

## **SUMMARY OF PRODUCT CHARACTERISTICS**

### **1 NAME OF THE MEDICINAL PRODUCT**

Irinotecan 20 mg/ml concentrate for solution for infusion

### **2 QUALITATIVE AND QUANTITATIVE COMPOSITION**

1 ml of concentrate contains 20 mg of irinotecan hydrochloride, trihydrate (equivalent to 17.33 mg/ml of irinotecan).

Each vial of 2 ml contains 40 mg of irinotecan hydrochloride trihydrate.

Each vial of 5 ml contains 100 mg of irinotecan hydrochloride trihydrate.

Each vial of 15 ml contains 300 mg of irinotecan hydrochloride trihydrate.

Each vial of 25 ml contains 500 mg of irinotecan hydrochloride trihydrate.

Excipients: each millilitre of solution contains 45 mg of sorbitol (E420).

Each millilitre of solution contains 0.138 mg of sodium.

For the full list of excipients, see section 6.1.

### **3 PHARMACEUTICAL FORM**

Concentrate for solution for infusion.

Irinotecan is a clear yellow solution.

pH: 3.0 – 4.0

Osmolality: 265-350 mosmol/kg

### **4 CLINICAL PARTICULARS**

#### **4.1 Therapeutic indications**

Irinotecan Hikma is indicated for the treatment of patients with advanced colorectal cancer:

- in combination with 5-fluorouracil and folinic acid in patients without prior chemotherapy for advanced disease,
- as a single agent in patients who have failed an established 5-fluorouracil containing treatment regimen.

Irinotecan Hikma in combination with cetuximab is indicated for the treatment of patients with epidermal growth factor receptor (EGFR) - expressing KRAS wild-type metastatic colorectal cancer, who had not received prior treatment for metastatic disease or after failure of irinotecan-including cytotoxic therapy.

Irinotecan Hikma in combination with 5-fluorouracil, folinic acid and bevacizumab is indicated for first-line treatment of patients with metastatic carcinoma of the colon or rectum.

Irinotecan in combination with capecitabine with or without bevacizumab is indicated for first-line treatment of patients with metastatic colorectal carcinoma.

## **4.2 Posology and method of administration**

For adults only. This medicinal product after dilution, should be infused into a peripheral or central vein.

### Posology

#### **Recommended dosage:**

##### In monotherapy (for previously treated patient):

The recommended dosage of Irinotecan is  $350 \text{ mg/m}^2$ , administered as an intravenous infusion over a 30 to 90 minute period, every three weeks (see sections 4.4 and 6.6).

##### In combination therapy (for previously untreated patient):

Safety and efficacy of Irinotecan in combination with 5-fluorouracil (5-FU) and folinic acid (FA) have been assessed with the following schedule (see section 5.1):

- Irinotecan Hikma plus 5-FU/FA in every 2 weeks schedule

The recommended dose of Irinotecan is  $180 \text{ mg/m}^2$  administered once every 2 weeks as an intravenous infusion over a 30 to 90 minute period, followed by infusion of folinic acid and 5-fluorouracil.

For the posology and method of administration of concomitant cetuximab, refer to the product information for this medicinal product.

Normally, the same dose of irinotecan is used as administered in the last cycles of the prior irinotecan-containing regimen. Irinotecan must not be administered earlier than 1 hour after the end of the cetuximab infusion.

For the posology and method of administration of bevacizumab, refer to the bevacizumab summary product of characteristics.

For the posology and method of administration of capecitabine combination, please see section 5.1 and refer to the appropriate sections in the capecitabine summary of product characteristics.

### **Dosage adjustments:**

Irinotecan should be administered after appropriate recovery of all adverse events to grade 0 or 1 of NCI-CTC grading (National Cancer Institute Common Toxicity Criteria) and when treatment-related diarrhoea is fully resolved.

At the start of a subsequent infusion of therapy, the dose of Irinotecan Hikma, and 5-FU when applicable, should be decreased according to the worst grade of adverse events observed in the prior infusion. Treatment should be delayed by 1 to 2 weeks to allow recovery from treatment-related adverse events.

With the following adverse events, a dose reduction of 15 to 20 % should be applied for Irinotecan and/or 5-FU when applicable:

- haematological toxicity (neutropenia grade 4, febrile neutropenia (neutropenia grade 3-4 and fever grade 2-4), thrombocytopenia and leukopenia (grade 4)),
- non haematological toxicity (grade 3-4),

Recommendations for dose modifications of cetuximab when administered in combination with irinotecan must be followed according to the product information for this medicinal product.

In combination with capecitabine for patients 65 years of age or more, a reduction of the starting dose of capecitabine to 800 mg/m<sup>2</sup> twice daily is recommended according to the summary of product characteristics for capecitabine. Refer also to the recommendations for dose modifications in combination regimen given in the summary of product characteristics for capecitabine.

### **Treatment Duration:**

Treatment with Irinotecan Hikma should be continued until there is an objective progression of the disease or an unacceptable toxicity.

### **Special populations:**

#### **Patients with Impaired Hepatic Function:**

In monotherapy: Blood bilirubin levels (up to 3 times the upper limit of the normal range (ULN)) in patients with performance status  $\leq 2$ , should determine the starting dose of Irinotecan Hikma. In these patients with hyperbilirubinemia and a prothrombin time greater than 50%, the clearance of irinotecan is reduced (see section 5.2) and therefore the risk of hematotoxicity is increased.

Thus, weekly monitoring of complete blood counts should be conducted in this patient population.

- In patients with bilirubin up to 1.5 times the upper limit of the normal range (ULN), the recommended dosage of Irinotecan Hikma is 350 mg/m<sup>2</sup>,
- In patients with bilirubin ranging from 1.5 to 3 times the ULN, the recommended dosage of Irinotecan Hikma is 200 mg/m<sup>2</sup>,
- Patients with bilirubin beyond to 3 times the ULN should not be treated with Irinotecan Hikma (see sections 4.3 and 4.4).

No data are available in patients with hepatic impairment treated by Irinotecan in combination.

#### **Patients with Impaired Renal Function:**

Irinotecan is not recommended for use in patients with impaired renal function, as studies in this population have not been conducted. (See sections 4.4 and 5.2).

#### **Elderly:**

No specific pharmacokinetic studies have been performed in elderly.

However, the dose should be chosen carefully in this population due to their greater frequency of decreased biological functions. This population should require more intense surveillance (see section 4.4).

### **4.3 Contraindications**

- History of severe hypersensitivity reactions to irinotecan hydrochloride trihydrate or to one of the excipients of Irinotecan Hikma.
- Chronic inflammatory bowel disease and/or bowel obstruction (see section 4.4).
- Lactation (see sections 4.6 and 4.4).
- Bilirubin > 3 times the upper limit of the normal range (see section 4.4).
- Severe bone marrow failure.
- WHO performance status > 2.
- Concomitant use with St John's Wort (see section 4.5).

For additional contraindications of cetuximab or bevacizumab or capecitabine, refer to the product information for these medicinal products.

### **4.4 Special warnings and precautions for use**

<p>The use of Irinotecan Hikma should be confined to units specialised in the administration of cytotoxic chemotherapy and it should only be administered under the supervision of a physician qualified in the use of anticancer chemotherapy.</p>
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Given the nature and incidence of adverse events, Irinotecan Hikma will only be prescribed in the following cases after the expected benefits have been weighted against the possible therapeutic risks:

- in patients presenting a risk factor, particularly those with a WHO performance status = 2.
- In the few rare instances where patients are deemed unlikely to observe recommendations regarding management of adverse events (need for immediate and prolonged antidiarrhoeal treatment, combined with high fluid intake at onset of delayed diarrhoea). Strict hospital supervision is recommended for such patients.

