

## WHO-PQ RECOMMENDED SUMMARY OF PRODUCT CHARACTERISTICS

*This summary of product characteristics focuses on uses of the medicine covered by WHO's Prequalification Team - Medicines. The recommendations for use are based on WHO guidelines and on information from stringent regulatory authorities.\**

*The medicine may be authorised for additional or different uses by national medicines regulatory authorities.*

---

\*[https://extranet.who.int/prequal/sites/default/files/document\\_files/75%20SRA%20clarification\\_Feb2017\\_newtempl.pdf](https://extranet.who.int/prequal/sites/default/files/document_files/75%20SRA%20clarification_Feb2017_newtempl.pdf)

## 1. NAME OF THE MEDICINAL PRODUCT

[MA195 trade name]†

## 2. QUALITATIVE AND QUANTITATIVE COMPOSITION

Each vial contains artesunate powder 180 mg

Each ampoule of solvent for reconstitution contains arginine 20 mg/mL and sodium bicarbonate 8.4 mg/mL

## 3. PHARMACEUTICAL FORM

Artesunate powder for injection: white crystalline powder

Solvent for reconstitution (arginine and sodium bicarbonate): clear colourless liquid

## 4. CLINICAL PARTICULARS

### 4.1 Therapeutic indications

[MA195 trade name] is indicated for the treatment of severe malaria.

Treatment regimens should take into account the most recent official treatment guidelines (e.g. those of the WHO) and local information on the prevalence of resistance to antimalarial drugs.

### 4.2 Posology and method of administration

#### *Posology*

After reconstitution, [MA195 trade name] is given by slow intravenous or intramuscular injection for a minimum of 3 doses given over 24 hours. Doses of artesunate depend on body weight and higher proportional doses are recommended in children weighing less than 20 kg, in whom exposure is lower than in adults and older children:

<i>Adults and children weighing 20 kg or more:</i>	2.4 mg/kg
<i>Children weighing less than 20 kg:</i>	3 mg/kg

A dose should be given at admission (0 hours), then at 12 and 24 hours after admission. Further doses may then be given once daily as necessary, until the patient can tolerate oral therapy.

Treatment should then be completed with an oral artemisinin-based combination regimen given for 3 days. The first oral dose should be taken 8 to 12 hours after the last injection of artesunate.

*Where complete treatment of severe malaria is not possible, but [MA195 trade name] injections are available, adults and children may be given a single intramuscular dose of artesunate before referral to an appropriate facility for further care.*

#### **Hepatic and renal impairment**

Dose adjustment is not necessary in patients with hepatic or renal impairment (see Sections 4.4 and 5.2).

#### *Method of administration*

For instructions on reconstitution of [MA195 trade name] before administration, see section 6.6. The injection solution should be freshly prepared before each dose is given and should not be stored.

[MA195 trade name] injection is given by intravenous bolus injection over 1 to 2 minutes or by slow intramuscular injection into the anterior thigh. If the total volume of solution to be injected intramuscularly is

† Trade names are not prequalified by WHO. This is the national medicines regulatory agency's responsibility.

large (more than 2 mL for small children or 5 mL for adults), it may be preferable to divide the volume and inject it at multiple sites, e.g. both thighs.

### 4.3 Contraindications

[MA195 trade name] is contraindicated in patients with hypersensitivity to artesunate or other artemisinins or to any of the components of the formulation listed in section 6.1.

### 4.4 Special warnings and precautions for use

#### *Non-falciparum malaria*

Artesunate has not been evaluated in the treatment of severe malaria due to *Plasmodium vivax*, *Plasmodium malariae* or *Plasmodium ovale* (see also section 5.1)

#### *Post-treatment haemolytic anaemia*

Delayed haemolytic anaemia following treatment with injectable artesunate has been observed in children in malaria endemic areas and in non-immune travelers presenting with severe falciparum malaria. Onset has typically occurred at least 7 days and sometimes several weeks after starting artesunate treatment. The risk was most pronounced in patients with hyperparasitaemia and in younger children. Some cases have been severe and required blood transfusion.

