4	2.9	3.4

30	---	1.4	2.2	2.9	3.6	---	---
40	1.0	1.9	2.9	3.8	---	---	---
50	1.2	2.4	3.6	---	---	---	---
60	1.4	2.9	---	---	---	---	---
70	1.7	3.4	---	---	---	---	---
80	1.9	3.8	---	---	---	---	---
90	2.2	---	---	---	---	---	---
100	2.4	---	---	---	---	---	---

Table 5: Infusion Rates for Epoprostenol for Injection at a Concentration of 10,000 ng/mL

Patient weight (kg)	Dose or Drug Delivery Rate (ng/kg/min)						
	4	6	8	10	12	14	16
	Infusion Delivery Rate (mL/hr)						
20	---	---	1.0	1.2	1.4	1.7	1.9
30	---	1.1	1.4	1.8	2.2	2.5	2.9
40	1.0	1.4	1.9	2.4	2.9	3.4	3.8
50	1.2	1.8	2.4	3.0	3.6	---	---
60	1.4	2.2	2.9	3.6	---	---	---
70	1.7	2.5	3.4	---	---	---	---
80	1.9	2.9	3.8	---	---	---	---
90	2.2	3.2	---	---	---	---	---
100	2.4	3.6	---	---	---	---	---

Table 6: Infusion Rates for Epoprostenol for Injection at a Concentration of 15,000 ng/mL

Patient weight (kg)	Dose or Drug Delivery Rate (ng/kg/min)						
	4	6	8	10	12	14	16
	Infusion Delivery Rate (mL/hr)						
20	---	---	---	---	1.0	1.1	1.3
30	---	---	1.0	1.2	1.4	1.7	1.9

40	---	1.0	1.3	1.6	1.9	2.2	2.6
50	---	1.2	1.6	2.0	2.4	2.8	3.2
60	1.0	1.4	1.9	2.4	2.9	3.4	3.8
70	1.1	1.7	2.2	2.8	3.4	3.9	---
80	1.3	1.9	2.6	3.2	3.8	---	---
90	1.4	2.2	2.9	3.6	---	---	---
100	1.6	2.4	3.2	4.0	---	---	---

Table 7: Infusion Rates for Epoprostenol for Injection at a Concentration of 30,000 ng/mL

Patient weight (kg)	Dose or Drug Delivery Rate (ng/kg/min)					
	6	8	10	12	14	16
30	---	---	---	---	---	1.0
40	---	---	---	1.0	1.1	1.3
50	---	---	1.0	1.2	1.4	1.6
60	---	1.0	1.2	1.4	1.7	1.9
70	---	1.1	1.4	1.7	2.0	2.2
80	1.0	1.3	1.6	1.9	2.2	2.6
90	1.1	1.4	1.8	2.2	2.5	2.9
100	1.2	1.6	2.0	2.4	2.8	3.2

3 DOSAGE FORMS AND STRENGTHS

Epoprostenol for injection contains epoprostenol sodium equivalent to 0.5 mg (500,000 ng) or 1.5 mg (1,500,000 ng) epoprostenol and is supplied as a sterile lyophilized material in a 10 mL vial.

4 CONTRAINDICATIONS

A large study evaluating the effect of epoprostenol on survival in NYHA Class III and IV patients with congestive heart failure due to severe left ventricular systolic dysfunction was terminated after an interim analysis of 471 patients revealed a higher mortality in patients receiving epoprostenol plus conventional therapy than in those receiving conventional therapy alone. The chronic use of epoprostenol for injection in patients with congestive heart failure due to severe left ventricular systolic dysfunction is therefore contraindicated.

Some patients with pulmonary hypertension have developed pulmonary edema during dose initiation, which may be associated with pulmonary veno-occlusive disease. Epoprostenol for injection should not be used chronically in patients who develop

pulmonary edema during dose initiation.

Epoprostenol for injection is also contraindicated in patients with known hypersensitivity to the drug or to structurally related compounds.

5 WARNINGS AND PRECAUTIONS

5.1 Dose Initiation

Epoprostenol for injection is a potent pulmonary and systemic vasodilator. Initiate epoprostenol for injection in a setting with adequate personnel and equipment for physiologic monitoring and emergency care. Dose initiation has been performed during right heart catheterization and without cardiac catheterization. During dose initiation, asymptomatic increases in pulmonary artery pressure coincident with increases in cardiac output occurred rarely. In such cases, consider dose reduction, but such an increase does not imply that chronic treatment is contraindicated.

5.2 Chronic Use and Dose Adjustment

During chronic use, deliver epoprostenol for injection continuously on an ambulatory basis through a permanent indwelling central venous catheter. Unless contraindicated, administer anticoagulant therapy to patients receiving epoprostenol for injection to reduce the risk of pulmonary thromboembolism or systemic embolism through a patent foramen ovale. To reduce the risk of infection, use aseptic technique in the reconstitution and administration of epoprostenol for injection and in routine catheter care. Because epoprostenol is metabolized rapidly, even brief interruptions in the delivery of epoprostenol for injection may result in symptoms associated with rebound pulmonary hypertension including dyspnea, dizziness, and asthenia. Intravenous therapy with epoprostenol for injection will likely be needed for prolonged periods, possibly years, so consider the patient's capacity to accept and care for a permanent intravenous catheter and infusion pump.

