

SUMMARY OF PRODUCT CHARACTERISTICS

1 NAME OF THE MEDICINAL PRODUCT

Meropenem 500 mg powder and solvent for solution for infusion

2 QUALITATIVE AND QUANTITATIVE COMPOSITION

Each two-chamber bag contains meropenem trihydrate equivalent to 500 mg anhydrous meropenem.

After reconstitution, the solution contains 10 mg meropenem per ml.

Excipients with known effect:

The total quantity of sodium per two-chamber bag is as follows:

Meropenem strength	Amount of sodium per two-chamber bag
500 mg	245 mg

For the full list of excipients, see section 6.1

3 PHARMACEUTICAL FORM

Powder and solvent for solution for infusion.

Before reconstitution, the two-chamber bag contains a white to light yellow powder and a clear and colourless solution.

After reconstitution, the clear and colourless solution is iso-osmotic and has a pH between 7.3 and 8.3.

4 CLINICAL PARTICULARS

4.1 Therapeutic indications

Meropenem is indicated for the treatment of the following infections in adults and

children aged 3 months and older (see sections 4.4 and 5.1).

- Severe pneumonia, including hospital and ventilator-associated pneumonia
- Broncho-pulmonary infections in cystic fibrosis
- Complicated urinary tract infections
- Complicated intra-abdominal infections
- Intra- and post-partum infections
- Complicated skin and soft tissue infections
- Acute bacterial meningitis

Meropenem may be used in the management of neutropenic patients with fever that is suspected to be due to a bacterial infection.

Treatment of patients with bacteraemia that occurs in association with, or is suspected to be associated with, any of the infections listed above.

Consideration should be given to official guidance on the appropriate use of antibacterial agents.

4.2 Posology and method of administration

Posology

The tables below provide general recommendations for dosing.

The dose of meropenem administered and the duration of treatment should take into account the type of infection to be treated, including its severity, and the clinical response.

A dose of up to 2000 mg three times daily in adults and adolescents and a dose of up to 40 mg/kg three times daily in children may be particularly appropriate when treating some types of infections, such as infections due to less susceptible bacterial species (e.g. *Enterobacteriaceae*, *Pseudomonas aeruginosa*, *Acinetobacter spp.*), or very severe infections.

Additional considerations for dosing are needed when treating patients with renal insufficiency (see further below).

Adults and adolescents

Infection	Dose to be administered every 8 hours
Severe pneumonia including hospital and ventilator-associated pneumonia	500 mg or 1000 mg
Broncho-pulmonary infections in cystic fibrosis	2000 mg
Complicated urinary tract infections	500 mg or 1000 mg
Complicated intra-abdominal infections	500 mg or 1000 mg
Intra- and post-partum infections	500 mg or 1000 mg
Complicated skin and soft tissue infections	500 mg or 1000 mg
Acute bacterial meningitis	2000 mg

Management of febrile neutropenic patients	1000 mg
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Renal impairment

The dose for adults and adolescents should be adjusted when creatinine clearance is less than 51 ml/min, as shown below. There are limited data to support the administration of these dose adjustments for a unit dose of 2000 mg.

Creatinine clearance (ml/min)	Dose (based on “unit” dose range of 500 mg or 1000 mg or 2000 mg, see table above)	Frequency
26 - 50	one unit dose	every 12 hours
10 - 25	half of one unit dose	every 12 hours
< 10	half of one unit dose	every 24 hours

Meropenem is cleared by haemodialysis and haemofiltration. The required dose should be administered after completion of the haemodialysis cycle.

There are no established dose recommendations for patients receiving peritoneal dialysis.

Hepatic impairment

No dose adjustment is necessary in patients with hepatic impairment (see section 4.4).

Dose in elderly patients

No dose adjustment is required for the elderly with normal renal function or creatinine clearance values above 50 ml/min.

Paediatric population

Children under 3 months of age

The safety and efficacy of meropenem in children under 3 months of age have not been established and the optimal dose regimen has not been identified. However, limited pharmacokinetic data suggest that 20 mg/kg every 8 hours may be an appropriate regimen (see section 5.2).

