WinRho® SDF
Rh_0 (D) Immune Globulin Intravenous (Human)
[win' ro s d f]

DESCRIPTION

Rh_0(D) Immune Globulin Intravenous (Human) (Rh_0(D) IGIV) – WinRho® SDF – is a sterile, freeze-dried gamma globulin (IgG) fraction containing antibodies to the Rh_0(D) antigen (D antigen). WinRho® SDF is prepared from human plasma by an anion-exchange column chromatography method.[1-3] The manufacturing process includes a solvent detergent treatment step (using tri-n-butyl phosphate and Triton® X-100) that is effective in inactivating lipid enveloped viruses such as hepatitis B, hepatitis C, and HIV.[4] WinRho® SDF is filtered using a Planova™ 35 nm Virus Filter which has been validated to be effective in the removal of some nonlipid enveloped viruses.[5-6] These two processes are designed to increase product safety by reducing the risk of transmission of enveloped and nonenveloped viruses, respectively.

The product potency is expressed in international units by comparison to the World Health Organization (WHO) standard. A 300 µg (1,500 International Unit [IU]*) vial contains sufficient anti-Rh_0(D) to effectively suppress the immunizing potential of approximately 17 mL of Rh_0(D) (Dpositive) red blood cells (RBCs). This product contains approximately 5 µg/mL IgA.

The product is stabilized with 0.1 M glycine, 0.04 M sodium chloride, and 0.01% polysorbate 80. It contains no preservative.

Treatment of ITP

For use in the treatment of immune thrombocytopenic purpura (ITP), WinRho® SDF **must be administered intravenously.**

Suppression of Rh Isoimmunization

For use in the suppression of Rh isoimmunization, WinRho® SDF may be administered either intramuscularly or intravenously.

CLINICAL PHARMACOLOGY

Treatment of ITP

WinRho® SDF, Rh_0(D) Immune Globulin Intravenous (Human), has been shown to increase platelet counts in non-splenectomized, Rh_0(D) positive patients with ITP. Platelet counts usually rise within one to two days and peak within seven to 14 days after initiation of therapy. The duration of response is variable; however, the average duration is approximately 30 days. The mechanism of action is not completely understood, but is thought to be due to the formation of anti-Rh_0(D) (anti-D)-coated RBC complexes resulting in Fc receptor blockade, thus sparing antibody-coated platelets.[7-8]

Suppression of Rh Isoimmunization

WinRho® SDF is used to suppress the immune response of non-sensitized Rh_0(D) negative individuals following exposure to Rh_0(D) positive RBCs by fetomaternal hemorrhage during delivery of a Rh_0(D) positive infant, abortion (spontaneous or induced), amniocentesis, abdominal trauma, or mismatched transfusion.[9-11] The mechanism of action is not completely understood.

WinRho® SDF, when administered within 72 hours of a full-term delivery of an Rh_0(D) positive infant by an Rh_0(D) negative mother, will reduce the incidence of Rh isoimmunization from 12 - 13% to 1 - 2%. The 1 - 2% is, for the most part, due to isoimmunization during the last trimester of pregnancy. When treatment is given both antenatally at 28 weeks gestation and postpartum, the Rh immunization rate drops to about 0.1%.[12-15]

When 120 µg (600 IU) of Rh_0(D) IGIV is administered to pregnant women, passive anti-Rh_0(D) antibodies are not detectable in the circulation for more than six weeks and therefore a dose of 300 µg (1,500 IU) should be used for antenatal administration.

In a clinical study with Rh_0(D) negative volunteers (nine males and one female), Rh_0(D) positive red cells were completely cleared from the circulation within eight hours of intravenous administration of Rh_0(D) IGIV. There was no indication of Rh isoimmunization of these subjects at six months after the clearance of the Rh_0(D) positive red cells.

Pharmacokinetics - IM versus IV Administration

In a clinical study involving Rh_0(D) negative volunteers, two subjects received 120 µg (600 IU) Rh_0(D) IGIV by intravenous (IV) administration and two subjects received this dose by intramuscular (IM) administration. Peak levels (36 to 48 ng/mL) were reached within two hours of IV administration and peak levels (18 to 19 ng/mL) were reached at five to 10 days after IM administration. The calculated areas under the curve were the same for both routes of administration. The $t_{1/2}$ for anti-Rh_0(D) was about 24 days following IV administration and about 30 days following IM administration.