When Irinotecan is used in monotherapy, it is usually prescribed with the every-3-week-dosage schedule. However, the weekly-dosage schedule (see section 5.) may be considered in patients who may need a closer follow-up or who are at particular risk of severe neutropenia.

#### **Delayed diarrhoea:**

Patients should be made aware of the risk of delayed diarrhoea occurring more than 24 hours after the administration of Irinotecan and at any time before the next cycle. In monotherapy, the median time of onset of the first liquid stool was on day 5 after the infusion of Irinotecan. Patients should quickly inform their physician of its occurrence and start appropriate therapy immediately.

Patients with an increased risk of diarrhoea are those who had a previous abdominal/pelvic radiotherapy, those with baseline hyperleucocytosis, those with performance status  $\geq 2$  and women. If not properly treated, diarrhoea can be life-threatening, especially if the patient is concomitantly neutropenic.

As soon as the first liquid stool occurs, the patient should start drinking large volumes of beverages containing electrolytes and an appropriate antidiarrhoeal therapy must be initiated immediately. This antidiarrhoeal treatment will be prescribed by the department where Irinotecan has been administered. After discharge from the hospital, the patients should obtain the prescribed drugs so that they can treat the diarrhoea as soon as it occurs. In addition, they must inform their physician or the department administering Irinotecan when/if diarrhoea is occurring.

The currently recommended antidiarrhoeal treatment consists of high doses of loperamide (4 mg for the first intake and then 2 mg every 2 hours). This therapy should continue for 12 hours after the last liquid stool and should not be modified. In no instance should loperamide be administered for more than 48 consecutive hours at these doses, because of the risk of paralytic ileus, nor for less than 12 hours.

In addition to the anti-diarrhoeal treatment, a prophylactic broad spectrum antibiotic should be given, when diarrhoea is associated with severe neutropenia (neutrophil count  $< 500$  cells/mm<sup>3</sup>).

In addition to the antibiotic treatment, hospitalization is recommended for management of the diarrhoea, in the following cases:

- Diarrhoea associated with fever,
- Severe diarrhoea (requiring intravenous hydration),
- Diarrhoea persisting beyond 48 hours following the beginning of high-dose loperamide therapy.

Loperamide should not be given prophylactically, even in patients who experienced delayed diarrhoea at previous cycles.

In patients who experienced severe diarrhoea, a reduction in dose is recommended for subsequent cycles (see section 4.2).

### **Haematology:**

In clinical studies, the frequency of NCI CTC grade 3 and 4 neutropenia has been significantly higher in patients who received previous pelvic/abdominal irradiation than in those who had not received such irradiation. Patients with baseline serum total bilirubin levels of 1.0 mg/dL or more have also had a significantly greater likelihood of experiencing first-cycle grade 3 or 4 neutropenia than those with bilirubin levels that were less than 1.0 mg/dL.

Weekly monitoring of complete blood cell counts is recommended during Irinotecan treatment. Patients should be aware of the risk of neutropenia and the significance of fever. Febrile neutropenia (temperature  $> 38^{\circ}\text{C}$  and neutrophil count  $\leq 1,000$  cells/ $\text{mm}^3$ ) should be urgently treated in the hospital with broad-spectrum intravenous antibiotics.

In patients who experienced severe haematological effects, a dose reduction is recommended for subsequent administration (see section 4.2).

There is an increased risk of infections and haematological toxicity in patients with severe diarrhoea. In patients with severe diarrhoea, complete blood cell counts should be performed.

### **Liver impairment**

Liver function tests should be performed at baseline and before each cycle. Weekly monitoring of complete blood counts should be conducted in patients with bilirubin ranging from 1.5 to 3 times ULN, due to decrease of the clearance of irinotecan (see section 5.2) and thus increasing the risk of hematotoxicity in this population. For patients with a bilirubin  $> 3$  times ULN (see section 4.3).

### **Nausea and vomiting**

A prophylactic treatment with antiemetics is recommended before each treatment with Irinotecan. Nausea and vomiting have been frequently reported. Patients with vomiting associated with delayed diarrhoea should be hospitalized as soon as possible for treatment.

### **Acute cholinergic syndrome**

If acute cholinergic syndrome appears (defined as early diarrhoea and various other signs and symptoms such as sweating, abdominal cramping, myosis and salivation), atropine sulphate (0.25 mg subcutaneously) should be administered unless clinically contraindicated (see section 4.8).

These symptoms may be observed during or shortly after infusion of irinotecan, are thought to be related to the anticholinesterase activity of the irinotecan parent compound, and are expected to occur more frequently with higher irinotecan doses.

Caution should be exercised in patients with asthma. In patients who experienced an acute and severe cholinergic syndrome, the use of prophylactic atropine sulphate is recommended with subsequent doses of Irinotecan.

### **Respiratory disorders**

Interstitial pulmonary disease presenting as pulmonary infiltrates is uncommon during irinotecan therapy. Interstitial pulmonary disease can be fatal. Risk factors possibly associated with the development of interstitial pulmonary disease include the use of pneumotoxic drugs, radiation therapy and colony stimulating factors. Patients with risk factors should be closely monitored for respiratory symptoms before and during irinotecan therapy.

### **Extravasation**

While irinotecan is not a known vesicant, care should be taken to avoid extravasation and the infusion site should be monitored for signs of inflammation. Should extravasation occur, flushing the site and application of ice is recommended.

### **Elderly**

Due to the greater frequency of decreased biological functions, in particular hepatic function, in elderly patients, dose selection with Irinotecan Hikma should be cautious in this population (see section 4.2).

### **Chronic inflammatory bowel disease and/or bowel obstruction**

Patients must not be treated with Irinotecan Hikma until resolution of the bowel obstruction (see section 4.3).

### **Patients with Impaired Renal Function**

Increases in serum creatinine or blood urea nitrogen have been observed. There have been cases of acute renal failure.

These events have generally been attributed to complications of infection or to dehydration related to nausea, vomiting, or diarrhoea. Rare instances of renal dysfunction due to tumour lysis syndrome have also been reported.

### **Irradiation therapy**

Patients who have previously received pelvic/abdominal irradiation are at increased risk of myelosuppression following the administration of irinotecan. Physicians should use caution in treating patients with extensive prior irradiation (e.g. >25% of bone marrow irradiated and within 6 weeks prior to start of treatment with irinotecan). Dosing adjustment may apply to this population (see section 4.2).

### **Cardiac Disorders**

Myocardial ischaemic events have been observed following irinotecan therapy predominately in patients with underlying cardiac disease, other known risk factors for cardiac disease, or previous cytotoxic chemotherapy (see section 4.8).

Consequently, patients with known risk factors should be closely monitored, and action should be taken to try to minimize all modifiable risk factors (e.g. smoking, hypertension, and hyperlipidaemia)

### **Vascular disorders**

Irinotecan has been rarely associated with thromboembolic events (pulmonary embolism, venous thrombosis, and arterial thromboembolism) in patients presenting with multiple risk factors in addition to the underlying neoplasm.

### **Immunosuppressant Effects/Increased Susceptibility to Infections**

Administration of live or live-attenuated vaccines in patients immunocompromised by chemotherapeutic agents including irinotecan, may result in serious or fatal infections. Vaccination with a live vaccine should be avoided in patients receiving irinotecan. Killed or inactivated vaccines may be administered; however, the response to such vaccines may be diminished.