Children from 3 months to 11 years of age and up to 50 kg body weight

The recommended dose regimens are shown in the table below:

Infection	Dose to be administered every 8 hours
Severe pneumonia including hospital and ventilator-associated pneumonia	10 or 20 mg/kg
Broncho-pulmonary infections in cystic fibrosis	40 mg/kg
Complicated urinary tract infections	10 or 20 mg/kg
Complicated intra-abdominal infections	10 or 20 mg/kg
Complicated skin and soft tissue infections	10 or 20 mg/kg
Acute bacterial meningitis	40 mg/kg

Management of febrile neutropenic patients	20 mg/kg
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Children over 50 kg body weight

The adult dose should be administered.

There is no experience in children with renal impairment.

Method of administration

Intravenous Infusion

Meropenem is usually given by intravenous infusion over approximately 15 to 30 minutes (see sections 6.2, 6.3, and 6.6). Extended infusion (i.e. 0.5 - 2 g meropenem infused over 3 hours) may be used for less susceptible bacteria to achieve a higher target of $T > MIC$.

For instructions on reconstitution of the medicinal product before administration, see section 6.6.

4.3 Contraindications

Hypersensitivity to the active substance or to any of the excipients listed in section 6.1.

Hypersensitivity to any other carbapenem antibacterial agent.

Severe hypersensitivity (e.g. anaphylactic reaction, severe skin reaction) to any other type of beta-lactam antibacterial agent (penicillin's or cephalosporins).

4.4 Special warnings and precautions for use

The selection of meropenem to treat an individual patient should take into account the appropriateness of using a carbapenem antibacterial agent based on factors such as severity of the infection, the prevalence of resistance to other suitable antibacterial agents and the risk of selecting for carbapenem-resistant bacteria.

Enterobacteriaceae, Pseudomonas aeruginosa and Acinetobacter spp. resistance

Resistance to penems of Enterobacteriaceae, Pseudomonas aeruginosa and Acinetobacter spp. varies across the European Union. Prescribers are advised to take into account the local prevalence of resistance in these bacteria to penems.

Hypersensitivity reactions

As with all beta-lactam antibiotics, serious and occasionally fatal hypersensitivity reactions have been reported (see sections 4.3 and 4.8).

Patients who have a history of hypersensitivity to carbapenems, penicillins or other beta-lactam antibiotics may also be hypersensitive to meropenem. Before initiating

therapy with meropenem, careful inquiry should be made concerning previous hypersensitivity reactions to beta-lactam antibiotics.

If a severe allergic reaction occurs, the medicinal product should be discontinued, and appropriate measures taken.

Severe cutaneous adverse reactions (SCAR), such as Stevens-Johnson syndrome (SJS), toxic epidermal necrolysis (TEN), drug reaction with eosinophilia and systemic symptoms (DRESS), erythema multiforme (EM) and acute generalized exanthematous pustulosis (AGEP) have been reported in patients receiving meropenem (see section 4.8). If signs and symptoms suggestive of these reactions appear, meropenem should be withdrawn immediately and an alternative treatment should be considered.

Antibiotic-associated colitis

Antibiotic-associated colitis and pseudomembranous colitis have been reported with nearly all anti-bacterial agents, including meropenem, and may range in severity from mild to life threatening. Therefore, it is important to consider this diagnosis in patients who present with diarrhoea during or subsequent to the administration of meropenem (see section 4.8). Discontinuation of therapy with meropenem and the administration of specific treatment for *Clostridium difficile* should be considered. Medicinal products that inhibit peristalsis should not be given.

Seizures

Seizures have infrequently been reported during treatment with carbapenems, including meropenem (see section 4.8).

Drug-induced liver injury (DILI)

Hepatic function should be closely monitored during treatment with meropenem due to the risk of DILI (see section 4.8). If severe DILI occurs, treatment discontinuation should be considered as clinically appropriate. Meropenem should be reintroduced only if assessed as essential for treatment.

Use in patients with liver disease: patients with pre-existing liver disorders should have liver function monitored during treatment with meropenem. There is no dose adjustment necessary (see section 4.2).

Direct antiglobulin test (Coombs test) seroconversion

A positive direct or indirect Coombs test may develop during treatment with meropenem.