INDICATIONS AND CLINICAL USE

Treatment of ITP

WinRho® SDF , Rh_0(D) Immune Globulin Intravenous (Human), is recommended for the treatment of non-splenectomized, Rh_0(D) positive

- children with chronic or acute ITP,
- adults with chronic ITP, or
- children and adults with ITP secondary to HIV infection

in clinical situations requiring an increase in platelet count to prevent excessive hemorrhage.

The safety and efficacy of WinRho® have not been evaluated in clinical trials for patients with non-ITP causes of thrombocytopenia or in previously splenectomized patients.

Suppression of Rh Isoimmunization

Pregnancy and Other Obstetric Conditions

WinRho® SDF is recommended for the suppression of Rh isoimmunization in non-sensitized, Rh_0(D) negative (D-negative) women within 72 hours after spontaneous or induced abortions, amniocentesis, chorionic villus sampling, ruptured tubal pregnancy, abdominal trauma or transplacental hemorrhage or in the normal course of pregnancy unless the blood type of the fetus or father is known to be Rh_0(D) negative. In the case of maternal bleeding due to threatened abortion, WinRho® SDF should be administered as soon as possible. Suppression of Rh isoimmunization reduces the likelihood of hemolytic disease in an Rh_0(D) positive fetus in present and future pregnancies.

The criteria for an Rh-incompatible pregnancy requiring administration of WinRho® SDF at 28 weeks gestation and within 72 hours after delivery are:

- the mother must be Rh_0(D) negative,
- the mother is carrying a child whose father is either Rh_0(D) positive or Rh_0(D) unknown,
- the baby is either Rh_0(D) positive or Rh_0(D) unknown, and
- the mother must not be previously sensitized to the Rh_0(D) factor.

Transfusion

WinRho® SDF, Rh_0(D) Immune Globulin Intravenous (Human), is recommended for the suppression of Rh isoimmunization in Rh_0(D) negative female children and female adults in their childbearing years transfused with Rh_0(D) positive RBCs or blood components containing Rh_0(D) positive RBCs. Treatment should be initiated within 72 hours of exposure. Treatment should be given (without preceding exchange transfusion) only if the transfused Rh_0(D) positive blood represents less than 20% of the total circulating red cells. A 300 µg (1,500 IU) dose will suppress the immunizing potential of approximately 17 mL of Rh_0(D) positive RBCs.

CLINICAL TRIALS

Treatment of ITP

Efficacy was documented in four subgroups of patients with ITP:

Childhood Chronic ITP

In an open-label, single arm, multicenter study, 24 non-splenectomized, Rh_0(D) positive children with ITP of greater than six months duration were treated initially with 50 µg/kg (250 IU/kg) Rh_0(D) Immune Globulin Intravenous (Human) (25 µg/kg (125 IU/kg) on days 1 and 2, with subsequent doses ranging from 25 to 55 µg/kg (125 to 275 IU/kg)). Response was defined as a platelet increase to at least 50,000/mm^3 and a doubling of the baseline. Nineteen of 24 patients responded for an overall response rate of 79%, an overall mean peak platelet count of 229,400/mm^3 (range 43,300 to 456,000), and a mean duration of response of 36.5 days (range 6 to 84).[16-17]

Childhood Acute ITP

A multicenter, randomized, controlled trial comparing Rh_0(D) IGIV to high dose and low dose Immune Globulin Intravenous (Human) and prednisone was conducted in 146 non-splenectomized, Rh_0(D) positive children with acute ITP and platelet counts less than 20,000/mm^3. Of 38 patients receiving Rh_0(D) IGIV (25 µg/kg (125 IU/kg) on days 1 and 2), 32 patients (84%) responded (platelet count ≥ 50,000/mm^3) with a mean peak platelet count of 319,500/mm^3 (range 61,000 to 892,000), with no statistically significant differences compared to other treatment arms. The mean times to achieving ≥ 20,000/mm^3 or ≥ 50,000/mm^3 platelets for patients receiving Rh_0(D) IGIV were 1.9 and 2.8 days, respectively. When comparing the different therapies for time to platelet count ≥ 20,000/mm^3 or ≥ 50,000/mm^3, no statistically significant differences among treatment groups were detected, with a range of 1.3 to 1.9 days and 2.0 to 3.2 days, respectively.[18-19]

