**Composition**
each tablet contains levofloxacin 500 & 750 mg

**Action**
Bactericidal; as a fluoroquinolone antibacterial agent, levofloxacin acts on the DNA-gyrase complex and topoisomerase IV needed for the synthesis of bacterial DNA. Due to the mechanism of action, there is generally no cross-resistance between levofloxacin and other classes of antibacterial agents.

**Antibacterial spectrum**
The prevalence of resistance may vary geographically and with time for selected species and local information on resistance is desirable, particularly when treating severe infections. As necessary, expert advice should be sought when the local prevalence of resistance is such that the utility of the agent in at least some types of infections is questionable.

### Commonly susceptible species

<table>
<thead>
<tr>
<th>Category</th>
<th>Species</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Aerobic Gram-positive bacteria</strong></td>
<td>Staphylococcus aureus* methicillin-susceptibleStaphylococcus saprophyticus Streptococci, group C and G Streptococcus agalactiae Streptococcus pneumoniae * Streptococcus pyogenes *</td>
</tr>
<tr>
<td><strong>Aerobic Gram-negative bacteria</strong></td>
<td>Burkholderia cepacia$ Eikenella corrodens Haemophilus influenzae * Haemophilus para-influenzae * Klebsiella oxytoca Klebsiellapneumoniae * Moraxella catarrhalis * Pasteurella multocida Proteusvulgaris Providencia rettgeri</td>
</tr>
<tr>
<td><strong>Anaerobic bacteria</strong></td>
<td>Peptostreptococcus</td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td>Chlamyphila pneumoniae * Chlamydophila psittaci Chlamydia trachomatis Legionella pneumophila* Mycoplasma pneumoniae * Mycoplasma hominis Ureaplasma urealyticum</td>
</tr>
<tr>
<td><strong>Species for which acquired resistance may be a problem</strong></td>
<td>Aerobic Gram-positive bacteria Enterococcus faecalis* Staphylococcus aureus methicillin-resistant Coagulase negative Staphylococcus spp</td>
</tr>
<tr>
<td><strong>Aerobic Gram-negative bacteria</strong></td>
<td></td>
</tr>
<tr>
<td>Acinetobacter baumannii *</td>
<td></td>
</tr>
<tr>
<td>---------------------------</td>
<td></td>
</tr>
<tr>
<td>Citrobacter freundii *</td>
<td></td>
</tr>
<tr>
<td>Enterobacter aerogenes</td>
<td></td>
</tr>
<tr>
<td>Enterobacter agglomerans</td>
<td></td>
</tr>
<tr>
<td>Enterobacter cloacae *</td>
<td></td>
</tr>
<tr>
<td>Escherichia coli *</td>
<td></td>
</tr>
<tr>
<td>Morganella morgani *</td>
<td></td>
</tr>
<tr>
<td>Proteus mirabilis *</td>
<td></td>
</tr>
<tr>
<td>Providencia stuartii</td>
<td></td>
</tr>
<tr>
<td>Pseudomonas aeruginosa*</td>
<td></td>
</tr>
<tr>
<td>Serratia marcescens *</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Anaerobic bacteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bacteroides fragilis</td>
</tr>
<tr>
<td>Bacteroides ovatus$</td>
</tr>
<tr>
<td>Bacteroides thetaiotamicron$</td>
</tr>
<tr>
<td>Bacteroides vulgatus$</td>
</tr>
<tr>
<td>Clostridium difficile$</td>
</tr>
</tbody>
</table>

Clinical efficacy has been demonstrated for susceptible isolates in the approved clinical indications.
$ Natural intermediate susceptibility
* More than 50% of resistance

Other information
Nosocomial infections due to *P. aeruginosa* may require combination therapy.

Pharmacokinetics

Absorption
Orally administered levofloxacin is rapidly and almost completely absorbed with peak plasma concentrations being obtained within 1 h. The absolute bioavailability is approximately 100%. Food has little effect on the absorption of levofloxacin.

Distribution
Approximately 30 - 40 % of levofloxacin is bound to serum protein. 500 mg once daily multiple dosing with levofloxacin showed negligible accumulation. There is modest but predictable accumulation of levofloxacin after doses of 500 mg twice daily. Steady-state is achieved within 3 days.

Penetration into tissues and body fluids:
**Penetration into Bronchial Mucosa, Epithelial Lining Fluid (ELF)**
Maximum levofloxacin concentrations in bronchial mucosa and epithelial lining fluid after 500 mg p.o. were 8.3 μg/g and 10.8 μg/ml respectively. These were reached approximately one hour after administration.