Vigilance for delayed onset anaemia is therefore advised, particularly in hyperparasitaemic patients and younger children, and prolonged follow-up should be considered (e.g. 14-28 days). The overall benefit-risk ratio remains highly favourable for injectable artesunate in the treatment of severe malaria, and such treatment continues to be recommended.

#### *Reticulocytopenia*

The artemisinins have shown direct inhibitory effects on human erythroid precursors in vitro and inhibit bone marrow responses (especially red blood cell precursors) in animal models. Both animal preclinical data and human data from clinical trials have suggested that reversible reticulocytopenia occurs at least commonly in association with treatment with intravenous artesunate (see section 4.8).

The reticulocyte count recovers after cessation of treatment.

#### *Hepatic / renal impairment:*

Data regarding artesunate pharmacokinetics in patients with hepatic and/or renal impairment are limited. Based on data from studies in patients with severe malaria, as well as the known metabolism of artesunate (see Section 5.2), dosage adjustment is not considered necessary in patients with hepatic or renal impairment.

#### *Paediatric population*

In clinical trials, the efficacy and safety of intravenous and intramuscular artesunate have been similar in adult and paediatric populations.

### 4.5 Interaction with other medicinal products and other forms of interaction

After intravenous administration, artesunate is rapidly and extensively converted to DHA, largely by plasma and erythrocyte esterases.

DHA is converted to inactive glucuronide conjugates primarily by UGT1A9. DHA elimination is also rapid (half-life approximately 45 minutes) so the potential for drug-drug interactions appears limited. However, co-administration of intravenous artesunate with strong inhibitors of UGT enzymes (e.g. axitinib, vandetanib, imatinib, diclofenac) may increase plasma exposures to DHA.

In vitro drug-interaction studies have demonstrated minimal effects of artesunate on cytochrome P450 isoenzymes. Few clinical drug-drug interaction studies have been performed but limited data from in vitro studies and from clinical drug-drug interaction studies with *oral* artesunate and/or *oral* DHA have indicated that DHA induces CYP3A and inhibits CYP1A2.

An increase in plasma concentrations of artesunate was observed with nevirapine and a reduced plasma concentration of dihydroartemisinin was observed when artesunate was given with ritonavir.

#### 4.6 Fertility, pregnancy and breastfeeding

##### *Pregnancy*

Severe malaria is especially hazardous during pregnancy, therefore full dose parenteral artesunate treatment should be administered at any stage of pregnancy without delay.

In animal studies, artesunate has been associated with fetal toxicity during the first trimester of pregnancy. Limited clinical experience with the use of artesunate in the first trimester of pregnancy as well as clinical data from more than 4,000 pregnant women, treated with artemisinin derivatives in the second and third trimester, do not indicate adverse effects of artesunate on pregnancy or on the health of the fetus/newborn child.

##### *Breast-feeding*

Limited information indicates that dihydroartemisinin, the active metabolite of artesunate, is present at low levels in breast milk. Patients with severe malaria may be too ill to breast-feed, but in any case the levels of metabolite present in breast milk are not expected to cause any adverse effects in breast-fed infants. The amount of drug present in breast milk does not protect the infant from malaria.

##### *Fertility*

No specific studies with artesunate in humans have been conducted to evaluate effects on fertility. In a reproduction toxicity study in rats, testicular and epididymal lesions were seen, but there were no effects on fertility (see section 5.3). The relevance of this finding for humans is unknown.

#### 4.7 Effects on ability to drive and use machines

There is no information on the effect of artesunate on the ability to drive or use machines. The patient's clinical status should be considered when assessing ability to drive or operate machinery.

#### 4.8 Undesirable effects

The most important reported side effect of artesunate is a rare severe allergic reaction (estimated risk approximately 1 in 3000 patients), which has involved urticarial rash as well as other symptoms, including hypotension, pruritus, oedema, and/or dyspnoea.