Adult Chronic ITP

Twenty-four non-splenectomized, Rh_0(D) positive adults with ITP of greater than six months duration and platelet counts < 30,000/mm^3 or requiring therapy were enrolled in a single-arm, open-label trial and treated with 20 to 75 µg/kg (100 to 375 IU/kg) Rh_0(D) IGIV (mean dose 46.2 µg/kg (231 IU/kg)). Twenty-one of 24 patients responded (increase ≥ 20,000/mm^3) during the first two courses of therapy for an overall response rate of 88% with a mean peak platelet count of 92,300/mm^3 (range 8,000 to 229,000).[20-21]

ITP Secondary to HIV Infection

Eleven children and 52 adults, who were nonsplenectomized and Rh_0(D) positive, with all Walter Reed classes of HIV infection and ITP, with initial platelet counts of ≤ 30,000/mm^3 or requiring therapy, were treated with 20 to 75 µg/kg (100 to 375 IU/kg) Rh_0(D) IGIV in an open label trial. Rh_0(D) IGIV was administered for an average of 7.3 courses (range 1 to 57) over a mean period of 407 days (range 6 to 1,952). Fifty-seven of 63 patients responded (increase ≥ 20,000/mm^3) during the first six courses of therapy for an overall response rate of 90%. The overall mean change in platelet count for six courses was 60,900/mm^3 (range -2,000 to 565,000), and the mean peak platelet count was 81,700/mm^3 (range 16,000 to 593,000).[21-23]

Suppression of Rh Isoimmunization

The pivotal study[24] supporting this indication was conducted in 1,186 non-sensitized, Rh_0(D) negative pregnant women in cases in which the blood types of the fathers were either Rh_0(D) positive or unknown. Rh_0(D) IGIV was administered according to one of three regimens: 1) 93 women received 120 µg (600 IU) at 28 weeks; 2) 131 women received 240 µg (1200 IU) each at 28 and 34 weeks; 3) 962 women received 240 µg (1200 IU) at 28 weeks. All women received a postnatal administration of 120 µg (600 IU) if the newborn was found to be Rh_0(D) positive. Of 1,186 women who received antenatal Rh_0(D) IGIV, 806 were given Rh_0(D) IGIV postnatally following the delivery of an Rh_0(D) positive infant, of which 325 women underwent testing at six months after delivery for evidence of Rh isoimmunization. Of these 325 women, 23 would have been expected to display signs of Rh isoimmunization; however, none was observed ($p < 0.001$ in a Chi-square test of significance of difference between observed and expected isoimmunization in the absence of Rh_0(D) IGIV).

CONTRAINDICATIONS

Treatment of ITP and Suppression of Rh Isoimmunization

Individuals known to have had an anaphylactic or severe systemic reaction to human globulin should not receive WinRho® SDF, Rh_0(D) Immune Globulin Intravenous (Human), or any other Immune Globulin (Human). WinRho® SDF contains trace amounts of IgA (approximately 5 µg/mL). Individuals who are deficient in IgA may have the potential for developing IgA antibodies and have anaphylactic reactions. The physician must weigh the potential benefit of treatment with WinRho® SDF against the potential for hypersensitivity reactions.

WARNINGS

WinRho® SDF, Rh_0(D) Immune Globulin Intravenous (Human), is made from human plasma. Products made from human plasma may carry a risk of transmitting infectious agents, e.g., viruses and theoretically, the Creutzfeldt-Jakob disease (CJD) agent. The risk that such products will transmit an infectious agent has been reduced by screening plasma donors for prior exposure to certain viruses, by testing for the presence of certain current virus infections, and by inactivating and/or removing certain viruses. The WinRho® SDF manufacturing process includes a solvent detergent treatment step (using tri-n-butyl phosphate and Triton® X-100) that is effective in inactivating lipid enveloped viruses such as hepatitis B, hepatitis C, and HIV. WinRho® SDF is filtered using a Planova™ 35 nm Virus Filter that is effective in reducing the level of some non-lipid enveloped viruses such as hepatitis A. These two processes are designed to increase product safety by reducing the risk of transmission of lipid enveloped and non-lipid enveloped viruses, respectively. Despite these measures, such products can still potentially transmit disease. There is also the possibility that unknown infectious agents may be present in such products. ALL infections thought by a physician possibly to have been transmitted by this product should be reported by the physician or other healthcare provider to the distributor, Baxter Healthcare Corporation (1-800-423-2090). The physician should discuss the risks and benefits of this product with the patient.