### **Others**

Since this medicinal contains sorbitol, it is unsuitable in hereditary fructose intolerance.

This medicine contains 45 mg sorbitol in each millilitre of solution

This medicine contains less than 1 mmol sodium (23 mg) per mL of solution, that is to say essentially 'sodium-free'.

Infrequent cases of renal insufficiency, hypotension or circulatory failure have been observed in patients who experienced episodes of dehydration associated with diarrhoea and/or vomiting, or sepsis.

Contraceptive measures must be taken during and for at least three months after cessation of therapy.

Concomitant administration of irinotecan with a strong inhibitor (e.g. ketoconazole) or inducer (e.g. rifampicin, carbamazepine, phenobarbital, phenytoin, St John's Wort) of CYP3A4 may alter the metabolism of irinotecan and should be avoided (see section 4.5).

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

Interaction between irinotecan and neuromuscular blocking agents cannot be ruled out. Since Irinotecan has anticholinesterase activity, drugs with anticholinesterase activity may prolong the neuromuscular blocking effects of suxamethonium and the neuromuscular blockade of non-depolarizing drugs may be antagonised.

Several studies have shown that concomitant administration of CYP3A-inducing anticonvulsant drugs (e.g. carbamazepine, phenobarbital or phenytoin) leads to

reduced exposure to irinotecan, SN-38 and SN-38 glucuronide, and reduced pharmacodynamic effects. The effects of such anticonvulsant drugs were reflected by a decrease in AUC of SN-38 and SN-38G by 50% or more. In addition to induction of cytochrome P450 3A enzymes, enhanced glucuronidation and enhanced biliary excretion may play a role in reducing exposure to irinotecan and its metabolites.

A study has shown that the co-administration of ketoconazole resulted in a decrease in the AUC of APC of 87% and in an increase in the AUC of SN-38 of 109%, in comparison to irinotecan given alone.

Caution should be exercised in patients concurrently taking drugs known to inhibit (e.g., ketoconazole) or induce (e.g., rifampicin, carbamazepine, phenobarbital or phenytoin) drug metabolism by cytochrome P450 3A4. Concurrent administration of irinotecan with an inhibitor/inducer of this metabolic pathway may alter the metabolism of irinotecan and should be avoided (see section 4.4).

In a small pharmacokinetic study (n=5), in which irinotecan 350 mg/m<sup>2</sup> was co-administered with St. John's Wort (*Hypericum perforatum*) 900 mg, a 42% decrease in the active metabolite of irinotecan, SN-38, plasma concentrations, was observed. St. John's Wort decreases SN-38 plasma levels. As a result, St. John's Wort should not be administered with irinotecan (see section 4.3).

Coadministration of 5-fluorouracil /folinic acid in the combination regimen does not change the pharmacokinetics of irinotecan.

Atazanavir sulphate. Coadministration of atazanavir sulphate, a CYP3A4 and UGT1A1 inhibitor, has the potential to increase systemic exposure to SN-38, the active metabolite of irinotecan. Physicians should take this into consideration when co-administering these drugs.

*Interactions common to all cytotoxic:*

The use of anticoagulants is common due to increased risk of thrombotic events in tumoral diseases. If vitamin K antagonist anticoagulants are indicated, an increased frequency in the monitoring of INR (International Normalised Ratio) is required due to their narrow therapeutic index, the high intra-individual variability of blood thrombogenicity and the possibility of interaction between oral anticoagulants and anticancer chemotherapy.

*Concomitant use contraindicated*

- Yellow fever vaccine: risk of fatal generalised reaction to vaccines

*Concomitant use not recommended*

- Live attenuated vaccines (except yellow fever): risk of systemic, possible fatal disease (eg-infections). This risk is increased in subjects who are already immunosuppressed by their underlying disease.

Use an inactivated vaccine where this exists (poliomyelitis)

- Phenytoin: Risk of exacerbation of convulsions resulting from the decrease of phenytoin digestive absorption by cytotoxic drug or risk of toxicity enhancement due to increased hepatic metabolism by phenytoin

#### Concomitant use to take into consideration

- Ciclosporine, Tacrolimus: Excessive immunosuppression with risk of lymphoproliferation

There is no evidence that the safety profile of irinotecan is influenced by cetuximab or *vice versa*.

Results from a dedicated drug-drug interaction trial demonstrated no significant effect of bevacizumab on the pharmacokinetics of irinotecan and its active metabolite SN-38. However, this does not preclude any increase of toxicities due to their pharmacological properties.

#### **4.6 Fertility, pregnancy and lactation**

##### **Pregnancy:**

There is no information on the use of irinotecan in pregnant women. Irinotecan was embryotoxic and teratogenic in animals. Based on results from animal studies and the mechanism of action of irinotecan, this medicine must not be used during pregnancy unless clearly necessary.

##### **Women of child-bearing potential/Contraception in males and females:**

Women of child-bearing potential and men have to use effective contraception during and up to 1 month and 3 months after treatment respectively.

##### **Fertility**

There are no human data on the effect of irinotecan on fertility. In animals adverse effects of irinotecan on the fertility of offspring has been documented (see section 5.3).

##### **Breastfeeding:**

In lactating rats, <sup>14</sup>C-irinotecan was detected in milk. It is unknown if irinotecan is excreted in human breast milk. Consequently, because of the potential for adverse reactions in nursing infants, breastfeeding is contraindicated during therapy with Irinotecan Hikma (see section 4.3).

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

Patients should be warned about the potential for dizziness or visual disturbances which may occur within 24 hours following the administration of Irinotecan, and advised not to drive or operate machinery if these symptoms occur.

#### **4.8 Undesirable effects**

##### **CLINICAL STUDIES**

Adverse reaction data have been extensively collected from studies in metastatic colorectal cancer; the frequencies are presented below. The adverse reactions for other indications are expected to be similar to those for colorectal cancer.

The most common ( $\geq 1/10$ ), dose-limiting adverse reactions of irinotecan are delayed diarrhoea (occurring more than 24 hours after administration) and blood disorders including neutropenia, anaemia and thrombocytopenia.

Neutropenia is a dose-limiting toxic effect. Neutropenia was reversible and not cumulative; the median day to nadir was 8 days whatever the use in monotherapy or in combination therapy.

Very commonly severe transient acute cholinergic syndrome was observed.

The main symptoms were defined as early diarrhoea and various other symptoms such as abdominal pain, sweating, myosis and increased salivation occurring during or within the first 24 hours after the infusion of irinotecan. These symptoms disappear after atropine administration (see section 4.4).

#### MONOTHERAPY

The following adverse reactions considered to be possibly or probably related to the administration of irinotecan have been reported from 765 patients at the recommended dose of 350 mg/m<sup>2</sup> in monotherapy. Within each frequency grouping, adverse reactions are presented in order of decreasing seriousness. Frequencies are defined as: 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  $< 1/1,000$ ), and very rare ( $< 1/10,000$ ).