Based on clinical trials, the acute hemodynamic response (reduction in pulmonary artery resistance) to epoprostenol did not correlate well with improvement in exercise tolerance or survival during chronic use of epoprostenol. Adjust dosage of epoprostenol for injection during chronic use at the first sign of recurrence or worsening of symptoms attributable to pulmonary hypertension or the occurrence of adverse events associated with epoprostenol [see *Dosage and Administration* (2.2)]. Following dosage adjustments, monitor standing and supine blood pressure and heart rate closely for several hours.

5.3 Withdrawal Effects

Abrupt withdrawal (including interruptions in drug delivery) or sudden large reductions in dosage of epoprostenol for injection may result in symptoms associated with rebound pulmonary hypertension, including dyspnea, dizziness, and asthenia. In clinical trials, one Class III primary pulmonary hypertension patient's death was judged attributable to the interruption of epoprostenol. Avoid abrupt withdrawal.

6 ADVERSE REACTIONS

6.1 Clinical Trials Experience

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 practice. During clinical trials, adverse events were classified as follows: (1) adverse events during dose initiation and escalation, (2) adverse events during chronic dosing, and (3) adverse events associated with the drug delivery system.

Adverse Events during Dose Initiation and Escalation

During early clinical trials, epoprostenol was increased in 2-ng/kg/min increments until the patients developed symptomatic intolerance. The most common adverse events and

the adverse events that limited further increases in dose were generally related to vasodilation, the major pharmacologic effect of epoprostenol. The most common dose-limiting adverse events (occurring in $\geq 1\%$ of patients) were nausea, vomiting, headache, hypotension, and flushing, but also include chest pain, anxiety, dizziness, bradycardia, dyspnea, abdominal pain, musculoskeletal pain, and tachycardia. Table 8 lists the adverse events reported during dose initiation and escalation in decreasing order of frequency.

Table 8: Adverse Events during Dose Initiation and Escalation

Adverse Events Occurring in $\geq 1\%$ of Patients	Epoprostenol (n = 391)
Flushing	58%
Headache	49%
Nausea/vomiting	32%
Hypotension	16%
Anxiety, nervousness, agitation	11%
Chest pain	11%
Dizziness	8%
Bradycardia	5%
Abdominal pain	5%
Musculoskeletal pain	3%
Dyspnea	2%
Back pain	2%
Sweating	1%
Dyspepsia	1%
Hypesthesia/paresthesia	1%
Tachycardia	1%

Adverse Events during Chronic Administration:

Interpretation of adverse events is complicated by the clinical features of PAH, which are similar to some of the pharmacologic effects of epoprostenol (e.g., dizziness, syncope). Adverse events which may be related to the underlying disease include dyspnea, fatigue, chest pain, edema, hypoxia, right ventricular failure, and pallor. Several adverse events, on the other hand, can clearly be attributed to epoprostenol. These include hypotension, bradycardia, tachycardia, pulmonary edema, bleeding at various sites, thrombocytopenia, headache, abdominal pain, pain (unspecified), sweating, rash, arthralgia, jaw pain, flushing, diarrhea, nausea and vomiting, flu-like symptoms, anxiety/nervousness, and agitation. In addition, chest pain, fatigue, and pallor have been reported during epoprostenol therapy, and a role for the drug in these events cannot be excluded.

Adverse Events during Chronic Administration for Idiopathic or Heritable PAH:

In an effort to separate the adverse effects of the drug from the adverse effects of the underlying disease, Table 9 lists adverse events that occurred at a rate at least 10% greater on epoprostenol than on conventional therapy in controlled trials for idiopathic or heritable PAH.

Table 9: Adverse Events Regardless of Attribution Occurring in Patients with Idiopathic or Heritable PAH with $\geq 10\%$ Difference between Epoprostenol and Conventional Therapy Alone

Adverse Event	Epoprostenol (n = 52)	Conventional Therapy (n = 54)
Occurrence More Common With Epoprostenol		
General		
Chills/fever/sepsis/flu-like symptoms	25%	11%
Cardiovascular		

Tachycardia	35%	24%
Flushing	42%	2%
Gastrointestinal		
Diarrhea	37%	6%
Nausea/vomiting	67%	48%
Musculoskeletal		
Jaw pain	54%	0%
Myalgia	44%	31%
Nonspecific musculoskeletal pain	35%	15%
Neurological		
Anxiety/nervousness/tremor	21%	9%
Dizziness	83%	70%
Headache	83%	33%
Hypesthesia, hyperesthesia, paresthesia	12%	2%

Thrombocytopenia has been reported during uncontrolled clinical trials in patients receiving epoprostenol.

Adverse Events during Chronic Administration for PAH/SSD

In an effort to separate the adverse effects of the drug from the adverse effects of the underlying disease, Table 10 lists adverse events that occurred at a rate at least 10% greater on epoprostenol in the controlled trial.

