ITEM: Amikacin Sulfate Injection USP, 1 gram/4mL (250 mg/mL) Vials by Teva: Recall - Glass Particulate Matter

SPECIFIC INCIDENT(S): Teva Pharmaceuticals announced a voluntary recall of one lot of amikacin sulfate injection USP, 1 gram/4mL (250 mg/mL) vials due to the potential presence of particulate matter identified as glass in one vial.

GENERAL INFORMATION:
- The administration of a glass particulate, if present in an intravenous drug or used in nebulization, may result in local irritation or swelling in response to the foreign material as well as blockage and clotting in blood vessels, which may be life-threatening if a critical organ is affected.
- Affected product includes:

<table>
<thead>
<tr>
<th>LOT #</th>
<th>EXP DATE</th>
<th>VIAL SIZE</th>
<th>NDC # (individual pack)</th>
<th>NDC# (shelf pack)</th>
</tr>
</thead>
<tbody>
<tr>
<td>4750915</td>
<td>9/2017</td>
<td>1 gram/4mL (250 mg/mL)</td>
<td>0703-9040-01</td>
<td>0703-9040-03</td>
</tr>
</tbody>
</table>

- This alert is an extension of the product sequestration actions in Product Recall Office Log # 10487 (available at: http://vaww.recalls.ncps.med.va.gov/WebRecalls/Recalls.html).
- Providers should continue to report any adverse reactions with the intravenous or nebulized use of amikacin sulfate injection USP, 1 gram/4mL (250 mg/mL) vials by entering the information into CPRS’ Allergies/ Adverse Reactions field and/or via local reporting mechanisms. Adverse events should also be reported, as appropriate, to the VA ADERS program and FDA MedWatch (1-800-FDA-1088, fax 1-800- FDA-0178, online at https://www.accessdata.fda.gov/scripts/medwatch/medwatch- online.htm, or by mail).

ACTIONS: PROVIDER NOTIFICATION:
- Facility Director (or physician designee): Forward this document to the Facility Chief of Staff (COS).
- Facility COS (and Chief Nurse Executives): Forward this document to all appropriate providers who prescribe this agent (e.g., primary care providers, infectious disease specialists, pulmonologists, and pharmacy staff, including contract providers, etc.). In addition, forward to the Associate Chief of Staff (ACOS) for Research and Development (R&D). Forward to other VA employees as deemed appropriate.
PATIENT NOTIFICATION:

• Chief of Pharmacy: Within 10 business days of issue (due 3/29/2016):
  o Determine whether the affected product(s) was dispensed to any patient(s) for home administration via intravenous or nebulized route. Sites may not have lot number information available locally, so in the case that the lot number data is not available, sites will need to call all patients that received the product and ask them to check the lot numbers.
  o If an affected lot(s) was dispensed to a patient(s) for home administration, then:
    ▪ Identify the patient(s).
    ▪ Contact the patient(s) who may have received the affected product(s) for home administration by letter (or other means).
      • A sample letter can be found at:
      • This template can be altered according to site-specific needs.
      ▪ Provide patient(s) in possession of the recalled product with instructions on the following:
        • How to return the product being recalled to the pharmacy.
        • How to obtain a new supply of product.
        • Patients should not continue to use the product until they obtain replacement product.
        • When the correct product is received, patients should begin using the new product and return the recalled supply as instructed.
  o Communicate to PBM/VAMedSAFE that all patient notification actions have been completed via the VHA Alerts and Recalls Website: http://vaww.recalls.ncps.med.va.gov/WebRecalls/Recalls.html.

SOURCE: FDA

REFERENCE(S):