<b>Adverse Reactions Reported with irinotecan in Monotherapy (350 mg/m<sup>2</sup> every 3 weeks schedule)</b>		
<b>MedDRA System Organ Class</b>	<b>Frequency Category</b>	<b>Preferred Term</b>
Infections and infestations	Common	Infection
Blood and lymphatic system disorders	Very common	Neutropenia
	Very common	Anaemia
	Common	Thrombocytopenia
	Common	Febrile neutropenia
Metabolism and nutrition disorders	Very common	Decreased appetite
Nervous system disorders	Very common	Cholinergic syndrome
Gastrointestinal disorders	Very common	Diarrhoea
	Very common	Vomiting
	Very common	Nausea
	Very common	Abdominal pain
	Common	Constipation
Skin and subcutaneous tissue disorders	Very common	Alopecia (reversible)
General disorders and administration site conditions	Very common	Mucosal inflammation
	Very common	Pyrexia
	Very common	Asthenia
Investigations	Common	Blood creatinine increased
	Common	Transaminases (SGPT SGOT) increased

	Common	Bilirubin increased
	Common	Blood alkaline phosph increased

### Description of selected adverse reactions (monotherapy)

**Severe diarrhoea** was observed in 20% of patients who follow recommendations for the management of diarrhoea. Of the evaluable cycles, 14% have severe diarrhoea. The median time of onset of the first liquid stool was on day 5 after the infusion of irinotecan.

**Nausea and vomiting** were severe in approximately 10% of patients treated with antiemetics.

**Constipation** has been observed in less than 10% of patients.

**Neutropenia** was observed in 78.7% of patients and was severe (neutrophil count < 500 cells/mm<sup>3</sup>) in 22.6% of patients. Of the evaluable cycles, 18 % had a neutrophil count below 1,000 cells/mm<sup>3</sup> including 7.6% with a neutrophil count < 500 cells/mm<sup>3</sup>.

Total recovery was usually reached by day 22.

**Fever with severe neutropenia** was reported in 6.2% of patients and in 1.7% of cycles.

Infectious episodes occurred in about 10.3% of patients (2.5% of cycles) and were associated with severe neutropenia in about 5.3% of patients (1.1% of cycles), and resulted in death in 2 cases.

**Anaemia** was reported in about 58.7% of patients (8% with haemoglobin < 8 g/dl and 0.9% with haemoglobin < 6.5 g/dl).

**Thrombocytopenia** (< 100,000 cells/mm<sup>3</sup>) was observed in 7.4 % of patients and 1.8% of cycles with 0.9% with platelets count ≤ 50,000 cells/mm<sup>3</sup> and 0.2% of cycles.

Nearly all the patients showed a recovery by day 22.

### Acute cholinergic syndrome

Severe transient acute cholinergic syndrome was observed in 9 % of patients treated in monotherapy.

**Asthenia** was severe in less than 10 % of patients treated in monotherapy. The causal relationship to irinotecan has not been clearly established. Fever in the absence of infection and without concomitant severe neutropenia, occurred in 12 % of patients treated in monotherapy.

### Laboratory tests

Transient and mild to moderate increases in serum levels of either transaminases, alkaline phosphatase or bilirubin were observed in 9.2 %, 8.1 % and 1.8 % of the patients, respectively, in the absence of progressive liver metastasis.

Transient and mild to moderate increases of serum levels of creatinine have been observed in 7.3 % of the patients.

### COMBINATION THERAPY

Adverse reactions detailed in this section refer to irinotecan.

There is no evidence that the safety profile of irinotecan is influenced by cetuximab or *vice versa*. In combination with cetuximab, additional reported adverse reactions were those expected with cetuximab (such as acneform rash 88%). For information on adverse reactions on irinotecan in combination with cetuximab, also refer to their respective summary of product characteristics.

Adverse drug reactions reported in patients treated with capecitabine in combination with irinotecan in addition to those seen with capecitabine monotherapy or seen at a higher frequency grouping compared to capecitabine monotherapy include: *Very common, all grade adverse drug reactions*: thrombosis/embolism; *Common, all grade adverse drug reactions*: hypersensitivity reaction, cardiac ischemia/infarction; *Common, grade 3 and grade 4 adverse drug reactions*: febrile neutropenia. For complete information on adverse reactions of capecitabine, refer to the capecitabine summary product of characteristics.

Grade 3 and Grade 4 adverse drug reactions reported in patients treated with capecitabine in combination with irinotecan and bevacizumab in addition to those seen with capecitabine monotherapy or seen at a higher frequency grouping compared to capecitabine monotherapy include: *Common, grade 3 and grade 4 adverse drug reactions*: neutropenia, thrombosis/embolism, hypertension, and cardiac ischemia/infarction. For complete information on adverse reactions of capecitabine and bevacizumab, refer to the respective capecitabine and bevacizumab summary of product characteristics.

Grade 3 hypertension was the principal significant risk involved with the addition of bevacizumab to bolus irinotecan/5-FU/FA. In addition, there was a small increase in the grade 3/4 chemotherapy adverse events of diarrhoea and leukopenia with this regimen compared to patients receiving bolus irinotecan/5-FU/FA alone. For other information on adverse reactions in combination with bevacizumab, refer to the bevacizumab summary of product characteristics.

Irinotecan has been studied in combination with 5-FU and FA for metastatic colorectal cancer.

Safety data of adverse reactions from clinical studies demonstrate very commonly observed NCI Grade 3 or 4 possibly or probably-related adverse events in the blood and the lymphatic system disorders, gastrointestinal disorders, and skin and subcutaneous tissue disorders MedDRA System Organ Classes.

The following adverse reactions considered to be possibly or probably related to the administration of irinotecan have been reported from 145 patients treated by irinotecan in combination therapy with 5FU/FA in every 2 weeks schedule at the recommended dose of 180 mg/m<sup>2</sup>.

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**Adverse Reactions Reported with irinotecan in Combination Therapy (180 mg/m<sup>2</sup> every 2 w**

schedule)		
MedDRA System Organ Class	Frequency Category	Preferred Term
Infections and infestations	Common	Infection
Blood and lymphatic system disorders	Very common	Thrombocytopenia
	Very common	Neutropenia
	Very common	Anaemia
	Common	Febrile neutropenia
Metabolism and nutrition disorders	Very common	Decreased appetite
Nervous system disorders	Very common	Cholinergic syndrome
Gastrointestinal disorders	Very common	Diarrhoea
	Very common	Vomiting
	Very common	Nausea
	Common	Abdominal pain
	Common	Constipation
Skin and subcutaneous tissue disorders	Very common	Alopecia (reversible)
General disorders and administration site conditions	Very common	Mucosal inflammation
	Very common	Asthenia
	Common	Pyrexia
Investigations	Very common	Transaminases (SGPT and SC increased
	Very common	Bilirubin increased
	Very common	Blood alkaline phosph increased

### Description of selected adverse reactions (combination therapy)

**Severe diarrhoea** was observed in 13.1 % of patients who follow recommendations for the management of diarrhoea. Of the evaluable cycles, 3.9 % have a severe diarrhoea.

A lower incidence of severe **nausea and vomiting** was observed (2.1 % and 2.8 % of patients respectively).

**Constipation** relative to irinotecan and/or loperamide has been observed in 3.4 % of patients.

**Neutropenia** was observed in 82.5% of patients and was severe (neutrophil count < 500 cells/mm<sup>3</sup>) in 9.8% of patients. Of the evaluable cycles, 67.3% had a neutrophil count below 1,000 cells/mm<sup>3</sup> including 2.7% with a neutrophil count < 500 cells/mm<sup>3</sup>. Total recovery was usually reached within 7-8 days.

**Fever with severe neutropenia** was reported in 3.4% of patients and in 0.9% of cycles.

Infectious episodes occurred in about 2% of patients (0.5% of cycles) and were associated with severe neutropenia in about 2.1% of patients (0.5% of cycles), and resulted in death in 1 case.