**Penetration into Lung Tissue**
Maximum levofloxacin concentrations in lung tissue after 500 mg p.o. were approximately 11.3 μg/g and were reached between 4 and 6 hours after administration. The concentrations in the lungs consistently exceeded those in plasma.

**Penetration into Blister Fluid**
Maximum levofloxacin concentrations of about 4.0 and 6.7 μg/ml in the blister fluid were reached 2 - 4 hours after administration following 3 days dosing at 500 mg once or twice daily, respectively.

**Penetration into Cerebro-Spinal Fluid**
Levofloxacin has poor penetration into cerebro-spinal fluid.

**Penetration into prostatic tissue**
After administration of oral 500mg levofloxacin once a day for three days, the mean concentrations in prostatic tissue were 8.7 µg/g, 8.2 µg/g and 2.0 µg/g respectively after 2 hours, 6 hours and 24 hours; the mean prostate/plasma concentration ratio was 1.84.

Concentration in urine
The mean urine concentrations 8 -12 hours after a single oral dose of 150 mg, 300 mg or 500 mg levofloxacin were 44 mg/L, 91 mg/L and 200 mg/L, respectively.

Biotransformation
Levofoxacin is metabolised to a very small extent, the metabolites being desmethyl-levofloxacin and levofloxacin N-oxide. These metabolites account for < 5 % of the dose excreted in urine. Levofloxacin is stereochemically stable and does not undergo chiral inversion.

Elimination
Following oral and intravenous administration of levofloxacin, it is eliminated relatively slowly from the plasma ($t_{1/2}$: 6 - 8 h). Excretion is primarily by the renal route > 85 % of the administered dose). There are no major differences in the pharmacokinetics of levofloxacin following intravenous and oral administration, suggesting that the oral and intravenous routes are interchangeable.

Subjects with renal insufficiency
The pharmacokinetics of levofloxacin are affected by renal impairment. With decreasing renal function renal elimination and clearance are decreased, and elimination half-lives increased as shown in the table below:

<table>
<thead>
<tr>
<th>$Cl_{re}$ [ml/min]</th>
<th>&lt; 20</th>
<th>20 - 40</th>
<th>50 - 80</th>
</tr>
</thead>
<tbody>
<tr>
<td>$Cl_{re}$ [ml/min]</td>
<td>13</td>
<td>26</td>
<td>57</td>
</tr>
<tr>
<td>T $1/2$ [h]</td>
<td>35</td>
<td>27</td>
<td>9</td>
</tr>
</tbody>
</table>

Elderly subjects
There are no significant differences in levofloxacin pharmacokinetics between young and elderly subjects, except those associated with differences in creatinine clearance.

Gender differences
Separate analysis for male and female subjects showed small to marginal gender differences in levofloxacin pharmacokinetics. There is no evidence that these gender differences are of clinical relevance.

Indications
In adults with infections of mild or moderate severity, Voloxal tablets are indicated for the treatment of the following infections when due to levofloxacin-susceptible microorganisms:

- Acute sinusitis
- Acute exacerbations of chronic bronchitis
- Community-acquired pneumonia
- Complicated urinary tract infections including pyelonephritis
- Chronic bacterial Prostatitis.
- Skin and soft tissue infections.

Before prescribing Voloxal, consideration should be given to national and/or local guidance on the appropriate use of fluoroquinolones.

Contraindications
- In patients hypersensitive to levofloxacin or other quinolones or any of the excipients,
- In patients with epilepsy,
- In patients with history of tendon disorders related to fluoroquinolone administration,
• In children or growing adolescents,
• During pregnancy,
• In breast-feeding women.

**Warnings & Precautions**

- May exacerbate muscle weakness in persons with myasthenia gravis. Avoid use in patients with a known history of myasthenia gravis.
- Anaphylactic reactions and allergic skin reactions, serious, occasionally fatal, may occur after first dose.
- Hematologic (including agranulocytosis, thrombocytopenia), and renal toxicities may occur after multiple doses.
- Hepatotoxicity: Severe, and sometimes fatal, hepatotoxicity has been reported. Discontinue immediately if signs and symptoms of hepatitis occur.
- Central nervous system effects, including convulsions, anxiety, confusion, depression, and insomnia may occur after the first dose. Use with caution in patients with known or suspected disorders that may predispose them to seizures or lower the seizure threshold.
- *Clostridium difficile*-associated colitis: evaluate if diarrhea occurs.
- Peripheral neuropathy: discontinue if symptoms occur in order to prevent irreversibility.
- Prolongation of the QT interval and isolated cases of torsade de pointes have been reported. Avoid use in patients with known prolongation, those with hypokalemia, and with other drugs that prolong the QT interval.