Concomitant use with valproic acid/sodium valproate/valpromide

The concomitant use of meropenem and valproic acid/sodium valproate/valpromide is not recommended (see section 4.5). Other antimicrobial agents should be considered as alternatives to carbapenem antibiotics. If administration of carbapenem is necessary, therapeutic drug monitoring of valproate concentration is warranted when a carbapenem-valproic acid combination therapy is applied, especially on initiating or stopping the carbapenem antibiotic.

Warnings/precautions regarding excipients

This medicinal product contains 245 mg sodium per bag, equivalent to 12.3 % of the WHO recommended maximum daily intake of 2 g sodium for an adult.

4.5 Interaction with other medicinal products and other forms of interaction

No specific medicinal product interaction studies other than probenecid were conducted.

Probenecid competes with meropenem for active tubular secretion and thus inhibits the renal excretion of meropenem with the effect of increasing the elimination half-life and plasma concentration of meropenem. Co-administration of meropenem with probenecid is not recommended.

Decreases in blood levels of valproic acid have been reported when it is co-administered with carbapenem agents resulting in a 60 – 100 % decrease in valproic acid levels in about two days. Due to the rapid onset and the extent of the decrease, co-administration of valproic acid/sodium valproate/valpromide with carbapenem agents is not considered to be manageable and therefore should be avoided (see section 4.4).

Oral anti-coagulants

Simultaneous administration of antibiotics with warfarin may augment its anti-coagulant effects. There have been many reports of increases in the anti-coagulant effects of orally administered anti-coagulant agents, including warfarin in patients who are concomitantly receiving antibacterial agents. The risk may vary with the underlying infection, age and general status of the patient so that the contribution of the antibiotic to the increase in INR (international normalised ratio) is difficult to assess. It is recommended that the INR should be monitored frequently during and shortly after co-administration of antibiotics with an oral anti-coagulant agent.

Paediatric population

Interaction studies have only been performed in adults.

4.6 Fertility, pregnancy and lactation

Pregnancy

There are limited data from the use of meropenem in pregnant women.

Animal studies do not indicate direct or indirect harmful effects with respect to reproductive toxicity (see section 5.3).

As a precautionary measure, it is preferable to avoid the use of meropenem during pregnancy.

Breast-feeding

Small amounts of meropenem have been reported to be excreted in human milk. Meropenem should not be used in breast-feeding women unless the potential benefit for the mother justifies the potential risk to the baby.

Fertility

There are no data on the effects of meropenem on fertility in humans. Reproductive studies in animals have shown no effects on fertility.

4.7 Effects on ability to drive and use machines

No studies on the effect on the ability to drive and use machines have been performed. However, when driving or operating machines, it should be taken into account that headache, paraesthesia and convulsions have been reported for meropenem.

4.8 Undesirable effects

Summary of the safety profile

In a review of 4,872 patients with 5,026 meropenem treatment exposures, meropenem-related adverse reactions most frequently reported were diarrhoea (2.3 %), rash (1.4 %), nausea/vomiting (1.4 %) and injection site inflammation (1.1 %). The most commonly reported meropenem-related laboratory adverse events were thrombocytosis (1.6 %) and increased hepatic enzymes (1.5 – 4.3 %).

Tabulated risk of adverse reactions

In the table below all adverse reactions are listed by system organ class and frequency: Very common ($\geq 1/10$); common ($\geq 1/100$ to $< 1/10$); uncommon ($\geq 1/1,000$ to $< 1/100$); rare ($\geq 1/10,000$ to $< 1/1,000$); very rare ($< 1/10,000$); not known (cannot be estimated from the available data). Within each frequency grouping, undesirable effects are presented in order of decreasing seriousness.