**Anaemia** was reported in 97.2% of patients (2.1% with haemoglobin < 8 g/dl).

**Thrombocytopenia** (< 100,000 cells/mm<sup>3</sup>) was observed in 32.6% of patients and 21.8% of cycles. No severe thrombocytopenia (< 50,000 cells/mm<sup>3</sup>) has been observed.

#### **Acute cholinergic syndrome**

Severe transient acute cholinergic syndrome was observed in 1.4 % of patients treated in combination therapy.

**Asthenia** was severe in 6.2 % of patients treated in combination therapy. The causal relationship to irinotecan has not been clearly established. Fever in the absence of infection and without concomitant severe neutropenia, occurred in 6.2 % of patients treated in combination therapy.

#### **Laboratory tests**

Transient serum levels (grades 1 and 2) of either SGPT, SGOT, alkaline phosphatase or bilirubin were observed in 15%, 11%, 11% and 10% of the patients, respectively, in the absence of progressive liver metastasis. Transient grade 3 were observed in 0%, 0%, 0% and 1% of the patients, respectively. No grade 4 was observed.

Increases of amylase and/or lipase have been very rarely reported.

Rare cases of hypokalemia and hyponatremia mostly related with diarrhea and vomiting have been reported.

### **OTHER ADVERSE EVENTS REPORTED IN CLINICAL STUDIES WITH THE WEEKLY REGIMEN FOR IRINOTECAN**

The following additional drug-related events have been reported in clinical studies with irinotecan: pain, sepsis, rectal disorder, GI monilia, hypomagnesemia, rash, cutaneous signs, abnormal gait, confusion, headache, syncope, flushing, bradycardia, urinary tract infection, breast pain, increased GGTP, extravasation, and tumour lysis syndrome, cardiovascular disorders (angina pectoris, heart arrest, myocardial infarction, myocardial ischaemia, peripheral vascular disorder, vascular disorder), and thromboembolic events (arterial thrombosis, cerebral infarction, cerebrovascular accident, deep thrombophlebitis, embolus of the lower extremity, pulmonary embolus, thrombophlebitis, thrombosis, and sudden death). (See section 4.4.)

#### **POST-MARKETING SURVEILLANCE**

Frequencies from post-marketing surveillance are not known (cannot be estimated from available data).

MedDRA System Organ Class	Preferred Term
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Infections and infestations	<ul style="list-style-type: none"> <li>• Pseudomembranous colitis one of which has been documented bacteriologically (<i>Clostridium difficile</i>)</li> <li>• Sepsis</li> <li>• Fungal infections <sup>a</sup></li> <li>• Viral infections <sup>b</sup></li> </ul>
Blood and lymphatic system disorders	<ul style="list-style-type: none"> <li>• Peripheral thrombocytopenia with antiplatelet antibodies</li> </ul>
Metabolism and nutrition disorders	<ul style="list-style-type: none"> <li>• Dehydration (due to diarrhoea and vomiting)</li> <li>• Hypovolaemia</li> </ul>
Immune system disorders	<ul style="list-style-type: none"> <li>• Hypersensitivity reaction</li> <li>• Anaphylactic reaction</li> </ul>
Nervous system disorders	<ul style="list-style-type: none"> <li>• Speech disorders generally transient in nature, in some cases, the disorder was attributed to the cholinergic syndrome observed during or shortly after infusion of irinotecan</li> <li>• Paraesthesia</li> </ul>
Cardiac disorders	<ul style="list-style-type: none"> <li>• Hypertension (during or after infusion)</li> <li>• Cardio circulatory failure*</li> </ul>
Respiratory, thoracic and mediastinal disorders	<ul style="list-style-type: none"> <li>• Interstitial pulmonary disease presenting as pulmonary infiltrates is uncommon during irinotecan therapy; Early effects such as dyspnoea have been reported (See section 4.4).</li> <li>• Dyspnoea (see section 4.4)</li> <li>• Hiccups</li> </ul>
Gastrointestinal disorders	<ul style="list-style-type: none"> <li>• Intestinal obstruction</li> <li>• Ileus: cases of ileus without preceding colitis have also been reported</li> <li>• Megacolon</li> <li>• Gastrointestinal haemorrhage</li> <li>• Colitis; In some cases, colitis was complicated by ulceration, bleeding, ileus, or infection.</li> <li>• Typhlitis</li> <li>• Ischemic colitis</li> <li>• Ulcerative colitis</li> <li>• Gastrointestinal bleeding</li> <li>• Symptomatic or asymptomatic elevated pancreatic enzymes</li> <li>• Intestinal perforation</li> </ul>
Hepatobiliary disorders	<ul style="list-style-type: none"> <li>• Hepatic steatosis</li> <li>• Steatohepatitis</li> </ul>
Skin and subcutaneous tissue disorders	<ul style="list-style-type: none"> <li>• Skin reactions</li> </ul>
General disorders and administration site conditions	<ul style="list-style-type: none"> <li>• Infusion site reactions</li> </ul>
Investigations	<ul style="list-style-type: none"> <li>• Blood amylase increased</li> <li>• Lipase increased</li> <li>• Hypokalaemia</li> <li>• Hyponatraemia mostly related with diarrhoea and vomiting</li> <li>• Increases in serum levels of transaminases (i.e., AST and ALT) in some cases</li> </ul>

	absence of progressive liver metastasis have been very rarely reported
Musculoskeletal and connective tissue disorders	• Muscular contraction or cramps
Renal and urinary disorders	• Renal impairment and acute renal failure generally in patients become infected and/or volume depleted from severe gastrointestinal toxicities.* • Renal insufficiency*
Vascular Disorders	• Hypotension*

\* Infrequent cases of renal insufficiency, hypotension or cardio circulatory failure have been observed in patients who experienced episodes of dehydration associated with diarrhoea and/or vomiting, or sepsis.

a. e.g. Pneumocystis jirovecii pneumonia, bronchopulmonary aspergillosis, systemic candida.

b. e.g. Herpes zoster, influenza, hepatitis B reactivation, cytomegalovirus colitis.

#### 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 national reporting system listed in Appendix V\*

#### **4.9 Overdose**

There have been reports of overdosage at doses up to approximately twice the recommended therapeutic dose, which may be fatal. The most significant adverse reactions were severe neutropenia and severe diarrhoea. There is no known antidote for Irinotecan. Maximum supportive care should be instituted to prevent dehydration due to diarrhoea and to treat any infectious complications.

## **5 PHARMACOLOGICAL PROPERTIES**

### **5.1 Pharmacodynamic properties**

Pharmacotherapeutic group: 16.1.4 – Antineoplastic and immunomodulating agents; Cytotoxics; Topoisomerase I inhibitor.  
ATC code: L01XX19

#### **Experimental data:**

Irinotecan is a semi-synthetic derivative of camptothecin. It is an antineoplastic agent which acts as a specific inhibitor of DNA topoisomerase I. It is metabolized by carboxylesterase in most tissues to SN-38, which was found to be more active than irinotecan in purified topoisomerase I and more cytotoxic than irinotecan against several murine and human tumour cell lines. The inhibition of DNA topoisomerase I by irinotecan or SN-38 induces single-strand DNA lesions which blocks the DNA

replication fork and are responsible for the cytotoxicity. This cytotoxic activity was found time-dependent and was specific to the S phase.

*In vitro*, irinotecan and SN-38 were not found to be significantly recognised by the P-glycoprotein MDR, and displays cytotoxic activities against doxorubicin and vinblastine resistant cell lines.