**Tendinopathy and Tendon Rupture**

Fluoroquinolones, including Levofloxacin, are associated with an increased risk of tendinitis and tendon rupture in all ages. This adverse reaction most frequently involves the Achilles tendon, and rupture of the Achilles tendon may require surgical repair. Tendinitis and tendon rupture in the rotator cuff (the shoulder), the hand, the biceps, the thumb, and other tendon sites have also been reported. The risk of developing fluoroquinolone-associated tendinitis and tendon rupture is further increased in older patients usually over 60 years of age, in those taking corticosteroid drugs, and in patients with kidney, heart or lung transplants. Factors, in addition to age and corticosteroid use, that may independently increase the risk of tendon rupture include strenuous physical activity, renal failure, and previous tendon disorders such as rheumatoid arthritis. Tendinitis and tendon rupture have been reported in patients taking fluoroquinolones who do not have the above risk factors.

Tendon rupture can occur during or after completion of therapy; cases occurring up to several months after completion of therapy have been reported. Levofloxacin should be discontinued if the patient experiences pain, swelling, inflammation or rupture of a tendon. Patients should be advised to rest at the first sign of tendinitis or tendon rupture, and to contact their healthcare provider regarding changing to a non-quinolone antimicrobial drug.

**Pregnancy**

*Pregnancy Category C*

Levofloxacin was not teratogenic in rats at oral doses as high as 810 mg/kg/day which corresponds to 9.4 times the highest recommended human dose based upon relative body surface area, or at intravenous doses as high as 160 mg/kg/day corresponding to 1.9 times the highest recommended human dose based upon relative body surface area. The oral dose of 810 mg/kg/day to rats caused decreased fetal body weight and increased fetal mortality. No teratogenicity was observed when rabbits were dosed orally as high as 50 mg/kg/day which correspond to 1.1 times the highest recommended human dose based upon relative body surface area, or when dosed intravenously as high as 25 mg/kg/day, corresponding to 0.5 times the highest recommended human dose based upon relative body surface area.

There are, however, no adequate and well-controlled studies in pregnant women. Levofloxacin should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

**Nursing Mothers**
Based on data on other fluoroquinolones and very limited data on Levofloxacin, it can be presumed that levofloxacin will be excreted in human milk. Because of the potential for serious adverse reactions from Levofloxacin in nursing infants, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

**Adverse Reactions**
The information given below is based on data from clinical studies in more than 5000 patients and on extensive post marketing experience.

The adverse reactions are described according to the MedDRA system organ class below. Frequencies are defined using the following convention: very common (≥ 1/10), common (≥1/100, <1/10), uncommon (≥1/1000, ≤ 1/100), rare (≥1/10000, ≤ 1/1000), very rare (≤ 1/10000), not known (cannot be estimated from the available data).

Within each frequency grouping, undesirable effects are presented in order of decreasing seriousness.

**Infections and infestations**
Uncommon: Fungal infection (and proliferation of other resistant microorganisms)

**Blood and lymphatic system disorders**
Uncommon: Leukopenia, eosinophilia
Rare: Thrombocytopenia, neutropenia
Very rare: Agranulocytosis
Not Known: Pancytopenia, haemolytic anaemia

**Immune system disorders**
Very rare: Anaphylactic shock

*Anaphylactic and anaphylactoid reactions may sometimes occur even after the first dose*
Not known: Hypersensitivity

**Metabolism and nutrition disorders**
Uncommon: Anorexia
Very rare: Hypoglycemia, particularly in diabetic patients

**Psychiatric disorders**
Uncommon: Insomnia, nervousness
Rare: Psychotic disorder, depression, confusional state, agitation, anxiety
Very rare: Psychotic reactions with self-endangering behavior including suicidal ideation or acts, hallucination

**Nervous system disorders**
Uncommon: Dizziness, headache, somnolence
Rare: Convulsion, tremor, paraesthesia
Very rare: sensory or sensorimotor peripheral neuropathy, dysgeusia including ageusia, parosmia including anosmia