Table 10: Adverse Events Regardless of Attribution Occurring in Patients with PAH/SSD With $\geq 10\%$ Difference Between Epoprostenol and Conventional Therapy Alone

Adverse Event	Epoprostenol (n = 56)	Conventional Therapy (n = 55)
Cardiovascular		
Flushing	23%	0%
Hypotension	13%	0%
Gastrointestinal		
Anorexia	66%	47%
Nausea/vomiting	41%	16%
Diarrhea	50%	5%
Musculoskeletal		
Jaw pain	75%	0%
Pain/neck pain/arthritis	84%	65%
Neurological		
Headache	46%	5%
Skin and Appendages		
Skin ulcer	39%	24%
Eczema/rash/urticaria	25%	4%

Although the relationship to epoprostenol administration has not been established, pulmonary embolism has been reported in several patients taking epoprostenol and there have been reports of hepatic failure.

Adverse Events Attributable to the Drug Delivery System

Chronic infusions of epoprostenol are delivered using a small, portable infusion pump through an indwelling central venous catheter. During controlled PAH trials of up to 12 weeks' duration, the local infection rate was about 18%, and the rate for pain was about 11%. During long-term follow-up, sepsis was reported at a rate of 0.3 infections/patient per year in patients treated with epoprostenol. This rate was higher than reported in patients using chronic indwelling central venous catheters to administer parenteral nutrition, but lower than reported in oncology patients using these catheters.

Malfunctions in the delivery system resulting in an inadvertent bolus of or a reduction in epoprostenol were associated with symptoms related to excess or insufficient epoprostenol, respectively.

6.2 Postmarketing Experience

In addition to adverse reactions reported from clinical trials, the following events have been identified during post-approval use of epoprostenol. Because they are reported voluntarily from a population of unknown size, estimates of frequency cannot be made. These events have been chosen for inclusion due to a combination of their seriousness, frequency of reporting, or potential causal connection to epoprostenol.

Blood and Lymphatic: Anemia, hypersplenism, pancytopenia, splenomegaly.

Cardiac: High output cardiac failure (consider dose reduction) [see *Dosage and Administration* (2.2), *Warnings and Precautions* (5.1), and *Warnings and Precautions* (5.3)].

Endocrine and Metabolic: Hyperthyroidism

7 DRUG INTERACTIONS

Additional reductions in blood pressure may occur when epoprostenol for injection is administered with diuretics, antihypertensive agents, or other vasodilators. When other antiplatelet agents or anticoagulants are used concomitantly, there is the potential for epoprostenol for injection to increase the risk of bleeding. However, patients receiving infusions of epoprostenol in clinical trials were maintained on anticoagulants without evidence of increased bleeding. In clinical trials, epoprostenol was used with digoxin, diuretics, anticoagulants, oral vasodilators, and supplemental oxygen.

In a pharmacokinetic substudy in patients with congestive heart failure receiving furosemide or digoxin in whom therapy with epoprostenol was initiated, apparent oral clearance values for furosemide (n = 23) and digoxin (n = 30) were decreased by 13% and 15%, respectively, on the second day of therapy and had returned to baseline values by day 87. The change in furosemide clearance value is not likely to be clinically significant. However, patients on digoxin may show elevations of digoxin concentrations after initiation of therapy with epoprostenol, which may be clinically significant in patients prone to digoxin toxicity.

8 USE IN SPECIFIC POPULATIONS

8.1 Pregnancy

Risk Summary

Limited published data from case series and case reports with epoprostenol have not established a drug associated risk of major birth defects, miscarriage or adverse maternal or fetal outcomes when used during pregnancy. There are risks to the mother and fetus from untreated pulmonary arterial hypertension (see *Clinical Considerations*). In animal reproduction studies, pregnant rats and rabbits received epoprostenol sodium during organogenesis at exposures of 2.5 and 4.8 times the maximum recommended human dose (MRHD), respectively, and there was no effect on the fetus (see *Data*).

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

Clinical Considerations

Disease-Associated Maternal and/or Embryo/Fetal Risk

Pregnant women with untreated pulmonary arterial hypertension are at risk for heart failure, stroke, preterm delivery, and maternal and fetal death.

Data

Animal Data

Embryo-fetal development studies have been performed in rats and rabbits during organogenesis. Epoprostenol sodium doses up to 100 mcg/kg/day, a dose that was maternally toxic in rabbits but not in rats, (600 mcg/m²/day in rats, 2.5 times the MRHD, and 1,180 mcg/m²/day in rabbits, 4.8 times the MRHD based on body surface area), had no effect on the fetus.

In a postnatal development study, epoprostenol sodium was administered subcutaneously to female rats for 2 weeks prior to mating through weaning and to male rats for 60 days prior to and through mating at a male and female toxic dose of up to 100 mcg/kg/day (600 mcg/m²/day, 2.5 times the MRHD based on body surface area). There was no effect on growth and development of the offspring.

8.2 Lactation

Risk Summary

There are no data on the presence of epoprostenol in either human or animal milk, the effects on the breastfed infant, or the effect on milk production.

The developmental and health benefits of breastfeeding should be considered along with the mother's clinical need for epoprostenol and any potential adverse effects on the breastfed child from epoprostenol or from the underlying maternal condition.

8.4 Pediatric Use

Safety and effectiveness in pediatric patients have not been established.

8.5 Geriatric Use

Clinical studies of epoprostenol in pulmonary hypertension did not include sufficient numbers of subjects aged 65 and over to determine whether they respond differently from younger patients. Other reported clinical experience has not identified differences in responses between the elderly and younger patients. In general, dose selection for an elderly patient should be cautious, usually starting at the low end of the dosing range, reflecting the greater frequency of decreased hepatic, renal, or cardiac function and of concomitant disease or other drug therapy.