Furthermore, irinotecan has a broad antitumor activity against murine tumour models (P03 pancreatic ductal adenocarcinoma, MAI6/C mammary adenocarcinoma, C38 and C51 colon adenocarcinomas) and against human xenografts (Co-4 colon adenocarcinoma, Mx-1 mammary adenocarcinoma, ST-15 and SC-16 gastric adenocarcinomas). Irinotecan is also active against tumours expressing the P-glycoprotein MDR (vincristine- and doxorubicin-resistant P388 leukaemia), Beside the antitumor activity of irinotecan, the most relevant pharmacological effect of irinotecan is the inhibition of acetyl cholinesterase.

### Clinical data:

#### **In combination therapy for the first-line treatment of metastatic colorectal carcinoma**

##### **In combination therapy with Folinic Acid and 5-Fluorouracil**

A phase III study was performed in 385 previously untreated metastatic colorectal cancer patients treated with either every 2 weeks schedule (see 4.2 section) or weekly schedule regimens. In the every 2 weeks schedule, on day 1, the administration of irinotecan at 180 mg/m<sup>2</sup>, once every 2 weeks is, followed by infusion with folinic acid (200 mg/m<sup>2</sup> over a 2-hour intravenous infusion) and 5-fluorouracil (400 mg/m<sup>2</sup> as an intravenous bolus, followed by 600 mg/m<sup>2</sup>, over a 22-hour intravenous infusion). On day 2, folinic acid and 5-fluorouracil are administered at the same doses and schedules.

In the weekly schedule, the administration of Irinotecan at 80 mg/m<sup>2</sup> is followed by infusion with folinic acid (500 mg/m<sup>2</sup> over a 2-hour intravenous infusion) and then by 5-fluorouracil (2300 mg/m<sup>2</sup> over a 24-hour intravenous infusion) over 6 weeks.

In the combination therapy trial with the 2 regimens described above, the efficacy of irinotecan was evaluated in 198 treated patients:

	Combined regimens (n=198)		Weekly schedule (n=50)		Every 2 weeks schedule (n=148)	
	Irinotecan +5FU/FA	5FU/FA	Irinotecan +5FU/FA	5FU/FA	Irinotecan +5FU/FA	5FU/FA
Response rate (%)	40.8 *	23.1 *	51.2 *	28.6 *	37.5 *	21.6 *
p value	p<0.001		p=0.045		p=0.005	
Median time to progression (months)	6,7	4,4	7,2	6,5	6,5	3,7
p value	p<0.001		NS		p=0.001	
Median	9.3	8.8	8.9	6.7	9.3	9.5

duration of response (months)						
p value	NS		p=0.043		NS	
Median duration of response and stabilization (months)	8.6	6.2	8.3	6.7	8.5	5.6
p value	p<0.001		NS		p=0.003	
Median time to treatment failure (months)	5.3	3.8	5.4	5.0	5.1	3.0
p value	p=0.0014		NS		p<0.001	
Median survival (months)	16.8	14.0	19.2	14.1	15.6	13.0
p value	p=0.028		NS		p=0.041	

5FU: 5-fluorouracil

FA: folinic acid

NS: not significant

\*: as per population analysis protocol

In the weekly schedule, the incidence of severe diarrhoea was 44.4% in patients treated with Irinotecan Hikma in combination with 5FU/FA and 25.6% in patients treated with 5FU/FA alone. The incidence of severe neutropenia (neutrophil count < 500 cells/mm<sup>3</sup>) was 5.8% in patients treated with Irinotecan Hikma in combination with 5FU/FA and in 2.4% in patients treated with 5FU/FA alone.

Additionally, median time to definitive performance status deterioration was significantly longer in irinotecan combination group than in 5FU/FA alone group (p=0.046).

Quality of life was assessed in this phase III study using the EORTC QLQ-C30 questionnaire. Time to definitive deterioration constantly occurred later in the irinotecan groups. The evolution of the Global Health Status/Quality of life was slightly better in irinotecan combination group although not significant showing that efficacy of irinotecan in combination could be reached without affecting the quality of life.

#### In combination therapy with bevacizumab:

A phase III randomised, double-blind, active-controlled clinical trial evaluated bevacizumab in combination with irinotecan/5FU/FA as first-line treatment for metastatic carcinoma of the colon or rectum (Study AVF2107g). The addition of bevacizumab to the combination of irinotecan /5FU/FA resulted in a statistically significant increase in overall survival. The clinical benefit, as measured by overall survival, was seen in all pre-specified patient subgroups, including those defined by age, sex, performance status, location of primary tumour, number of organs involved, and duration of metastatic disease. Refer also to the bevacizumab summary of product

characteristics. The efficacy results of Study AVF2107g are summarized in the table below.

	AVF2107g	
	Arm 1 Irinotecan/5FU/FA + Placebo	Arm 2 Irinotecan/5FU/FA + bevacizumab <sup>a</sup>
Number of patients	411	402
Overall survival		
Median time (months)	15.6	20,3
95 % Confidence interval	14.29 – 16.99	18,46 – 24.18
<i>Hazard ratio</i> <sup>b</sup>		0.660
p-value		0.00004
Progression-free survival		
Median time (months)	6.2	10.6
<i>Hazard ratio</i>		0.54
p-value		< 0,0001
Overall response rate		
Rate (%)	34.8	44.8
95 % Confidence interval	30.2 – 39.6	39.9 – 49,8
p-value		0.0036
Duration of response		
Median time (months)	7.1	10.4
25–75 percentile (months)	4.7 – 11.8	6.7 – 15.0

<sup>a</sup> 5 mg/kg, every 2 weeks

<sup>b</sup> relative to control arm

In combination therapy with cetuximab:

EMR 62 202-013: This randomised study in patients with metastatic colorectal cancer who had not received prior treatment for metastatic disease compared the combination of cetuximab and irinotecan plus infusional 5-fluorouracil/folinic acid (5-FU/FA) (599 patients) to the same chemotherapy alone (599 patients). The proportion of patients with KRAS wild-type tumours from the patient population evaluable for KRAS status comprised 64%.

The efficacy data generated in this study are summarised in the table below:

Variable/statistic	Overall population		KRAS wild-type population	
	Cetuximab plus FOLFIRI (N=599)	FOLFIRI (N=599)	Cetuximab plus FOLFIRI (N=172)	FOLFIRI (N=176)
<b>ORR</b>				
% (95%CI)	46.9 (42.9, 51.0)	38.7 (34.8, 42.8)	59.3 (51.6, 66.7)	43.2 (35.8, 50.9)
p-value	0.0038		0.0025	
<b>PFS</b>				
Hazard Ratio (95% CI)	0.85 (0.726, 0.998)		0.68 (0.501, 0.934)	

p-value	0.0479	0.0167
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CI = confidence interval, FOLFIRI = irinotecan plus infusional 5-FU/FA, ORR = objective response rate (patients with complete response or partial response), PFS = progression-free survival time

In combination therapy with capecitabine

Data from a randomised, controlled phase III study (CAIRO) support the use of capecitabine at a starting dose of 1000 mg/m<sup>2</sup> for 2 weeks every 3 weeks in combination with irinotecan for the first-line treatment of patients with metastatic colorectal cancer. 820 Patients were randomized to receive either sequential treatment (n=410) or combination treatment (n=410). Sequential treatment consisted of first-line treatment with capecitabine (1250 mg/m<sup>2</sup> twice daily for 14 days), second-line irinotecan (350 mg/m<sup>2</sup> on day 1), and third-line combination of capecitabine (1000 mg/m<sup>2</sup> twice daily for 14 days) with oxaliplatin (130 mg/m<sup>2</sup> on day 1). Combination treatment consisted of first-line treatment of capecitabine (1000 mg/m<sup>2</sup> twice daily for 14 days) combined with irinotecan (250 mg/m<sup>2</sup> on day 1) (XELIRI) and second-line capecitabine (1000 mg/m<sup>2</sup> twice daily for 14 days) plus oxaliplatin (130 mg/m<sup>2</sup> on day 1). All treatment cycles were administered at intervals of 3 weeks. In first-line treatment the median progression-free survival in the intent-to-treat population was 5.8 months (95%CI, 5.1 -6.2 months) for capecitabine monotherapy and 7.8 months (95%CI, 7.0-8.3 months) for XELIRI (p=0.0002).