System organ class	Frequency	Event
Infections and infestations	Uncommon	oral and vaginal candidiasis
Blood and lymphatic system disorders	Common	thrombocytopenia

	Uncommon	eosinophilia, thrombocytopenia, leucopenia, neutropenia, agranulocytosis, haemolytic anaemia
Immune system disorders	Uncommon	angioedema, anaphylaxis (see sections 4.3 and 4.4)
Metabolism and nutrition disorders	Uncommon	hypokalaemia
Psychiatric disorders	Rare	delirium
Nervous system disorders	Common	headache
	Uncommon	paraesthesiae
	Rare	convulsions (see section 4.4)
Gastrointestinal disorders	Common	diarrhoea, vomiting, nausea, abdominal pain increase
	Uncommon	antibiotic-associated colitis (see section 4.4)
Hepatobiliary disorders	Common	transaminases increased, blood alkaline phosphatase increased, blood lactate dehydrogenase increased.
	Uncommon	blood bilirubin increased, drug-induced liver injury ¹
Skin and subcutaneous tissue disorders	Common	rash, pruritus

	Uncommon	urticaria, toxic epidermal necrolysis, Stevens Johnson syndrome, erythema multiforme (see section 4.4)
	Not known	drug reaction with eosinophilia and systemic symptoms (DRESS), acute generalised exanthematous pustulosis (see section 4.4)
Renal and urinary disorders	Uncommon	blood creatinine increased, blood urea increased
General disorders and administration site conditions	Common	inflammation, pain
	Uncommon	thrombophlebitis, pain at the injection site

¹ DILI includes hepatitis and liver failure.

Paediatric population

Meropenem is licensed for children over 3 months of age. There is no evidence of an increased risk of any adverse drug reaction in children based on the limited available data. All reports received were consistent with events observed in the adult population.

Reporting of suspected adverse reactions

Reporting suspected adverse reactions after authorisation of the medicinal product is important. It allows continued monitoring of the benefit/risk balance of the medicinal product. Healthcare professionals are asked to report any suspected adverse reactions via the Yellow Card Scheme at: www.mhra.gov.uk/yellowcard or search for MHRA Yellow Card in the Google Play or Apple App Store.

4.9 Overdose

Relative overdose may be possible in patients with renal impairment if the dose is not adjusted as described in section 4.2. Limited post-marketing experience indicates that if adverse reactions occur following overdose, they are consistent with the adverse reaction profile described in section 4.8, are generally mild in severity and resolve on withdrawal or dose reduction. Symptomatic treatments should be considered.

In individuals with normal renal function, rapid renal elimination will occur.

Haemodialysis will remove meropenem and its metabolite.

5 PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: antibacterials for systemic use, carbapenems

ATC code: J01DH02

Mechanism of action

Meropenem exerts its bactericidal activity by inhibiting bacterial cell wall synthesis in Gram-positive and Gram-negative bacteria through binding to penicillin-binding proteins (PBPs).

Pharmacokinetic/Pharmacodynamic (PK/PD) relationship

Similar to other beta-lactam antibacterial agents, the time that meropenem concentrations exceed the MIC ($T > MIC$) has been shown to best correlate with efficacy. In preclinical models meropenem demonstrated activity when plasma concentrations exceeded the MIC of the infecting organisms for approximately 40 % of the dosing interval. This target has not been established clinically.

Mechanism of resistance

Bacterial resistance to meropenem may result from: (1) decreased permeability of the outer membrane of Gram-negative bacteria (due to diminished production of porins) (2) reduced affinity of the target PBPs (3) increased expression of efflux pump components, and (4) production of beta-lactamases that can hydrolyse carbapenems.

Localised clusters of infections due to carbapenem-resistant bacteria have been reported in the European Union.

There is no target-based cross-resistance between meropenem and agents of the quinolone, aminoglycoside, macrolide and tetracycline classes. However, bacteria may exhibit resistance to more than one class of antibacterial agents when the mechanism involved include impermeability and/or an efflux pump(s).

Susceptibility testing breakpoints

MIC (minimum inhibitory concentration) interpretive criteria for susceptibility testing have been established by the European Committee on Antimicrobial Susceptibility Testing (EUCAST) for meropenem and are listed here:

https://www.ema.europa.eu/documents/other/minimum-inhibitory-concentration-mic-breakpoints_en.xlsx

The prevalence of acquired 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.

The following table of pathogens listed is derived from clinical experience and therapeutic guidelines.