Treatment of ITP

WinRho® SDF **must be administered via the intravenous route** for the treatment of ITP as its efficacy has not been established by the intramuscular or subcutaneous routes.

WinRho® SDF should not be administered to Rh_0(D) negative or splenectomized individuals as its efficacy in these patients has not been demonstrated.

Suppression of Rh Isoimmunization

For the suppression of Rh isoimmunization in the mother, do not administer to the infant.

PRECAUTIONS

WinRho® SDF, Rh_0(D) Immune Globulin Intravenous (Human), should not be administered as immunoglobulin replacement therapy for immune globulin deficiency syndromes.

Treatment of ITP

Following administration of WinRho® SDF, Rh_0(D) positive ITP patients should be monitored for signs and/or symptoms of intravascular hemolysis (IVH), clinically compromising anemia, and renal insufficiency.

If patients are to be transfused, Rh_0(D) negative red blood cells (PRBCs) should be used so as not to exacerbate ongoing IVH. Platelet products may contain up to 5.0 mL of RBCs, thus caution should likewise be exercised if platelets from Rh_0(D) positive donors are transfused.

If the patient has a lower than normal hemoglobin level (less than 10 g/dL), a reduced dose of 25 to 40 µg/kg (125 to 200 IU/kg) should be given to minimize the risk of increasing the severity of anemia in the patient. WinRho® SDF must be used with extreme caution in patients with a hemoglobin level that is less than 8 g/dL due to the risk of increasing the severity of the anemia (See DOSAGE AND ADMINISTRATION, Treatment of ITP).

Suppression of Rh Isoimmunization

WinRho® SDF should not be administered to Rh_0(D) negative individuals who are Rh immunized as evidenced by an indirect antiglobulin (Coombs') test revealing the presence of anti-Rh_0(D) (anti-D) antibody.

A large fetomaternal hemorrhage late in pregnancy or following delivery may cause a weak mixed field positive D^u test result. Such an individual should be assessed for a large fetomaternal hemorrhage and the dose of WinRho® SDF adjusted accordingly. WinRho® SDF should be administered if there is any doubt about the mother's blood type.

Laboratory Tests

In addition to anti-D, WinRho® SDF contains trace amounts of anti-A, anti-B, anti-C and anti-E antibodies.

Treatment of ITP

Passively acquired anti-A, anti-B, anti-C, and anti-E blood group antibodies may be detectable in direct and indirect antiglobulin (Coombs') tests obtained following WinRho® SDF, Rh_0(D) Immune Globulin Intravenous (Human), administration. Interpretation of direct and indirect antiglobulin tests must be made in the context of the patient's underlying clinical condition and supporting laboratory data.

Suppression of Rh Isoimmunization

The presence of passively administered anti-Rh_0(D) in maternal or fetal blood can lead to a positive direct antiglobulin (Coombs') test. If there is an uncertainty about the mother's Rh group or immune status, WinRho® SDF should be administered to the mother.

Drug Interactions

Treatment of ITP and Suppression of Rh Isoimmunization

Administration of WinRho® SDF concomitantly with other drugs has not been evaluated. Other antibodies contained in WinRho® SDF may interfere with the response to live virus vaccines such as measles, mumps, polio or rubella. Therefore, immunization with live vaccines should not be given within 3 months after WinRho® SDF administration.

Refer to Dosage and Administration section for information on drug compatibility.

Pregnancy Category C

Treatment of ITP and Suppression of Rh Isoimmunization

Animal reproduction studies have not been conducted with WinRho® SDF. It is not known whether WinRho® SDF can cause fetal harm when administered to a pregnant woman or can affect reproductive capacity. WinRho® SDF should be given to a pregnant woman only if clearly needed.

ADVERSE REACTIONS

Treatment of ITP

In clinical trials of subjects (n=161) with childhood acute ITP, adults and children with chronic ITP, and adults and children with ITP secondary to HIV, 60/848 (7%) of infusions were associated with at least one adverse event that was considered to be related to the study medication. The most common adverse events were headache (19 infusions; 2%), chills (14 infusions; <2%), and fever (nine infusions; 1%). All are expected adverse events associated with infusions of immunoglobulins.