Data from an interim analysis of a multicentre, randomised, controlled phase II study (AIO KRK 0604) support the use of capecitabine at a starting dose of 800 mg/m<sup>2</sup> for 2 weeks every 3 weeks in combination with irinotecan and bevacizumab for the first-line treatment of patients with metastatic colorectal cancer. 115 patients were randomised to treatment with capecitabine combined with irinotecan (XELIRI) and bevacizumab: capecitabine (800 mg/m<sup>2</sup> twice daily for two weeks followed by a 7-day rest period), irinotecan (200 mg/m<sup>2</sup> as a 30 minute infusion on day 1 every 3 weeks), and bevacizumab (7.5 mg/kg as a 30 to 90 minute infusion on day 1 every 3 weeks); a total of 118 patients were randomised to treatment with capecitabine combined with oxaliplatin plus bevacizumab: capecitabine (1000 mg/m<sup>2</sup> twice daily for two weeks followed by a 7-day rest period), oxaliplatin (130 mg/m<sup>2</sup> as a 2 hour infusion on day 1 every 3 weeks), and bevacizumab (7.5 mg/kg as a 30 to 90 minute infusion on day 1 every 3 weeks). Progression-free survival at 6 months in the intent-to-treat population was 80% (XELIRI plus bevacizumab) versus 74% (XELOX plus bevacizumab). Overall response rate (complete response plus partial response) was 45% (XELOX plus bevacizumab) versus 47% (XELIRI plus bevacizumab).

In monotherapy for the second-line treatment of metastatic colorectal carcinoma:

Clinical phase II/III studies were performed in more than 980 patients, in the every 3week dosage schedule with metastatic colorectal cancer who failed a previous 5-FU regimen. The efficacy of irinotecan was evaluated in 765 patients with documented progression on 5-FU at study entry.

Phase III	
Irinotecan <i>versus</i> supportive care	Irinotecan <i>versus</i> 5FU

	Irinotecan n=183	Supportive care n=90	p values	Irinotecan n=127	5FU n=129	p values
Progression free survival at 6 months (%)	NA	NA		33.5 *	26.7	p=0.03
Survival at 12 months (%)	36.2 *	13,8	p=0.0001	44.8 *	32.4	p=0.0351
Median survival (months)	9.2 *	6.5	p=0.0001	10.8 *	8.5	p=0.0351

NA: Not applicable

\*: Statistically significant

In phase II studies, performed on 455 patients in the every 3-week dosage schedule, the progression free survival at 6 months was 30 % and the median survival was 9 months. The median time to progression was 18 weeks

Additionally, non-comparative phase II studies were performed in 304 patients treated with a weekly schedule regimen, at a dose of 125 mg/m<sup>2</sup> administered as an intravenous infusion over 90 minutes for 4 consecutive weeks, followed by a 2 week rest. In these studies, the median time to progression was 17 weeks and median survival was 10 months. A similar safety profile has been observed in the weekly-dosage schedule in 193 patients at the starting dose of 125 mg/m<sup>2</sup>, compared to the every 3-week-dosage schedule. The median time of onset of the first liquid stool was on day 11.

In combination with cetuximab after failure of irinotecan-including cytotoxic therapy:

The efficacy of the combination of cetuximab with irinotecan was investigated in two clinical studies. A total of 356 patients with EGFR-expressing metastatic colorectal cancer, who had recently failed irinotecan-including cytotoxic therapy and who had a minimum Karnofsky performance status of 60, but the majority of whom had a Karnofsky performance status of ≥ 80 received the combination treatment.

EMR 62 202-007: This randomized study compared the combination of cetuximab and irinotecan (218 patients) with cetuximab monotherapy (111 patients).

IMCL CPO2-9923: This single arm open-label study investigated the combination therapy in 138 patients.

The efficacy data from these studies are summarized in the table below:

Study	N	ORR		DCR		PFS (months)		OS (months)	
		n (%)	95% CI	n (%)	95% CI	Median	95% CI	Median	95% CI
<b>Cetuximab + Irinotecan</b>									
EMR 62 202-007	218	50 (22.9)	17,5; 29.1	121 (55.5)	48.6; 62.2	4,1	2.8; 4.3	8.6	7.6; 9.6
IMCLCP02-9923	138	21 (15.2)	9.7; 22.3	84 (60.9)	52.2; 69.1	2.9	2.6; 4.1	8.4	7.2; 10.3
<b>Cetuximab</b>									
EMR 62 202-007	111	12 (10.8)	5.7; 18.1	36 (32.4)	23.9; 42.0	1.5	1.4; 2.0	6.9	5.6; 9.1

CI = confidence interval, DCR = disease control rate (*patients with complete response, partial response, or, stable disease for at least 6 weeks*), ORR= *objective response rate (patients with complete response or partial response)*, OS = overall survival time, PFS = progression-free survival.

The efficacy of the combination of cetuximab with irinotecan was superior to that of cetuximab monotherapy, in terms of objective response rate (ORR), disease control rate (DCR) and progression-free survival (PFS). In the randomized trial, no effects on overall survival were demonstrated {*hazard ratio 0.91, p=0.48*}.

### **Pharmacokinetic/ Pharmacodynamic data**

The intensity of the major toxicities encountered with irinotecan (e.g., leukoneutropenia and diarrhoea) are related to the exposure (AUC) to the parent drug and metabolite SN-38. Significant correlations were observed between haematological toxicity (decrease in white blood cells and neutrophil at nadir) or diarrhoea intensity and both irinotecan and metabolite SN-38 AUC values in monotherapy.

#### Patients with Reduced UGT1A1 Activity:

Uridine diphosphate-glucuronosyl transferase 1A1 (UGT1A1) is involved in the metabolic deactivation of SN-38, the active metabolite of irinotecan to inactive SN-38 glucuronide (SN-38G). The UGT1A1 gene is highly polymorphic, resulting in variable metabolic capacities among individuals. One specific variation of the UGT1A1 gene includes a polymorphism in the promoter region known as the UGT1A1\*28 variant. This variant and other congenital deficiencies in UGT1A1 expression (such as Crigler-Najjar and Gilbert's syndrome) are associated with reduced activity of this enzyme. Data from a meta analysis indicate that individuals with Crigler-Najjar syndrome (types 1 and 2) or those who are homozygous for the UGT1A1\*28 allele (Gilbert's syndrome) are at increased risk of haematological toxicity (grades 3 and 4) following administration of irinotecan at moderate or high doses (>150 mg/m<sup>2</sup>). A relationship between UGT1A1 genotype and the occurrence of irinotecan induced diarrhea was not established.