Commonly susceptible species

Gram-positive aerobes

Enterococcus faecalis^{\$}

Staphylococcus aureus (methicillin-susceptible)[£]

Staphylococcus species (methicillin-susceptible) including *Staphylococcus epidermidis*

Streptococcus agalactiae (Group B)

Streptococcus milleri group (*S. anginosus*, *S. constellatus*, and *S. intermedius*)

Streptococcus pneumoniae

Streptococcus pyogenes (Group A)

Gram-negative aerobes

Citrobacter freundii

Citrobacter koseri

Enterobacter aerogenes

Enterobacter cloacae

Escherichia coli

Haemophilus influenzae

Klebsiella oxytoca

Klebsiella pneumoniae

Morganella morganii

Neisseria meningitidis

Proteus mirabilis

Proteus vulgaris

Serratia marcescens

Gram-positive anaerobes

Clostridium perfringens

Peptoniphilus asaccharolyticus

Peptostreptococcus species (including *P. micros*, *P. anaerobius*, *P. magnus*)

Gram-negative anaerobes

Bacteroides caccae

Bacteroides fragilis group

Prevotella bivia

Prevotella disiens

Species for which acquired resistance may be a problem

Gram-positive aerobes

Enterococcus faecium^{\$†}

Gram-negative aerobes

Acinetobacter species

Burkholderia cepacia

Pseudomonas aeruginosa

Inherently resistant organisms

Gram-negative aerobes

Stenotrophomonas maltophilia

Legionella species

Other micro-organisms

Chlamydophila pneumoniae

Chlamydophila psittaci

Coxiella burnetii

Mycoplasma pneumoniae

^{\$} Species that show natural intermediate susceptibility

[£] All methicillin-resistant staphylococci are resistant to meropenem

[†] Resistance rate $\geq 50\%$ in one or more EU countries.

Glanders and melioidosis: Use of meropenem in humans is based on *in vitro* *B.mallei* and *B. pseudomallei* susceptibility data and on limited human data. Treating physicians should refer to national and/or international consensus documents regarding the treatment of glanders and melioidosis.

5.2 Pharmacokinetic properties

Absorption

In healthy subjects the mean plasma half-life is approximately 1 hour; the mean volume of distribution is approximately 0.25 l/kg (11 – 27 l) and the mean clearance is 287 ml/min at 250 mg falling to 205 ml/min at 2000 mg. Doses of 500, 1000 and 2000 mg doses infused over 30 minutes give mean C_{max} values of approximately 23, 49 and 115 $\mu\text{g/ml}$ respectively, corresponding AUC values were 39.3, 62.3 and 153 $\mu\text{g}\times\text{h/ml}$. After infusion over 5 minutes C_{max} values are 52 and 112 $\mu\text{g/ml}$ after 500 and 1000 mg doses respectively. When multiple doses are administered 8-hourly to subjects with normal renal function, accumulation of meropenem does not occur.

A study of 12 patients administered meropenem 1000 mg 8 hourly post-surgically for intra-abdominal infections showed a comparable C_{max} and half-life to normal subjects but a greater volume of distribution 27 l.

Distribution

The average plasma protein binding of meropenem was approximately 2 % and was independent of concentration. After rapid administration (5 minutes or less) the pharmacokinetics are biexponential but this is much less evident after 30 minutes infusion. Meropenem has been shown to penetrate well into several body fluids and tissues: including lung, bronchial secretions, bile, cerebrospinal fluid, gynaecological tissues, skin, fascia, muscle, and peritoneal exudates.

Biotransformation

Meropenem is metabolised by hydrolysis of the beta-lactam ring generating a microbiologically inactive metabolite. *In vitro* meropenem shows reduced susceptibility to hydrolysis by human dehydropeptidase-I (DHP-I) compared to imipenem and there is no requirement to co-administer a DHP-I inhibitor.

Elimination

Meropenem is primarily excreted unchanged by the kidneys; approximately 70 % (50 – 75 %) of the dose is excreted unchanged within 12 hours. A further 28 % is recovered as the microbiologically inactive metabolite. Faecal elimination represents only approximately 2 % of the dose. The measured renal clearance and the effect of probenecid show that meropenem undergoes both filtration and tubular secretion.