WinRho® SDF, Rh_0(D) Immune Globulin Intravenous (Human), is administered to Rh_0(D) positive patients with ITP. Therefore, side effects related to the destruction of Rh_0(D) positive red blood cells, most notably a decreased hemoglobin, can be expected. In four clinical trials of patients treated with the recommended initial intravenous dose of 50 µg/kg (250 IU/kg), the mean maximum decrease in hemoglobin was 1.70 g/dL (range: +0.40 to -6.1 g/dL). At a reduced dose, ranging from 25 to 40 µg/kg (125 to 200 IU/kg), the mean maximum decrease in hemoglobin was 0.81 g/dL (range: +0.65 to -1.9 g/dL). Only 5/137 (3.7%) of patients had a maximum decrease in hemoglobin of greater than 4 g/dL (range 4.2 to 6.1 g/dL).

In most cases, the RBC destruction is believed to occur in the spleen. However, signs and symptoms consistent with IVH, including back pain, shaking chills, and/or hemoglobinuria, have been reported, occurring within 4 hours of WinRho® administration. IVH-related complications that have been reported include death (four cases reported between May 1996 and April 1999), acute onset or exacerbation of anemia, and acute onset or exacerbation of renal insufficiency. One patient died from complications secondary to IVH-induced exacerbation of anemia after administration of WinRho for treatment of ITP. Although the primary cause of death in the other three ITP patients treated with WinRho was related to underlying disease, the extent to which IVH-related clinical complications exacerbated their conditions and contributed to their deaths is unknown.

The mean maximum decrease in hemoglobin in patients who were not transfused with PRBCs was 3.7 g/dL (range: 0.0-7.6 g/dL). Transfusions for treatment-associated anemia were administered within hours to days of the onset of IVH and consisted of between 1-6 units of PRBCs. Acute renal insufficiency was noted within 2 to 48 hours of the onset of IVH. The mean maximum increase in serum creatinine was 3.5 mg/dL (range: 0.8-10.3 mg/dL) and occurred within 2-9 days. The renal insufficiency in all surviving patients resolved with medical management, including dialysis, within 4-23 days.

The etiology of IVH following WinRho® administration is unknown. No known risk factors associated with this adverse event have yet been identified from among those examined, which included age, gender, pre-treatment renal function, pretreatment hemoglobin, concomitantly administered PRBCs, or WinRho® dose.

Baxter

Suppression of Rh Isoimmunization

Adverse reactions to Rh_0(D) Immune Globulin Intravenous (Human) are infrequent in Rh_0(D) negative individuals. In the clinical trial[24] of 1,186 Rh_0(D) negative pregnant women, no adverse events were attributed to Rh_0(D) IGIV. Discomfort and slight swelling at the site of injection and slight elevation in temperature have been reported in a small number of cases. A post-marketing survey conducted since the Canadian licensure of Rh_0(D) IGIV in 1980 for this indication included data obtained from 31,059 injections (25,068 for routine Rh prophylaxis and 5,991 following abortions, amniocentesis, chorionic villus sampling and antepartum hemorrhage). There were 9,905 Rh_0(D) negative women who delivered Rh_0(D) positive infants, almost all of whom had received antenatal as well as postnatal prophylaxis. Of the patients followed in this survey, there were 26 reported treatment failures that resulted in the development of Rh_0(D) antibodies. There were no adverse experiences related to Rh_0(D) IGIV reported in this survey.

General Adverse Reactions

In addition to the adverse reactions described above, the following have been reported infrequently in clinical trials and/or postmarketing experience, in patients treated for ITP or the suppression of Rh isoimmunization, and are thought to be temporally associated with WinRho® SDF, Rh_0(D) Immune Globulin Intravenous (Human), use: asthenia, abdominal or back pain, hypotension, pallor, diarrhea, increased LDH, arthralgia, myalgia, dizziness, hyperkinesia, somnolence, vasodilation, pruritus, rash, and sweating.

As is the case with all drugs of this nature, there is a remote chance of an idiosyncratic or anaphylactic reaction with WinRho® SDF in individuals with hypersensitivity to blood products.