10 OVERDOSAGE

Signs and symptoms of excessive doses of epoprostenol during clinical trials are the expected dose-limiting pharmacologic effects of epoprostenol, including flushing, headache, hypotension, tachycardia, nausea, vomiting, and diarrhea. Treatment will ordinarily require dose reduction of epoprostenol.

One patient with secondary pulmonary hypertension accidentally received 50 mL of an unspecified concentration of epoprostenol. The patient vomited and became unconscious with an initially unrecordable blood pressure. Epoprostenol was discontinued and the patient regained consciousness within seconds. In clinical practice, fatal occurrences of hypoxemia, hypotension, and respiratory arrest have been reported following overdosage of epoprostenol.

Single intravenous doses of epoprostenol at 10 and 50 mg/kg (2,703 and 27,027 times the recommended acute phase human dose based on body surface area) were lethal to mice and rats, respectively. Symptoms of acute toxicity were hypoactivity, ataxia, loss of righting reflex, deep slow breathing, and hypothermia.

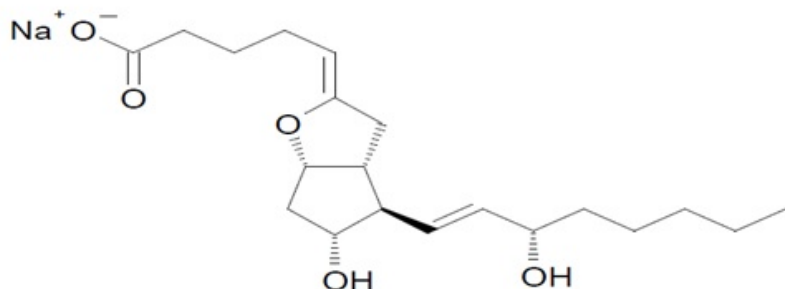
11 DESCRIPTION

Epoprostenol sodium is the sodium salt of epoprostenol, formulated as a sterile lyophilized cake or powder for intravenous (IV) administration. Each vial of epoprostenol

for injection contains epoprostenol sodium equivalent to either 0.5 mg (500,000 ng) or 1.5 mg (1,500,000 ng) epoprostenol, 100 mg sucrose, and 5 mg glycine. Sodium hydroxide is added to adjust pH.

Epoprostenol (PGI_2 , PGX, prostacyclin), a metabolite of arachidonic acid, is a naturally occurring prostaglandin with potent vasodilatory activity and inhibitory activity of platelet aggregation.

Epoprostenol is (5Z,9 α ,11 α ,13E,15S)-6,9-epoxy-11,15-dihydroxy-prosta-5,13-dien-1-oic acid, sodium salt. Epoprostenol sodium has a molecular weight of 374.45 and a molecular formula of $\text{C}_{20}\text{H}_{31}\text{NaO}_5$. The structural formula is:



Epoprostenol for injection is a white to off-white lyophilized cake or powder material. It is reconstituted with Sterile Water for Injection, USP, or Sodium Chloride 0.9% Injection, USP.

The reconstituted solution of epoprostenol for injection has a pH ranging from 12.0 to 13.2 and is increasingly unstable at a lower pH.

12 CLINICAL PHARMACOLOGY

12.1 Mechanism of Action

Epoprostenol has 2 major pharmacological actions: (1) direct vasodilation of pulmonary and systemic arterial vascular beds, and (2) inhibition of platelet aggregation.

12.2 Pharmacodynamics

In animals, the vasodilatory effects reduce right- and left-ventricular afterload and increase cardiac output and stroke volume. The effect of epoprostenol on heart rate in animals varies with dose. At low doses, there is vagally mediated bradycardia, but at higher doses, epoprostenol causes reflex tachycardia in response to direct vasodilation and hypotension. No major effects on cardiac conduction have been observed. Additional pharmacologic effects of epoprostenol in animals include bronchodilation, inhibition of gastric acid secretion, and decreased gastric emptying.

12.3 Pharmacokinetics

Epoprostenol is rapidly hydrolyzed at neutral pH in blood and is also subject to enzymatic degradation. Animal studies using tritium-labeled epoprostenol have indicated a high clearance (93 mL/kg/min), small volume of distribution (357 mL/kg), and a short half-life (2.7 minutes).

During infusions in animals, steady-state plasma concentrations of tritium-labeled epoprostenol were reached within 15 minutes and were proportional to infusion rates. No available chemical assay is sufficiently sensitive and specific to assess the *in vivo* human pharmacokinetics of epoprostenol. The *in vitro* half-life of epoprostenol in human blood at 37°C and pH 7.4 is approximately 6 minutes; therefore, the *in vivo* half-life of epoprostenol in humans is expected to be no greater than 6 minutes. The *in vitro* pharmacologic half-life of epoprostenol in human plasma, based on inhibition of platelet aggregation, was similar for males (n = 954) and females (n = 1,024).

Tritium-labeled epoprostenol has been administered to humans in order to identify the metabolic products of epoprostenol. Epoprostenol is metabolized to 2 primary metabolites: 6-keto-PGF_{1α} (formed by spontaneous degradation) and 6,15-diketo-13,14-dihydro-PGF_{1α} (enzymatically formed), both of which have pharmacological activity orders of magnitude less than epoprostenol in animal test systems. The recovery of radioactivity in urine and feces over a 1-week period was 82% and 4% of the administered dose, respectively. Fourteen additional minor metabolites have been isolated from urine, indicating that epoprostenol is extensively metabolized in humans.