**Eye disorders**
Very rare: Visual disturbance

**Ear and Labyrinth disorders**
Uncommon: Vertigo
Very rare: Hearing impaired
Not known: Tinnitus
**Cardiac disorders**  
Rare: Tachycardia  
Not Known: Electrocardiogram QT prolonged

**Vascular disorders**  
Rare: Hypotension

**Respiratory, thoracic and mediastinal disorders**  
Rare: Bronchospasm, dyspnoea  
Very rare: Pneumonitis allergic

**Gastrointestinal disorders**  
Common: Diarrhoea, nausea  
Uncommon: Vomiting, abdominal pain, dyspepsia, flatulence, constipation.  
Rare: Diarrhoea –haemorrhagic which in very rare cases may be indicative of enterocolitis, including pseudomembranous colitis

**Hepatobiliary disorders**  
Common: Hepatic enzyme increased (ALT/AST, alkaline phosphatase, GGT)  
Uncommon: Blood bilirubin increased  
Very rare: Hepatitis  
Not known: Jaundice and severe liver injury, including cases with liver failure, have been reported with levofloxacin, primarily in patients with severe underlying diseases

**Skin and subcutaneous tissue disorders**  
Uncommon: Rash, pruritus  
Rare: Urticaria  
Very rare: Angioneurotic oedema, photosensitivity reaction  
Not Known: Toxic epidermal necrolysis, Stevens-Johnson syndrome, erythema multiforme, hyperhidrosis. Mucocutaneous reactions may sometimes occur even after the first dose

**Musculoskeletal and Connective tissue disorders**  
Rare: Tendon disorder .including tendinitis (e.g. Achilles tendon), Arthralgia, Myalgia  
Very rare: Tendon ruptures. This undesirable effect may occur within 48 hours of starting treatment and may be bilateral, muscular weakness which may be of special importance in patients with myasthenia gravis  
Not Known: Rhabdomyolysis

**Renal and urinary disorders**  
Uncommon: Blood creatinine increased  
Very rare: Renal failure acute (e.g. due to nephritis interstitial)

**General disorders and administration site conditions**  
Uncommon: Asthenia  
Very rare: Pyrexia  
Not known: Pain (including pain in back, chest, and extremities)

Other undesirable effects which have been associated with fluoroquinolone administration include:  
• Extrapyramidal symptoms and other disorders of muscular coordination,  
• Hypersensitivity vasculitis,  
• Attacks of porphyria in patients with porphyria.

**Drug Interactions**  
*Chelation Agents: Antacids, Sucralfate, Metal Cations, Multivitamins*  
While the chelation by divalent cations is less marked than with other fluoroquinolones, concurrent administration of Levofloxacin Tablets and Oral Solution with antacids containing magnesium, or
aluminum, as well as sucralfate, metal cations such as iron, and multivitamin preparations with zinc may interfere with the gastrointestinal absorption of levofloxacin, resulting in systemic levels considerably lower than desired. Tablets with antacids containing magnesium, aluminum, as well as sucralfate, metal cations such as iron, and multivitamins preparations with zinc or didanosine may substantially interfere with the gastrointestinal absorption of levofloxacin, resulting in systemic levels considerably lower than desired. These agents should be taken at least two hours before or two hours after oral Levofloxacin administration.

**Warfarin**

No significant effect of Levofloxacin on the peak plasma concentrations, AUC, and other disposition parameters for R- and S- warfarin was detected in a clinical study involving healthy volunteers. Similarly, no apparent effect of warfarin on levofloxacin absorption and disposition was observed. However, there have been reports during the post marketing experience in patients that Levofloxacin enhances the effects of warfarin. Elevations of the prothrombin time in the setting of concurrent warfarin and Levofloxacin use have been associated with episodes of bleeding. Prothrombin time, International Normalized Ratio (INR), or other suitable anticoagulation tests should be closely monitored if Levofloxacin is administered concomitantly with warfarin. Patients should also be monitored for evidence of bleeding.

**Antidiabetic Agents**

Disturbances of blood glucose, including hyperglycemia and hypoglycemia, have been reported in patients treated concomitantly with fluoroquinolones and an antidiabetic agent. Therefore, careful monitoring of blood glucose is recommended when these agents are co-administered.

**Non-Steroidal Anti-Inflammatory Drugs**

The concomitant administration of a non-steroidal anti-inflammatory drug with a fluoroquinolone, including Levofloxacin, may increase the risk of CNS stimulation and convulsive seizures.