SYMPTOMS AND TREATMENT OF OVERDOSAGE

Treatment of ITP and Suppression of Rh Isoimmunization

There are no reports of known overdoses in patients being treated for Rh isoimmunization or ITP. In clinical studies with nonpregnant Rh_0(D) positive patients with ITP (n=141) treated with 120 to 6,500 µg (600 to 32,500 IU) of Rh_0(D) IGIV, there were no signs or symptoms that warranted medical intervention. However, these same doses were associated with a mild, transient hemolytic anemia.

DOSAGE AND ADMINISTRATION

Treatment of ITP and Suppression of Rh Isoimmunization

WinRho® SDF, Rh_0(D) Immune Globulin Intravenous (Human), should be reconstituted only with the accompanying vial of Sterile Diluent (0.8% sodium chloride, 10mM sodium phosphate). It should not be administered concurrently with other products.

Reconstitution

Intravenous Administration

Aseptically reconstitute the product shortly before use with 2.5 mL of Sterile Diluent for 120 µg (600 IU) and 300 µg (1,500 IU) and 8.5 mL of Sterile Diluent for 1,000 µg (5,000 IU) (see the next table). Discard unused portion of diluent. Inject the diluent slowly onto the inside wall of the vial and gently swirl until dissolved. **Do not shake.**

Intramuscular Administration

Aseptically reconstitute the product shortly before use with 1.25 mL of Sterile Diluent for 120 µg (600 IU) and 300 µg (1,500 IU) and 8.5 mL of Sterile Diluent for 1,000 µg (5,000 IU) (see the next table). Inject the diluent slowly onto the inside wall of the vial and gently swirl until dissolved. **Do not shake.**

Reconstitution of WinRho® SDF

Vial Size	Volume of Diluent to be Added to Vial
Intravenous Injection	—
120 µg (600 IU)	2.5 mL
300 µg (1,500 IU)	2.5 mL
1,000 µg (5,000 IU)	8.5 mL
Intramuscular Injection	—
120 µg (600 IU)	1.25 mL
300 µg (1,500 IU)	1.25 mL
1,000 µg (5,000 IU)	8.5 mL*

** To be administered into several sites*

Injection

Parenteral products such as WinRho® SDF should be inspected for particulate matter and discoloration prior to administration. Use the product within 12 hours of reconstitution. Discard any unused portion.

Intravenous Administration

Infuse the entire dose into a suitable vein over three to five minutes. WinRho® SDF should be administered separately from other drugs.

Intramuscular Administration

Administer into the deltoid muscle of the upper arm or the anterolateral aspects of the upper thigh. Due to the risk of sciatic nerve injury, the gluteal region should not be used as a routine injection site. If the gluteal region is used, use only the upper, outer quadrant.

Treatment of ITP

WinRho® SDF, Rh_0(D) Immune Globulin Intravenous (Human), **must be given by intravenous administration** for the treatment of ITP.

Initial Dosing: After confirming that the patient is Rh_0(D) positive, an initial dose of 50 µg/kg (250 IU/kg) body weight, given as a single injection, is recommended for the treatment of ITP. The initial dose may be administered in two divided doses given on separate days, if desired. If the patient has a hemoglobin level that is less than 10 g/dL, a reduced dose of 25 to 40 µg/kg (125 to 200 IU/kg) should be given to minimize the risk of increasing the severity of anemia in the patient. All patients should be monitored to determine clinical response by assessing platelet counts, red cell counts, hemoglobin, and reticulocyte levels (See PRECAUTIONS, *Treatment of ITP*).

Subsequent Dosing: If subsequent therapy is required to elevate platelet counts, an intravenous dose of 25 to 60 µg/kg (125 to 300 IU/kg) body weight of WinRho® SDF is recommended. The frequency and dose used in maintenance therapy should be determined by the patient's clinical response by assessing platelet counts, red cell counts, hemoglobin, and reticulocyte levels.

If patient responded to initial dose with a satisfactory increase in platelets:

Maintenance Therapy:

Dosing (25-60 µg/kg (125-300 IU/kg)) individualized based on platelet and Hgb levels.

If patient did not respond to initial dose, administer a subsequent dose based on Hgb:

If Hgb between 8-10 g/dL, redose between 25-40 µg/kg (125-200 IU/kg).

If Hgb >10 g/dL, redose between 50-60 µg/kg (250-300 IU/kg).

