

# Medication Safety Alert!



## ◀IMPORTANT ERROR PREVENTION ADVISORY▶

### ***Tamiflu oral suspension shortage contributing to dosing errors***

The Institute for Safe Medication Practices (ISMP) is alerting all healthcare professionals about a risk of dosing errors related to the concentration of pharmacy-compounded **TAMIFLU** (oseltamivir phosphate) oral suspension being dispensed in response to shortages of the manufacturer's oral suspension.



would be dispensed. This resulted in providing too large of a dose being dispensed to children. It is also possible for a lower than intended amount to be administered if prescribers base the dose on the 15 mg/mL concentration but the 12 mg/mL commercial product is available.

The commercially manufactured Tamiflu product (Roche) is provided in a 12 mg/mL suspension (oseltamivir base), which is available for pediatric and adult patients who have difficulty swallowing capsules. In light of the influenza epidemic, pharmacies in some areas nationally have been unable to purchase the commercial oral suspension from the manufacturer or drug wholesalers. As a result, pharmacists have begun to compound the product on an emergency basis, according to FDA-approved directions listed in the Tamiflu labeling. The suspension is made from powder in Tamiflu capsules, which remain available. The compounding directions found in the labeling, however, result in a 15 mg/mL oseltamivir base concentration, not the 12 mg/mL base concentration which is available commercially ([www.tamiflu.com/hcp/dosing/extprep.aspx](http://www.tamiflu.com/hcp/dosing/extprep.aspx)).

ISMP has communicated with Roche and the US Food and Drug Administration (FDA) about the above-mentioned confusion. At this time, we are advising prescribers to communicate suspension doses in mg rather than by volume. In hospitals with computerized prescribing, only the available concentration should be listed on computer selections screens. Otherwise, direct communication is necessary between the prescriber and pharmacist to assure the intended dose reaches the patient.

Unless prescribers specify the patient's dose in mg, a dosing error is possible. ISMP is aware of incidents in which prescribers expecting the 12 mg/mL product were unaware of the shortage and did not know a 15 mg/mL concentration

If pharmacists are experiencing a shortage of commercial Tamiflu oral suspension, we also suggest communicating directly with medical practices in the area to advise them of the shortage and steps being taken to reduce the possibility of dosing errors when dispensing the pharmacy-compounded solution. As an alternative, Roche provides instructions for an extemporaneous preparation of capsule contents (30, 45 and 75 mg) mixed with sweetened liquids, such as regular or sugar-free chocolate syrup, for single doses.