**Theophylline**

No significant effect of Levofloxacin on the plasma concentrations, AUC, and other disposition parameters for theophylline was detected in a clinical study involving healthy volunteers. Similarly, no apparent effect of theophylline on levofloxacin absorption and disposition was observed. However, concomitant administration of other fluoroquinolones with theophylline has resulted in prolonged elimination half-life, elevated serum theophylline levels, and a subsequent increase in the risk of theophylline-related adverse reactions in the patient population. Therefore, theophylline levels should be closely monitored and appropriate dosage adjustments made when Levofloxacin is co-administered. Adverse reactions, including seizures, may occur with or without an elevation in serum theophylline levels.

**Cyclosporine**

No significant effect of Levofloxacin on the peak plasma concentrations, AUC, and other disposition parameters for cyclosporine was detected in a clinical study involving healthy volunteers. However, elevated serum levels of cyclosporine have been reported in the patient population when co-administered with some other fluoroquinolones. Levofloxacin C<sub>max</sub> and k<sub>e</sub> were slightly lower while T<sub>max</sub> and t<sub>1/2</sub> were slightly longer in the presence of cyclosporine than those observed in other studies without concomitant medication. The differences, however, are not considered to be clinically significant. Therefore, no dosage adjustment is required for Levofloxacin or cyclosporine when administered concomitantly.

**Digoxin**

No significant effect of Levofloxacin on the peak plasma concentrations, AUC, and other disposition parameters for digoxin was detected in a clinical study involving healthy volunteers. Levofloxacin absorption and disposition kinetics were similar in the presence or absence of digoxin. Therefore, no dosage adjustment for Levofloxacin or digoxin is required when administered concomitantly.

**Probenecid and Cimetidine**
No significant effect of probenecid or cimetidine on the $C_{\text{max}}$ of levofloxacin was observed in a clinical study involving healthy volunteers. The $AUC$ and $t_{1/2}$ of levofloxacin were higher while $CL/F$ and CLR were lower during concomitant treatment of Levofloxacin with probenecid or cimetidine compared to Levofloxacin alone. However, these changes do not warrant dosage adjustment for Levofloxacin when probenecid or cimetidine is co-administered.

**Interactions with Laboratory or Diagnostic Testing**

Some fluoroquinolones, including Levofloxacin, may produce false-positive urine screening results for opiates using commercially available immunoassay kits. Confirmation of positive opiate screens by more specific methods may be necessary.

**Dosage and Administration**

The usual dose of Voloxal Tablets is 500 mg or 750 mg administered orally every 24 hours, as indicated by infection and described in Table 1. These recommendations apply to patients with creatinine clearance $\geq 50$ mL/min.

<table>
<thead>
<tr>
<th>Type of Infection*</th>
<th>Dosed Every 24 hours (mg)</th>
<th>Duration (days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nosocomial Pneumonia</td>
<td>750</td>
<td>7-14</td>
</tr>
<tr>
<td>Community Acquired Pneumonia$^\dagger$</td>
<td>500</td>
<td>7-14</td>
</tr>
<tr>
<td>Community Acquired Pneumonia$^\ddagger$</td>
<td>750</td>
<td>5</td>
</tr>
<tr>
<td>Acute Bacterial Sinusitis</td>
<td>750</td>
<td>5</td>
</tr>
<tr>
<td>Acute Bacterial Exacerbation of Chronic Bronchitis</td>
<td>500</td>
<td>7</td>
</tr>
<tr>
<td>Complicated Skin and Skin Structure Infections (SSSI)</td>
<td>750</td>
<td>7-14</td>
</tr>
<tr>
<td>Uncomplicated SSSI</td>
<td>500</td>
<td>7-10</td>
</tr>
<tr>
<td>Chronic Bacterial Prostatitis</td>
<td>500</td>
<td>28</td>
</tr>
<tr>
<td>Complicated Urinary Tract Infection (cUTI) or Acute Pyelonephritis (AP)$^\ddagger$</td>
<td>750</td>
<td>5</td>
</tr>
<tr>
<td>Complicated Urinary Tract Infection (cUTI) or Acute Pyelonephritis (AP)$^\ddagger$</td>
<td>250</td>
<td>10</td>
</tr>
<tr>
<td>Uncomplicated Urinary Tract Infection</td>
<td>250</td>
<td>3</td>
</tr>
<tr>
<td>Inhalational Anthrax (Post-Exposure), adult and pediatric patients &gt; 50 kg</td>
<td>500</td>
<td>60$^\beta$</td>
</tr>
</tbody>
</table>

* Due to the designated pathogens.