13 NONCLINICAL TOXICOLOGY

13.1 Carcinogenesis and Mutagenesis and Impairment of Fertility

Long-term studies in animals have not been performed to evaluate carcinogenic potential. A micronucleus test in rats revealed no evidence of mutagenicity. The Ames test and DNA elution tests were also negative, although the instability of epoprostenol makes the significance of these tests uncertain. Fertility was not impaired in rats given epoprostenol by subcutaneous injection at doses up to 100 mcg/kg/day (600 mcg/m²/day, 2.5 times the recommended human dose [4.6 ng/kg/min or 245.1 mcg/m²/day, IV] based on body surface area).

14 CLINICAL STUDIES

14.1 Clinical Trials in Pulmonary Arterial Hypertension (PAH)

Acute Hemodynamic Effects: Acute intravenous infusions of epoprostenol for up to 15 minutes in patients with idiopathic or heritable PAH or PAH associated with scleroderma spectrum of diseases (PAH/SSD) produce dose-related increases in cardiac index (CI) and stroke volume (SV) and dose-related decreases in pulmonary vascular resistance (PVR), total pulmonary resistance (TPR), and mean systemic arterial pressure (SAPm). The effects of epoprostenol on mean pulmonary arterial pressure (PAPm) were variable and minor.

Chronic Infusion in Idiopathic or Heritable PAH:

Hemodynamic Effects: Chronic continuous infusions of epoprostenol in patients with idiopathic or heritable PAH were studied in 2 prospective, open, randomized trials of 8 and 12 weeks' duration comparing epoprostenol plus conventional therapy to conventional therapy alone. Dosage of epoprostenol was determined as described in **DOSAGE AND ADMINISTRATION (2)** and averaged 9.2 ng/kg/min at study's end. Conventional therapy varied among patients and included some or all of the following: anticoagulants in essentially all patients; oral vasodilators, diuretics, and digoxin in one half to two thirds of patients; and supplemental oxygen in about half the patients. Except for 2 New York Heart Association (NYHA) functional Class II patients, all patients were either functional Class III or Class IV. As results were similar in the 2 studies, the pooled results are described.

Chronic hemodynamic effects were generally similar to acute effects. Increases in CI,

SV, and arterial oxygen saturation and decreases in PAPm, mean right atrial pressure (RAPm), TPR, and systemic vascular resistance (SVR) were observed in patients who received epoprostenol chronically compared to those who did not. Table 11 illustrates the treatment-related hemodynamic changes in these patients after 8 or 12 weeks of treatment.

Table 11: Hemodynamics during Chronic Administration of Epoprostenol in Patients with Idiopathic or Heritable PAH

	Baseline		Mean Change from Baseline at End of Treatment Period^a	
Hemodynamic Parameter	Epoprostenol (N = 52)	Standard Therapy (N = 54)	Epoprostenol (N = 48)	Standard Therapy (N = 41)
CI (L/min/m ²)	2.0	2.0	0.3 ^b	-0.1
PAPm (mm Hg)	60	60	-5 ^b	1
PVR (Wood U)	16	17	-4 ^b	1
SAPm (mm Hg)	89	91	-4	-3
SV (mL/beat)	44	43	6 ^b	-1
TPR (Wood U)	20	21	-5 ^b	1

^aAt 8 weeks: Epoprostenol N = 10, conventional therapy N = 11 (N is the number of patients with hemodynamic data).

At 12 weeks: Epoprostenol N = 38, conventional therapy N = 30 (N is the number of patients with hemodynamic data).

^b Denotes statistically significant difference between Epoprostenol and conventional therapy groups. CI = cardiac index, PAPm = mean pulmonary arterial pressure, PVR = pulmonary vascular resistance, SAPm = mean systemic arterial pressure, SV = stroke volume, TPR = total pulmonary resistance.

These hemodynamic improvements appeared to persist when epoprostenol was administered for at least 36 months in an open, nonrandomized study.

Clinical Effects: Statistically significant improvement was observed in exercise capacity, as measured by the

6-minute walk test in patients receiving continuous intravenous epoprostenol plus conventional therapy

(N = 52) for 8 or 12 weeks compared to those receiving conventional therapy alone (N = 54). Improvements were apparent as early as the first week of therapy. Increases in exercise capacity were accompanied by statistically significant improvement in dyspnea and fatigue, as measured by the Chronic Heart Failure Questionnaire and the Dyspnea Fatigue Index.

Survival was improved in NYHA functional Class III and Class IV patients with idiopathic or heritable PAH treated with epoprostenol for 12 weeks in a multicenter, open, randomized, parallel study. At the end of the treatment period, 8 of 40 (20%) patients receiving conventional therapy alone died, whereas none of the 41 patients receiving epoprostenol died (p = 0.003).