If Hgb <8 g/dL, use with caution.

The following equations are provided to determine the dosage and number of vials needed for the treatment of ITP:

- weight in lbs. / 2.2083 = weight in kg
- weight in kg X selected µg (IU) dosing level = dosage
- dosage / vial size = number of vials needed

Suppression of Rh Isoimmunization

WinRho® SDF may be given by intravenous or intramuscular administration for the suppression of Rh isoimmunization.

Pregnancy

The same dosage, as described below, is to be administered by either the intramuscular or intravenous routes.

A 300 µg (1,500 IU) dose of WinRho® SDF should be administered at 28 weeks gestation. If WinRho® SDF is administered early in the pregnancy, it is recommended that WinRho® SDF be administered at 12-week intervals in order to maintain an adequate level of passively acquired anti-Rh.

A 120 µg (600 IU) dose should be administered as soon as possible after delivery of a confirmed Rh_0(D) positive baby and normally no later than 72 hours after delivery. In the event that the Rh status of the baby is not known at 72 hours, WinRho® SDF should be administered to the mother at 72 hours after delivery. If more than 72 hours have elapsed, WinRho® SDF should not be withheld, but administered as soon as possible up to 28 days after delivery.

Other Obstetric Conditions

The same dosage, as described below, is to be administered by either the intramuscular or intravenous routes.

A 120 µg (600 IU) dose of WinRho® SDF should be administered immediately after abortion, amniocentesis (after 34 weeks gestation) or any other manipulation late in pregnancy (after 34 weeks gestation) associated with increased risk of Rh isoimmunization. Administration should take place within 72 hours after the event.

A 300 µg (1,500 IU) dose of WinRho® SDF should be administered immediately after amniocentesis before 34 weeks gestation or after chorionic villus sampling. This dose should be repeated every 12 weeks while the woman is pregnant. In the case of threatened abortion, WinRho® SDF should be administered as soon as possible.

Obstetric Indications and Recommended Dose

Indication	Dose (Administer IM or IV)
Pregnancy:	
• 28 weeks gestation	300 µg (1,500 IU)
• Postpartum (if newborn Rh positive)	120 µg (600 IU)
Obstetric Conditions:	
• Threatened abortion at any time	300 µg (1,500 IU)
• Amniocentesis and chorionic villus sampling before 34 weeks gestation	300 µg (1,500 IU)
• Abortion, amniocentesis, or any other manipulation after 34 weeks gestation	120 µg (600 IU)

Transfusion

WinRho® SDF should be administered within 72 hours after exposure for treatment of incompatible blood transfusions or massive fetal hemorrhage.

Transfusion Indication and Recommended Dose

Route of Administration	WinRho® SDF Dose	
	If exposed to Rh_0(D) Positive Whole Blood:	If exposed to Rh_0(D) Positive Red Blood Cells:
Intravenous	9 µg (45 IU)/ mL blood	18 µg (90 IU)/mL cells
Intramuscular	12 µg (60 IU)/ mL blood	24 µg (120 IU)/mL cells

Administer 600 µg (3,000 IU) **every 8 hours via the intravenous route,** until the total dose, calculated from the above table, is administered.

Administer 1,200 µg (6,000 IU) **every 12 hours via the intramuscular route,** until the total dose, calculated from the above table, is administered.

HOW SUPPLIED

WinRho® SDF, Rh_0(D) Immune Globulin Intravenous (Human), is available in packages containing:

NDC Number	Contents
0944-2950-02	A box containing a single dose vial of 120 µg (600 IU) anti-Rh_0(D) IGIV, a single dose vial of Sterile Diluent, and a package insert
0944-2950-04	A box containing a single dose vial of 300 µg (1,500 IU) anti-Rh_0(D) IGIV, a single dose vial of Sterile Diluent, and a package insert
0944-2950-06	A box containing a single dose vial of 1,000 µg (5,000 IU) anti-Rh_0(D) IGIV, a single dose vial of Sterile Diluent, and a package insert

STORAGE

Store at 2 to 8 °C (35 to 46 °F). Do not freeze. Do not use after expiration date.

If the reconstituted product is not used immediately, store it at room temperature for no longer than 12 hours. Do not freeze the reconstituted product. Discard the product if not administered within 12 hours.

Rx Only

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