More common minor side effects associated with IV administration have included dizziness, light-headedness, rash, and taste alteration (metallic/ bitter taste). Nausea, vomiting, anorexia and diarrhea have also been reported, however it is uncertain whether such events have been symptoms of severe malaria.

Adverse events considered at least possibly related to artesunate are listed below by body system, organ class and absolute frequency. Frequencies are defined as very common ( $\geq 1/10$ ), common (1/100–1/10), uncommon (1/1000–1/100), rare (1/10 000–1/1000), and very rare ( $< 1/10 000$ ).

##### **Blood and lymphatic systems disorders**

Very common	anaemia, post-treatment delayed haemolysis, mild and transient decrease in reticulocyte count
Not known	immune haemolytic anaemia

##### **Metabolism and nutrition disorders**

Uncommon	anorexia
----------	----------

##### **Nervous system disorders**

Common	dizziness, dysgeusia, headache
--------	--------------------------------

### **Cardiac disorders**

Common	bradycardia
Not known	QT prolongation

### **Vascular disorders**

Common	hypotension, phlebitis
Uncommon	flushing

### **Respiratory disorders**

Common	cough, rhinitis
--------	-----------------

### **Gastrointestinal disorders**

Common	vomiting, abdominal pain or cramps, diarrhoea
Uncommon	nausea, constipation

### **Hepatobiliary disorders**

Common	transient rises in liver transaminases (AST, ALT), hyperbilirubinaemia, jaundice
--------	--

### **Renal and urinary disorders**

Common	haemoglobinuria, acute renal failure
--------	--------------------------------------

### **Skin and subcutaneous tissue disorders**

Uncommon	Stevens-Johnson syndrome, pruritus, urticaria, rash
----------	---

### **Musculoskeletal and connective tissue disorders**

Common	arthralgia, muscle disorders
--------	------------------------------

### **General disorders and administration site conditions**

Common	fever
Uncommon	fatigue, pain at injection site

### **Immune system disorders**

Not known	anaphylaxis
-----------	-------------

#### *\*Post-artesunate delayed haemolysis*

Post-artesunate delayed haemolysis (PADH) is characterised by decreased haemoglobin with laboratory evidence of haemolysis (such as decreased haptoglobin and increased lactate dehydrogenase) with onset at least 7 days and sometimes several weeks after initiating artesunate treatment. PADH has been reported to occur very commonly after successful treatment of severe malaria that commenced with IV artesunate in returning travellers. The risk of PADH may be highest in patients with hyperparasitaemia and in younger children.

Patients should be monitored for evidence of haemolytic anaemia for 4 weeks after starting artesunate treatment. Spontaneous recovery from PADH usually occurs within a few weeks. However, cases of post-artesunate haemolytic anaemia severe enough to require transfusion have been reported. Since a subset of patients with delayed haemolysis after artesunate therapy have evidence of immune haemolytic anaemia, performing a direct antiglobulin test should be considered to determine if therapy, e.g. with corticosteroids, is necessary.

#### *Paediatric population:*

The safety profile of injectable artesunate is similar in children and adults.

#### ***Reporting of suspected adverse reactions***

Health care providers are asked to report adverse reactions that may be linked to a medicine, to the marketing authorisation holder, or, if available, to the national reporting system. Reports of suspected adverse reactions to a medicine are important for the monitoring of the medicine's benefits and risks.

## 4.9 Overdose

Experience of acute overdose with artesunate is limited. A case of overdose has been documented in a 5 year-old child who was inadvertently administered rectal artesunate at a dose of 88 mg/kg/day over 4 days, representing a dose more than 7-fold higher than the highest recommended artesunate dose. The overdose was associated with pancytopenia, melena, seizures, multi-organ failure and death.

Treatment of overdose should consist of general supportive measures.