Chronic Infusion in PAH/Scleroderma Spectrum of Diseases (SSD):

Hemodynamic Effects: Chronic continuous infusions of epoprostenol in patients with PAH/SSD were studied in a prospective, open, randomized trial of 12 weeks' duration comparing epoprostenol plus conventional therapy (N = 56) to conventional therapy alone (N = 55). Except for 5 NYHA functional Class II patients, all patients were either functional Class III or Class IV. Dosage of epoprostenol was determined as described in **DOSAGE AND ADMINISTRATION (2)** and averaged 11.2 ng/kg/min at study's end. Conventional therapy varied among patients and included some or all of the following: anticoagulants in essentially all patients, supplemental oxygen and diuretics in two thirds of the patients, oral vasodilators in 40% of the patients, and digoxin in a third of the patients. A statistically significant increase in CI, and statistically significant decreases in PAPm, RAPm, PVR, and SAPm after 12 weeks of treatment were observed in patients who received epoprostenol chronically compared to those who did not. Table 12 illustrates the treatment-related hemodynamic changes in these patients after 12 weeks of treatment.

Table 12: Hemodynamics during Chronic Administration of Epoprostenol in Patients with PAH/SSD

	Baseline		Mean Change from Baseline at 12 Weeks	
Hemodynamic Parameter	Epoprostenol (N = 56)	Conventional Therapy (N = 55)	Epoprostenol (N = 50)	Conventional Therapy (N = 48)
CI (L/min/m ²)	1.9	2.2	0.5 ^a	-0.1
PAPm (mm Hg)	51	49	-5 ^a	1
RAPm (mm Hg)	13	11	-1 ^a	1
PVR (Wood U)	14	11	-5 ^a	1
SAPm (mm Hg)	93	89	-8 ^a	-1

^aDenotes statistically significant difference between Epoprostenol and conventional therapy groups (N is the number of patients with hemodynamic data).

CI = cardiac index, PAPm = mean pulmonary arterial pressure, RAPm = mean right atrial pressure, PVR = pulmonary vascular resistance, SAPm = mean systemic arterial pressure.

Clinical Effects: Statistically significant improvement was observed in exercise capacity, as measured by the 6-minute walk, in patients receiving continuous intravenous epoprostenol plus conventional therapy for 12 weeks compared to those receiving conventional therapy alone. Improvements were apparent in some patients at the end of the first week of therapy. Increases in exercise capacity were accompanied by statistically significant improvements in dyspnea and fatigue, as measured by the Borg Dyspnea Index and Dyspnea Fatigue Index. At week 12, NYHA functional class improved in 21 of 51 (41%) patients treated with epoprostenol compared to none of the 48 patients treated with conventional therapy alone. However, more patients in both treatment groups (28/51 [55%] with epoprostenol and 35/48 [73%] with conventional therapy alone) showed no change in functional class, and 2/51 (4%) with epoprostenol and 13/48 (27%) with conventional therapy alone worsened. Of the patients

randomized, NYHA functional class data at 12 weeks were not available for 5 patients treated with epoprostenol and 7 patients treated with conventional therapy alone. No statistical difference in survival over 12 weeks was observed in PAH/SSD patients treated with epoprostenol as compared to those receiving conventional therapy alone. At the end of the treatment period, 4 of 56 (7%) patients receiving epoprostenol died, whereas 5 of 55 (9%) patients receiving conventional therapy alone died. No controlled clinical trials with epoprostenol have been performed in patients with pulmonary hypertension associated with other diseases.

16 HOW SUPPLIED/STORAGE AND HANDLING

16.1 How Supplied

Epoprostenol for injection is supplied as a sterile lyophilized material in 10 mL vials. 10 mL vial with an orange flip top containing epoprostenol sodium equivalent to 0.5 mg (500,000 ng) epoprostenol, is packaged in carton of 1 vial (**NDC 62756-059-40**). 10 mL vial with a purple flip top containing epoprostenol sodium equivalent to 1.5 mg (1,500,000 ng) epoprostenol, is packaged in carton of 1 vial (**NDC 62756-060-40**). Store the vials of epoprostenol for injection at 20° to 25°C (68° to 77°F); excursions permitted to 15° to 30°C (59° to 86°F) [see USP Controlled Room Temperature]. Protect from light.

16.2 Storage and Stability

Unopened vials of epoprostenol for injection are stable until the date indicated on the package when stored at 68° to 77°F (20° to 25°C). The unopened vial should be kept in the carton and not exposed to direct sunlight.

Use after reconstitution and immediate dilution to final concentration can be found in **DOSAGE AND ADMINISTRATION (2.4)** Reconstitution, Table 1: Maximum duration of administration (hours) at room temperature (77°F /25°C) of fully diluted solutions in the drug delivery reservoir.

Inspect parenteral drug products for particulate matter and discoloration prior to administration whenever solution and container permit. If either occurs, do not administer.

17 PATIENT COUNSELING INFORMATION

Patients receiving epoprostenol for injection should receive the following information.

Epoprostenol for injection must be reconstituted as directed using only Sterile Water for Injection, USP, or Sodium Chloride 0.9% Injection, USP. Epoprostenol for injection is infused continuously through a permanent indwelling central venous catheter via a small, portable infusion pump. Thus, therapy with epoprostenol for injection requires commitment by the patient to drug reconstitution, drug administration, and care of the permanent central venous catheter. Patients must adhere to sterile technique in preparing the drug and in the care of the catheter, and even brief interruptions in the delivery of epoprostenol for injection may result in rapid symptomatic deterioration. A patient's decision to receive epoprostenol for injection should be based upon the understanding that there is a high likelihood that therapy with epoprostenol for injection will be needed for prolonged periods, possibly years. The patient's ability to accept and care for a permanent intravenous catheter and infusion pump should also be carefully considered.