Renal insufficiency

Renal impairment results in higher plasma AUC and longer half-life for meropenem. There were AUC increases of 2.4 fold in patients with moderate impairment (CrCL 33 – 74 ml/min), 5 fold in severe impairment (CrCL 4 – 23 ml/min) and 10 fold in haemodialysis patients (CrCL < 2 ml/min) when compared to healthy subjects (CrCL > 80 ml/min). The AUC of the microbiologically inactive ring opened metabolite was also considerably increased in patients with renal impairment. Dose adjustment is recommended for patients with moderate and severe renal impairment (see section 4.2).

Meropenem is cleared by haemodialysis with clearance during haemodialysis being approximately 4 times higher than in anuric patients.

Hepatic insufficiency

A study in patients with alcoholic cirrhosis shows no effect of liver disease on the pharmacokinetics of meropenem after repeated doses.

Adult patients

Pharmacokinetic studies performed in patients have not shown significant pharmacokinetic differences versus healthy subjects with equivalent renal function. A population model developed from data in 79 patients with intra-abdominal infection

or pneumonia, showed a dependence of the central volume on weight and the clearance on creatinine clearance and age.

Paediatric population

The pharmacokinetics in infants and children with infection at doses of 10, 20 and 40 mg/kg showed C_{max} values approximating to those in adults following 500, 1000 and 2000 mg doses, respectively. Comparison showed consistent pharmacokinetics between the doses and half-lives similar to those observed in adults in all but the youngest subjects (< 6 months $t_{1/2}$ 1.6 hours). The mean meropenem clearance values were 5.8 ml/min/kg (6 – 12 years), 6.2 ml/min/kg (2 – 5 years), 5.3 ml/min/kg (6 – 23 months) and 4.3 ml/min/kg (2 – 5 months). Approximately 60 % of the dose is excreted in urine over 12 hours as meropenem with a further 12 % as metabolite. Meropenem concentrations in the CSF of children with meningitis are approximately 20 % of concurrent plasma levels although there is significant inter-individual variability.

The pharmacokinetics of meropenem in neonates requiring anti-infective treatment showed greater clearance in neonates with higher chronological or gestational age with an overall average half-life of 2.9 hours. Monte Carlo simulation based on a population PK model showed that a dose regimen of 20 mg/kg 8 hourly achieved 60 % T > MIC for *P. aeruginosa* in 95 % of pre-term and 91 % of full term neonates.

Elderly

Pharmacokinetic studies in healthy elderly subjects (65 – 80 years) have shown a reduction in plasma clearance, which correlated with age-associated reduction in creatinine clearance, and a smaller reduction in non-renal clearance. No dose adjustment is required in elderly patients, except in cases of moderate to severe renal impairment (see section 4.2).

5.3 Preclinical safety data

Animal studies indicate that meropenem is well tolerated by the kidney. Histological evidence of renal tubular damage was seen in mice and dogs only at doses of 2000 mg/kg and above after a single administration and above and in monkeys at 500 mg/kg in a 7-day study.

Meropenem is generally well tolerated by the central nervous system. Effects were seen in acute toxicity studies in rodent at doses exceeding 1000 mg/kg.

The IV LD₅₀ of meropenem in rodents is greater than 2000 mg/kg.

In repeat dose studies of up to 6 months duration only minor effects were seen including a decrease in red cell parameters in dogs.

There was no evidence of mutagenic potential in a conventional test battery and no evidence of reproductive toxicity including teratogenic potential in studies in rats up to 750 mg/kg and in monkeys up to 360 mg/kg.

There was no evidence of increased sensitivity to meropenem in juveniles compared to adult animals. The intravenous formulation was well tolerated in animal studies.

The sole metabolite of meropenem had a similar profile of toxicity in animal studies.

6 PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Solvent

Sodium chloride

Water for Injections

Powder

Sodium carbonate

6.2 Incompatibilities

This medicinal product must not be mixed with other medicinal products.

6.3 Shelf life

Shelf life before reconstitution

2 years

Shelf life after reconstitution

The reconstituted drug product is intended for single use only.

Chemical and physical in-use stability has been demonstrated for 3 hours at 25°C or 24 hours at 2 – 8 °C. From a microbiological point of view, unless the method of opening and reconstitution precludes the risk of microbial contamination, the product should be used immediately. If not used immediately, in-use storage times and conditions are the responsibility of the user.

Shelf life after first opening

The opened two-chamber bag should be used immediately.