## 5. PHARMACOLOGICAL PROPERTIES

### 5.1 Pharmacodynamic properties

Pharmacotherapeutic group: Antimalaria, ATC code: P01BE03

#### *Mechanism of action*

Artesunate is a hemisuccinate derivative of dihydroartemisinin, which is itself formed by the reduction of artemisinin. Artemisinin is a sesquiterpene lactone endoperoxide extracted from qinghao (sweet wormwood, *Artemisia annua L.*), a plant which has been used for centuries in traditional Chinese medicine.

The mechanism of action of the artemisinins likely involves cleavage of the internal endoperoxide bridge through reaction with haeme within the infected erythrocyte, thereby generating free radicals which alkylate vital parasite proteins. However, artemisinins have also been reported to inhibit an essential parasite calcium adenosine triphosphatase.

The artemisinins are distinguished from other antimalarials by their ability to kill all erythrocytic stages of the malaria parasite, including the relatively inactive ring stage and late schizonts, as well as the gametocytes responsible for malaria transmission. Artesunate and the artemisinins are the most rapid acting of the antimalarials, and they have also been shown to enhance splenic clearance of infected erythrocytes by reducing cytoadherence.

In vitro, dihydroartemisinin (DHA), the active metabolite of artesunate, exhibits similar potency against chloroquine-resistant and chloroquine-sensitive clones of *P. falciparum*.

Artesunate and the other artemisinins are essentially inactive against extra-erythrocytic forms, sporozoites, liver schizontes or merozoites.

#### *Clinical efficacy and safety*

In the SEAQUAMAT (South East Asian Quinine Artesunate Malaria Trial), an international randomised, open-label, multicenter trial conducted in Bangladesh, India, Indonesia and Myanmar, 1461 patients with severe malaria (including 1259 adults) were treated intravenously with either artesunate or quinine. Artesunate was administered at 2.4 mg/kg IV at 0, 12 and 24 h and then every 24 h until the patient could tolerate oral medication. Quinine was given IV at 20 mg/kg over 4 hours, followed by 10 mg/kg over 2-8 hours, 3 times daily until oral therapy could be started. Mortality in the artesunate group was 15% versus 22% in the quinine group, for a reduction in risk of death of 34.7% ( $p=0.0002$ ). Subgroup analysis suggested a greater benefit of artesunate versus quinine in patients with parasitaemia >10%. The reduction in mortality observed in the 202 paediatric patients (<15 years of age) appeared consistent with the overall results, however the number of children was too small to demonstrate statistical significance. Post-treatment hypoglycaemia was more common in the quinine-treated group.

#### *Paediatrics*

The AQUAMAT (African Quinine Artesunate Malaria Trial) was an international, randomized open-label multicenter trial which sought to extend the results of the SEAQUAMAT study by comparing parenteral artesunate versus IV quinine for severe malaria in 5425 African children (< 15 years) in 9 African countries (Mozambique, The Gambia, Ghana, Kenya, Tanzania, Nigeria, Uganda, Rwanda, and Democratic Republic of the Congo). Dosing was similar to SEAQUAMAT, except that both artesunate and quinine could be administered either intravenously or intramuscularly, using the same doses for IM and IV administration for

each drug. Roughly one third of patients received study drug by intramuscular injection. Mortality in the artesunate group was 8.5% compared to 10.9% in the quinine group, resulting in a relative risk reduction for death of 22.5% ( $p=0.0022$ ); the risk reduction was similar for IV and IM administration. In addition, although the risk of neurological sequelae in survivors in both groups did not differ significantly by 28 days following treatment, in-hospital coma, convulsions, and deterioration of coma were all less frequent in the artesunate-treated patients. As in the SEAQUAMAT, post-treatment hypoglycaemia was more common in the quinine-treated group.