Distributed by:

Sun Pharmaceutical Industries, Inc.

Cranbury, NJ 08512

Manufactured by:

Sun Pharmaceutical Industries, Inc.

Billerica, MA 01821

PL-000075

Rev. 2.0

October 2020

PACKAGE LABEL.PRINCIPAL DISPLAY PANEL - 0.5 mg-vial

NDC 62756-059-40

Epoprostenol for Injection

0.5 mg (500,000 ng)/vial

For Intravenous Infusion Only

Sterile, Lyophilized Product

Single-dose Vial

Discard Unused Portion

Rx only

Sun Pharma

PL-000076, Rev 1.3, Apr 2025
Mfg. by: Sun Pharmaceutical Industries, Inc.,
Billerica, MA 01821

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

NDC 62756-059-40
Epoprostenol for Injection
0.5 mg (500,000 ng)/vial

For Intravenous Infusion Only
Sterile, Lyophilized Product
Single-dose Vial
Discard Unused Portion

Rx only

SUN PHARMA

After reconstitution, immediately withdraw correct dose, and dilute to final concentration in reservoir. Discard unused portion remaining in vial.

STORAGE: Store at 20° to 25°C (68° to 77°F); excursions permitted to 15° to 30°C (59° to 86°F)[see USP Controlled Room Temperature]. Protect from light.