6.4 Special precautions for storage

Do not store above 30 °C.

Do not freeze the reconstituted solution.

For storage conditions after reconstitution of the medicinal product, see section 6.3.

6.5 Nature and contents of container

Meropenem is provided in colourless multilayer plastic two-chamber bags of PET/Alu/polypropylene-ethylene copolymer and thermoplastic rubber (not made with Latex, PVC or DEHP) with a set-port. One side is opaque, the other side is transparent.

One two-chamber bag contains 570 mg powder and 50 ml sterile sodium chloride solution.

The two-chamber bags are packed in cartons with 24 units.

6.6 Special precautions for disposal

Do not cover any portion of foil strip with patient label.

Do not use in series connection.

Discard unit if foil strip of container is damaged.

Peel foil strip only when ready for use.

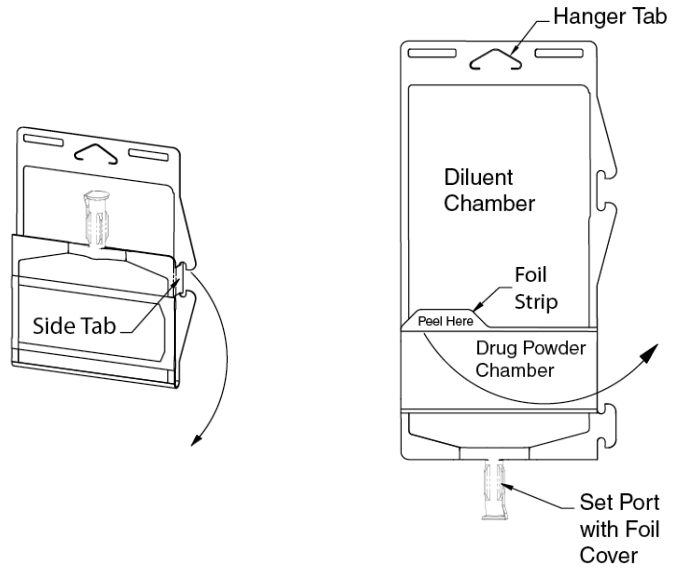
Visually inspect medicinal product prior to reconstitution. The solution should only be used if it is clear, colourless and practically free from particles.

Instructions for reconstitution of the Meropenem two-chamber bag

1. Unlatch side tab and unfold container.
2. Peel foil strip from drug powder chamber.
3. Fold container just below solvent meniscus and squeeze until seal between solvent and powder pops open.
4. Shake the solvent-powder mixture until the drug powder is completely dissolved.
5. Visually inspect the reconstituted solution for particulate matter. Do not use unless the solution is clear, colourless and practically free from particles.
6. Squeeze folded container just below the solution meniscus to pop the second seal and release liquid into the port.
7. Remove foil tab cover from set port and attach sterile administration set.
Hang bag on IV pole.

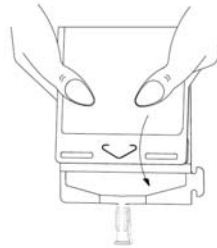
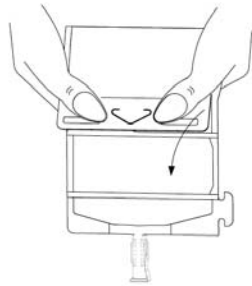
1. Unlatch side tab and
unfold container

2. Peel foil strip from powder
chamber

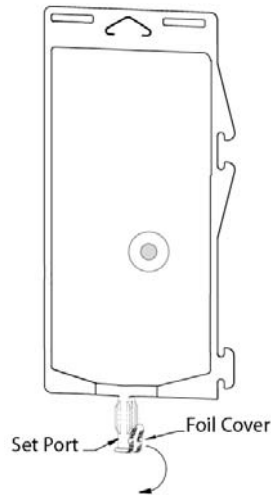


3. Fold container to open first seal

6. Squeeze folded container to open second seal



7. Remove foil tab cover from set port



Any unused medicinal product or waste material should be disposed of in accordance with local requirements.

7 MARKETING AUTHORISATION HOLDER

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8 MARKETING AUTHORISATION NUMBER(S)

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28/06/2024

10 DATE OF REVISION OF THE TEXT

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