## 5.2 Pharmacokinetic properties

### Pharmacokinetics of Artesunate

<b>Absorption</b>	
Oral bioavailability	Not applicable
Food effect	Not applicable
<b>Distribution</b>	
Volume of distribution (mean)	Artesunate: 15 L/kg Dihydroartemisinin: 1.6-2.6 L/kg
Plasma protein binding in vitro	Artesunate: 75% Dihydroartemisinin: 80-90% with decreased binding at higher concentrations
Tissue distribution	Dihydroartemisinin accumulates substantially in <i>P.falciparum</i> -infected erythrocytes
<b>Metabolism</b>	
	Extensively hydrolysed by plasma esterases and perhaps also by CYP2A6.
Active metabolite(s)	Dihydroartemisinin is further metabolised through glucuronidation
<b>Elimination</b>	
Elimination half life	Artesunate: 3–29 minutes Dihydroartemisinin: 40–95 minutes
Mean systemic clearance (Cl/F)	Artesunate: 20 L/kg/h Dihydroartemisinin: 1.4 – 2.7 L/kg/h
% of dose excreted in urine	NA*
% of dose excreted in faeces	NA*

\*Information not available.

## 5.3 Preclinical safety data

### *General toxicity*

Artesunate presents low acute toxicity. After repeated administration of 50 mg/kg/day in rats and 82.5 mg/kg/day in dogs, i.e. approximately 10 and 17 times the proposed maximal therapeutic dose in man, evidence of toxicity was observed in the haematopoietic organs, the immune system and response, the liver and kidneys.

### *Genotoxicity*

Artesunate did not show any mutagenic or clastogenic potential in in vitro and in vivo tests (Ames, mouse micronucleus).

### *Carcinogenesis*

No studies of the carcinogenic potential of artesunate have been conducted.

### *Reproductive toxicology studies*

Oral artesunate caused dose-dependent fetal toxicity in rats, rabbits, and monkeys, resulting in fetal resorption and abortion, as well as a low incidence of cardiac and skeletal defects. The no-observed-adverse-effect-level (NOAEL) was 12 mg/kg in pregnant monkeys (3- and 7-day exposures) and the no or low adverse effects level was 5-7 mg/kg in pregnant rats or rabbits (12-day exposures), both of which are above the therapeutic dose range (2.4-4.8 mg/kg) and expected duration of exposure for treatment of severe malaria in humans. In rats, the embryo-fetuses were most sensitive from gestational days 9-14; at other times embryotoxicity was significantly reduced. A study of artesunate administered to male rats daily for 6 weeks noted testicular and epididymal lesions, although these lesions did not affect fertility. The lesions were reversible after cessation of treatment.

### *Safety pharmacology studies*

A slight sedative effect, decrease in body temperature, mild natriuretic effect, and a decrease in creatinine clearance were observed with artesunate after single intravenous doses of 200 mg/kg (mice), 450 mg/kg (rats, rabbits and dogs), and following single oral doses of 180 mg/kg in male rats. Beagle dogs administered IV artesunate at 10, 20 and 50 mg/kg for 14 days did not display significant clinical effects, including any signs of neurotoxicity, effects on body weight, ECG abnormalities (including QT interval changes), heart rate, blood pressure, or respiratory rate.

## **6. PHARMACEUTICAL PARTICULARS**

### **6.1 List of excipients**

Artesunate powder for injection: No excipients

Solvent: Arginine  
Sodium bicarbonate,  
Phosphoric acid (for pH adjustment)  
Water for injection

This medicine is essentially 'sodium-free'. It contains less than 1 mmol sodium (23 mg) per ampule

### **6.2 Incompatibilities**

In the absence of compatibility studies, this medicinal product must not be mixed with other medicinal products

### **6.3 Shelf life**

36 months

### **6.4 Special precautions for storage**

Store below 30°C. Do not refrigerate or freeze. Avoid excursions above 30°C.

Keep the vial and ampoule in the provided carton to protect from light.

### *Reconstituted solution*

The reconstituted solution should be stored below 30°C and should be used within one hour.