PACKAGE LABEL.PRINCIPAL DISPLAY PANEL-0.5 mg-carton

NDC 62756-059-40

Single-dose Vial

Discard Unused Portion

Epoprostenol for Injection

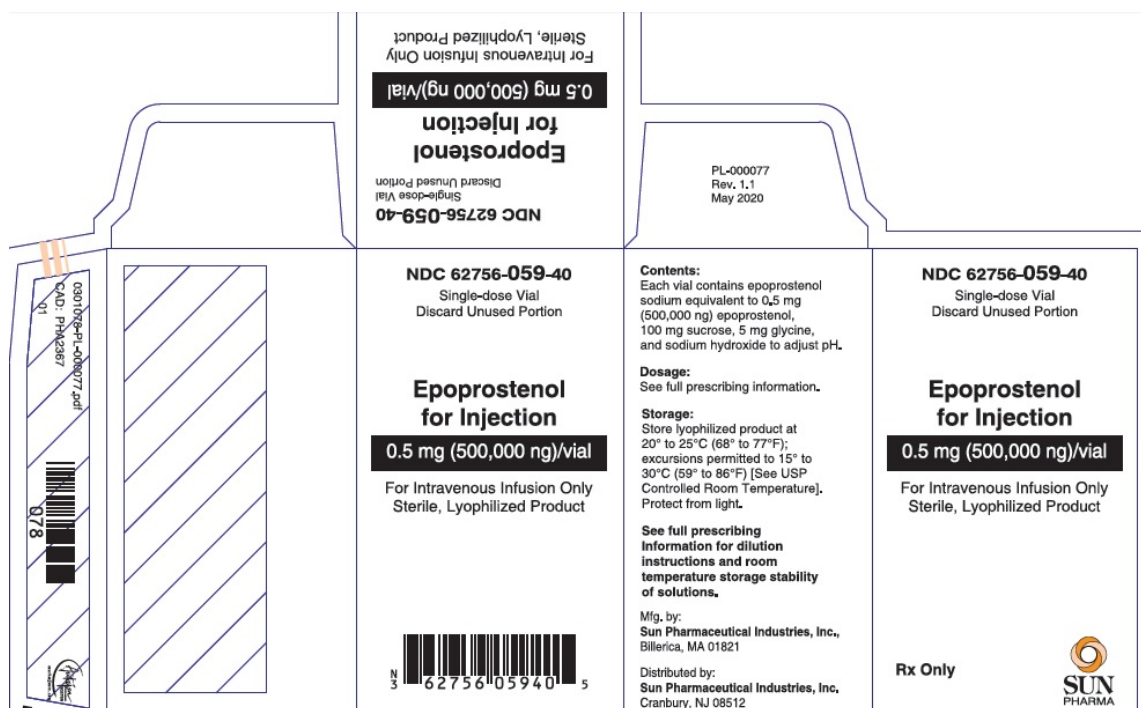
0.5 mg (500,000 ng)/vial

For Intravenous Infusion Only

Sterile, Lyophilized Product

Rx only

Sun Pharma



PACKAGE LABEL.PRINCIPAL DISPLAY PANEL-1.5 mg-vial

NDC 62756-060-40

Epoprostenol for Injection

1.5 mg (1,500,000 ng)/vial

For Intravenous Infusion Only

Sterile, Lyophilized Product

Single-dose Vial

Discard Unused Portion

Rx only

Sun Pharma



PACKAGE LABEL.PRINCIPAL DISPLAY PANEL-1.5 mg-carton

NDC 62756-060-40

Single-dose Vial

Discard Unused Portion

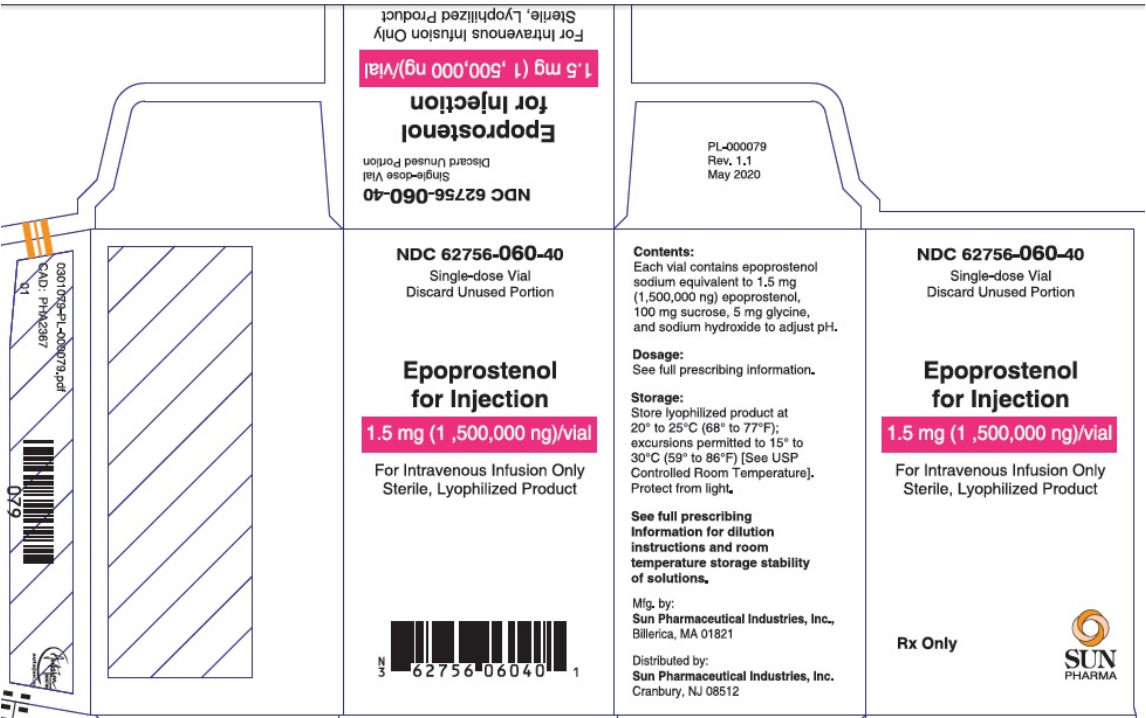
Epoprostenol for Injection

1.5 mg (1,500,000 ng)/vial

For Intravenous Infusion Only

Sterile, Lyophilized Product

Rx only



EPOPROSTENOL				
epoprostenol injection, powder, lyophilized, for solution				
Product Information				
Product Type	HUMAN PRESCRIPTION DRUG	Item Code (Source)	NDC:62756-059	
Route of Administration	INTRAVENOUS			
Active Ingredient/Active Moiety				
Ingredient Name		Basis of Strength	Strength	
EPOPROSTENOL SODIUM (UNII: 4K04IQ10F4) (EPOPROSTENOL - UNII:DCR9Z582X0)		EPOPROSTENOL	0.5 mg in 10 mL	
Inactive Ingredients				
Ingredient Name			Strength	
SUCROSE (UNII: C151H8M554)				
GLYCINE (UNII: TE7660XO1C)				
SODIUM HYDROXIDE (UNII: 55X04QC32I)				
Packaging				
#	Item Code	Package Description	Marketing Start Date	Marketing End Date
1	NDC:62756-059-40	1 in 1 CARTON	01/16/2021	
1		10 mL in 1 VIAL; Type 0: Not a Combination Product		

Marketing Information			
Marketing Category	Application Number or Monograph Citation	Marketing Start Date	Marketing End Date
ANDA	ANDA210473	01/16/2021	

EPOPROSTENOL				
epoprostenol injection, powder, lyophilized, for solution				
Product Information				
Product Type	HUMAN PRESCRIPTION DRUG	Item Code (Source)	NDC:62756-060	
Route of Administration	INTRAVENOUS			
Active Ingredient/Active Moiety				
Ingredient Name		Basis of Strength	Strength	
EPOPROSTENOL SODIUM (UNII: 4K04IQ1OF4) (EPOPROSTENOL - UNII:DCR9Z582X0)		EPOPROSTENOL	1.5 mg in 10 mL	
Inactive Ingredients				
Ingredient Name			Strength	
SUCROSE (UNII: C151H8M554)				
GLYCINE (UNII: TE7660XO1C)				
SODIUM HYDROXIDE (UNII: 55X04QC32I)				
Packaging				
#	Item Code	Package Description	Marketing Start Date	Marketing End Date
1	NDC:62756-060-40	1 in 1 CARTON	01/16/2021	
1		10 mL in 1 VIAL; Type 0: Not a Combination Product		
Marketing Information				
Marketing Category	Application Number or Monograph Citation		Marketing Start Date	Marketing End Date
ANDA	ANDA210473		01/16/2021	

Labeler - Sun Pharmaceutical Industries, Inc. (146974886)

Establishment			
Name	Address	ID/FEI	Business Operations
Sun Pharmaceutical Industries, Inc.		037074409	ANALYSIS(62756-059, 62756-060) , MANUFACTURE(62756-059, 62756-060)