‡ Due to methicillin-susceptible *Staphylococcus aureus, Streptococcus pneumoniae* (including multi-drug-resistant strains [MDRSP]), *Haemophilus influenzae, Haemophilus parainfluenzae, Klebsiella pneumoniae, Moraxella catarrhalis, Chlamydophila pneumoniae, Legionella pneumophila, or Mycoplasma pneumoniae*.

§ Due to *Streptococcus pneumoniae* (excluding multi-drug-resistant strains [MDRSP]), *Haemophilus influenzae, Haemophilus parainfluenzae, Mycoplasma pneumoniae, or Chlamydophila pneumoniae*.

¶ This regimen is indicated for cUTI due to *Escherichia coli, Klebsiella pneumoniae, Proteus mirabilis* and AP due to *E. coli*, including cases with concurrent bacteremia.

# This regimen is indicated for cUTI due to *Enterococcus faecalis, Enterococcus cloacae, Escherichia coli, Klebsiella pneumoniae, Proteus mirabilis, Pseudomonas aeruginosa*; and for AP due to *E. coli*.

P Drug administration should begin as soon as possible after suspected or confirmed exposure to aerosolized *B. anthracis*. This indication is based on a surrogate endpoint. Levofloxacin plasma concentrations achieved in humans are reasonably likely to predict clinical benefit.

$^\beta$ the safety of Levofloxacin in adults for durations of therapy beyond 28 days has not been studied.

**Dosage Adjustment in Adults with Renal Impairment**

Administer Voloxal with caution in the presence of renal insufficiency. Careful clinical observation and appropriate laboratory studies should be performed prior to and during therapy since elimination of levofloxacin may be reduced. No adjustment is necessary for patients with a creatinine clearance $\geq 50$ mL/min.
In patients with impaired renal function (creatinine clearance <50 mL/min), adjustment of the dosage regimen is necessary to avoid the accumulation of levofloxacin due to decreased clearance. Table 2 shows how to adjust dose based on creatinine clearance.

Table 2: Dosage Adjustment in Adult Patients with Renal Impairment (creatinine clearance < 50 mL/min)

<table>
<thead>
<tr>
<th>Dosage in Normal Renal Function Every 24 hours</th>
<th>Creatinine Clearance 20 to 49 mL/min</th>
<th>Creatinine Clearance 10 to 19 mL/min</th>
<th>Hemodialysis or Chronic Ambulatory Peritoneal Dialysis (CAPD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>750 mg</td>
<td>750 mg every 48 hours</td>
<td>750 mg initial dose, then 500 mg every 48 hours</td>
<td>750 mg initial dose, then 500 mg every 48 hours</td>
</tr>
<tr>
<td>500 mg</td>
<td>500 mg initial dose, then 250 mg every 24 hours</td>
<td>500 mg initial dose, then 250 mg every 48 hours</td>
<td>500 mg initial dose, then 250 mg every 48 hours</td>
</tr>
</tbody>
</table>

Voloxal Tablets should be administered at least two hours before or two hours after antacids containing magnesium, aluminum, as well as sucralfate, metal cations such as iron, and multivitamin preparations with zinc or didanosine chewable/buffered tablets.

Voloxal Tablets can be administered without regard to food.

Adequate hydration of patients receiving Voloxal should be maintained to prevent the formation of highly concentrated urine. Crystalluria and cylindruria have been reported with quinolones.

**Over Dosage**
According to toxicity studies in animals or clinical pharmacology studies performed with supra-therapeutic doses, the most important signs to be expected following acute overdosage of Levofloxacin tablets are central nervous system symptoms such as confusion, dizziness, impairment of consciousness, and convulsive seizures, increases in QT interval as well as gastro-intestinal reactions such as nausea and mucosal erosions.

In the event of overdose, symptomatic treatment should be implemented. ECG monitoring should be undertaken, because of the possibility of QT interval prolongation. Antacids may be used for protection of gastric mucosa. Haemodialysis, including peritoneal dialysis and CAPD, are not effective in removing levofloxacin from the body. No specific antidote exists.

**Presentation**
**Voloxal 500**  
Box of 7 tablets

**Voloxal 750**  
Box of 5 tablets