## 6.5 Nature and contents of container

Artesunate powder for injection is packed in a clear colourless type I glass vial (10 mL) with a type I grey halogenated butyl rubber stopper, crimped with a purple aluminium-plastic cap

Solvent for reconstitution (arginine and sodium bicarbonate) is packed in a clear colourless type I glass ampoule (9 mL).

Co-pack: one vial of artesunate powder for injection and one ampoule of the solvent (arginine and sodium bicarbonate) are packed in a plastic (PVC) tray. The tray is packed in an outer carton.

## 6.6 Special precautions for disposal and other handling

### Instructions for reconstitution

When reconstituted correctly, one vial of [MA195 trade name] will yield 9 mL of a solution for intravenous or intramuscular administration (20 mg/mL).

For patients weighing over 75 kg, more than 1 vial of [MA195 trade name] will be needed for each dose. The required number of product packs should be determined as follows.

Patient weight	Number of vials of artesunate (180 mg) needed
up to 75 kg	1
76 to 100 kg	2

- Using a syringe, withdraw 9 mL of the supplied sodium bicarbonate and arginine solvent from the ampoule and inject into the vial containing the artesunate powder. The product must be prepared with the supplied solvent.
- Gently shake the vial for as long as necessary until the powder is completely dissolved and the solution is clear. This may take several minutes. If the solution appears cloudy or a precipitate is present, it should be discarded.
- The reconstituted solution will contain 20 mg artesunate per mL of solvent, for intravenous or intramuscular use.

Once reconstituted, the artesunate solution must be used within one hour. Discard any unused solution.

## 7. SUPPLIER

Guilin Pharmaceutical Co., Ltd  
No. 43, Qilidian Road, Guilin 541004  
Guangxi, China.  
Tel: +86 773 3675053  
Fax: +86 773 3675692

## 8. WHO REFERENCE NUMBER (WHO Prequalification Programme)

MA195

## 9. DATE OF PREQUALIFICATION

12 December 2024

## 10. DATE OF REVISION OF THE TEXT

January 2025

Section 6 was updated in April 2026

## References

### General

WHO Guidelines for malaria, 14 March 2023. Geneva: World Health Organization; 2023. (WHO/UCN/GMP/ 2023.01; <https://apps.who.int/iris/rest/bitstreams/1493946/retrieve>, accessed 16 September 2023).

Artesunate Amivas 110 mg powder and solvent for solution for injection: summary of product characteristics. European Medicines Agency; 26 June 2024 ([https://www.ema.europa.eu/en/documents/product-information/artesunate-amivas-epar-product-information\\_en.pdf](https://www.ema.europa.eu/en/documents/product-information/artesunate-amivas-epar-product-information_en.pdf), accessed 21 Jan 2025)

### 4.2 Posology and method of administration

Médecins sans Frontières. MSF Medical Guidelines: Essential drugs. Artesunate injectable.

(<https://medicalguidelines.msf.org/en/viewport/EssDr/english/artesunate-injectable-16682465.html>, accessed 16 September 2023).

Medicines for Malaria Venture (MMV). Guidelines for administration of injectable artesunate for severe malaria, 2014. ([https://www.mmv.org/sites/default/files/uploads/docs/access/Injectable\\_Artesunate\\_Tool\\_Kit/InjectableArtesunate\\_pos terEN.pdf](https://www.mmv.org/sites/default/files/uploads/docs/access/Injectable_Artesunate_Tool_Kit/InjectableArtesunate_pos terEN.pdf), accessed 17 September 2023).

### 4.4 Special warnings and precautions for use

WHO/Global Malaria Programme. WHO information note on delayed haemolytic anaemia following treatment with artesunate. (<https://apps.who.int/iris/bitstream/handle/10665/338347/WHO-HTM-GMP-2013.04-eng.pdf>, accessed 16 September 2023)

Rolling T et al. Delayed Hemolysis After Treatment With Parenteral Artesunate in African Children With Severe Malaria—A Double-center Prospective Study. *J Infect Dis* 2014; 209: 1921-1928  
<https://academic.oup.com/jid/article/209/12/1921/798188>

### 4.6 Pregnancy and lactation

McGready R et al. Artemisinin antimalarials in pregnancy: a prospective treatment study of 539 episodes of multidrug-resistant *Plasmodium falciparum*. *Clin Infect Dis* 2001;33:2009-2016.  
<https://academic.oup.com/cid/article/33/12/2009/364395>

Centers for Disease Control and Prevention (CDC). Intravenous artesunate for treatment of severe malaria in the United States 2007: Protocol, IND #76,725. 1-28.

Jansen FH et al. Is artesunate or its active metabolite dihydroartemisinin being excreted in the milk of lactating mothers? *Am J Trop Med Hyg*. 2006;75 Suppl. S :158. Abstract.

Olumide SA, Raji Y. 2011. Long-term administration of artesunate induces reproductive toxicity in male rats. *J Reprod Infertil* 12(4): 249-260.  
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3719311/>

### 4.8 Undesirable effects

Maude RJ et al. Does artesunate prolong the electrocardiograph QT interval in patients with severe malaria? *Am J Trop Med Hyg* 2009;80:126-32

Rolling T et al. Delayed Hemolysis After Treatment With Parenteral Artesunate in African Children With Severe Malaria—A Double-center Prospective Study. *J Infect Dis* 2014; 209: 1921-1928

Zoller T et al. Intravenous artesunate for severe malaria in travelers, Europe *Emerging Infect Dis* 2011;17:771-777.

### 4.9 Overdose

Campos S, de la Cerda P, Rivera A Fatal artesunate toxicity in a child *J Ped Inf Dis* 2008;3:69-75

### 5.1 Pharmacodynamic properties

Hess KM, Goad JA, Argui PM Intravenous artesunate for the treatment of severe malaria *Ann Pharmacotherapy* 2010;44:1250-1258.

Lin AJ, Klayman DL, Milhous WK Antimalarial activity of new water-soluble dihydroartemisinin derivatives *J Med Chem* 1987;30:2147-2150.

Dondorp AM et al. Artesunate versus quinine for treatment of severe *falciparum* malaria: a randomised trial. *Lancet* 2005;366:717-725

Jones KL, Donegan S, Lalloo DG. Artesunate versus quinine for treating severe malaria. *Cochrane Database Syst Rev* 2007;4:CD005967-CD005967

Dondorp AM et al. Artesunate vs. quinine in the treatment of severe *falciparum* malaria in African children (AQUAMAT): an open-label randomized trial. *Lancet* 2010; 376: 1647–57

### 5.2 Pharmacokinetic properties

Nealon C et al. Intramuscular bioavailability and clinical efficacy of artesunate in Gabonese children with severe malaria. *Antimicrob Agents Chemother* 2002;46:3933-3939.

Ilett KF et al. The pharmacokinetic properties of intramuscular artesunate and rectal dihydroartemisinin in uncomplicated *falciparum* malaria *Br J ClinPharmacol* 2002;53:23-30.

Batty KT et al. A pharmacokinetic and pharmacodynamic study of intravenous vs oral artesunate in uncomplicated *falciparum* malaria. *Br J ClinPharmacol* 1998;45:123-129.

Hien TT et al. Comparative pharmacokinetics of intramuscular artesunate and artemether in patients with severe *falciparum* malaria. *Antimicrob Agents Chemother* 2004;48:4234-4239.

### 5.3 Preclinical safety data

Efferth T, Kaina B. Toxicity of the antimalarial artemisinin and its derivatives. *Critical Reviews in Toxicol* 2010;40:405-421.

Detailed information on this medicine is available on the World Health Organization (WHO) website:  
<https://extranet.who.int/prequal/medicines/prequalified/finished-pharmaceutical-products>