Patients known to be homozygous for UGT1A1\*28 should be administered the normally indicated irinotecan starting dose. However, these patients should be monitored for haematologic toxicities. A reduced irinotecan starting dose should be considered for patients who have experienced prior haematologic toxicity with previous treatment. The exact reduction in starting dose in this patient population has not been established and any subsequent dose modifications should be based on a patient's tolerance of the treatment (see sections 4.2 and 4.4). There is at present insufficient data to conclude on clinical utility of UGT1A1 genotyping.

## **5.2 Pharmacokinetic properties**

In a phase I study in 60 patients with a dosage regimen consisting of a 30-minute intravenous infusion of 100 to 750 mg/m<sup>2</sup> every three weeks, irinotecan showed a biphasic or triphasic elimination profile. The mean plasma clearance was 15 L/h/m<sup>2</sup> and the volume of distribution at steady state (V<sub>ss</sub>): 157 L/m<sup>2</sup>. The mean plasma half-life of the first phase of the triphasic model was 12 minutes, of the second phase 2.5 hours, and the terminal phase half-life was 14.2 hours. SN-38 showed a biphasic elimination profile with a mean terminal elimination half-life of 13.8 hours. At the end of the infusion, at the recommended dose of 350 mg/m<sup>2</sup>, the mean peak plasma

concentrations of irinotecan and SN-38 were 7.7 µg/ml and 56 ng/ml, respectively and the mean area under the curve (AUC) values were 34 µg.h/ml and 451 ng.h/ml, respectively. A large interindividual variability in pharmacokinetic parameters is generally observed for SN-38.

A population pharmacokinetic analysis of irinotecan has been performed in 148 patients with metastatic colorectal cancer, treated with various schedules and at different doses in phase II trials. Pharmacokinetic parameters estimated with a three compartment model were similar to those observed in phase I studies. All studies have shown that irinotecan (CPT-11) and SN-38 exposure increase proportionally with the CPT-11 administered dose; their pharmacokinetics are independent of the number of previous cycles and of the administration schedule.

*In vitro*, plasma protein binding was approximately 65 % for irinotecan and 95% for SN-38.

Mass balance and metabolism studies with 14 C-labelled drug have shown that more than 50% of an intravenously administered dose of irinotecan is excreted as unchanged drug, with 33% in the faeces mainly via the bile and 22% in urine.

Two metabolic pathways account each for at least 12% of the dose:

- hydrolysis by carboxylesterase into active metabolite SN-38. SN-38 is mainly eliminated by glucuronidation, and further by biliary and renal excretion (less than 0.5 % of the irinotecan dose). The SN-38 glucuronite is subsequently probably hydrolysed in the intestine.
- Cytochrome P450 3A -dependent oxidation, resulting in opening of the outer piperidine ring with formation of APC (aminopentanoic acid derivate) and NPC (primary amine derivate) (see section 4.5).

Unchanged irinotecan is the major entity in plasma, followed by APC, SN-38 glucuronide and SN-38. Only SN-38 has significant cytotoxic activity.

Irinotecan clearance is decreased by about 40% in patients with bilirubinemia between 1.5 and 3 times the upper normal limit. In these patients a 200 mg/m<sup>2</sup> irinotecan dose leads to plasma drug exposure comparable to that observed at 350 mg/m<sup>2</sup> in cancer patients with normal liver parameters.

### 5.3 Preclinical safety data

Irinotecan and SN-38 have been shown to be mutagenic *in vitro* in the chromosomal aberration test on CHO-cells as well as in the *in vivo* micronucleus test in mice. However, they have been shown to be devoid of any mutagenic potential in the Ames test.

In rats treated once a week during 13 weeks at the maximum dose of 150 mg/m<sup>2</sup> (which is less than half the human recommended dose), no treatment related tumours were reported 91 weeks after the end of treatment.

Single-and repeated-dose toxicity studies with Irinotecan have been carried out in mice, rats and dogs. The main toxic effects were observed in the hematopoietic and lymphatic systems. In dogs, delayed diarrhoea associated with atrophy and focal necrosis of the intestinal mucosa was reported. Alopecia was also observed in the dog. The severity of these effects was dose-related and was reversible.

#### Reproduction

Irinotecan was teratogenic in rats and rabbits at doses below the human therapeutic dose. In rats, pups born to treated animals with external abnormalities showed a decrease in fertility. This was not seen in morphologically normal pups. In pregnant rats there was a decrease in placental weight and in the offspring a decrease in fetal viability and increase in behavioural abnormalities.

## **6 PHARMACEUTICAL PARTICULARS**

### **6.1 List of excipients**

Sorbitol (E420)

Lactic acid

Sodium hydroxide and/or hydrochloric acid (for pH adjustment to 3.5)

Water for injections

### **6.2 Incompatibilities**

Do not co-administer Irinotecan, except those mentioned in section 6.6 (also see section 4.2).

### **6.3 Shelf life**

3 years.

For single use only.

Irinotecan Hikma should be diluted and used immediately after opening.

After dilution with 5% glucose, physical and chemical stability was demonstrated for 24 hours, when stored between 2-8°C and for 12 hours when stored at 25±2°C, protected from light.

After dilution with 0.9% sodium chloride, physical and chemical stability was demonstrated for 12 hours when stored at  $25\pm 2^{\circ}\text{C}$ , protected from light.

From a microbiologic point of view unless the method of dilution 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 user and would normally not be longer than 24 hours at 2 to 8 °C, unless reconstitution/dilution (etc.) has taken place in controlled and validated aseptic conditions.

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

Store below  $25^{\circ}\text{C}$

Store in the original package in order to protect from light

For storage conditions of the reconstituted and diluted medicinal product, see section 6.3.

#### **6.5 Nature and contents of container**

Amber glass vial, with FluroTec rubber stopper or equivalent and aluminium flip-off cap.

Package size:

Pack with 1 vial of 2 ml

Pack with 1 vial of 5 ml

Pack with 1 vial of 15 ml

Pack with 1 vial of 25 ml

Not all pack sizes may be marketed.

#### **6.6 Special precautions for disposal**

Handling:

As with other antineoplastic/cytotoxic agents, Irinotecan Hikma must be prepared and handled with caution. The use of goggles, mask and gloves is mandatory.

In case of skin contact with the concentrate or diluted solution, wash immediately and thoroughly with soap and water. If Irinotecan Hikma solution or infusion solution come into contact with the mucous membranes, wash immediately with water.

Instructions for dilution:

As with any other injectable drugs, Irinotecan Hikma solution must be prepared aseptically.

If any precipitate is observed in the original vials or after reconstitution, the product should be discarded according to standard procedures for cytotoxic agents

Aseptically withdraw the required amount of Irinotecan Hikma solution from the vial with a calibrated syringe and inject into a 250 ml infusion bag or bottle containing either 0.9 % sodium chloride solution or 5% glucose solution. The infusion should then be thoroughly mixed by manual rotation.

Instructions for protection for dilution:

The preparation should be performed in a defined area for manipulation of the drug (preferably under system of vertical laminar air flow). The working area should be protected by coating with disposable absorbent paper and plastic. Protective clothing should be used: protective goggles, hair cap, gown and gloves and disposable masks.

Open containers such as bottles of the injection and infusion bottles and tubes, syringes, catheters and tubes used, as well as cytotoxic waste, should be considered hazardous waste and be disposed of in accordance with local guidelines for handling of HAZARDOUS waste.

In case of spillage, protective clothing should be used. Broken glass should be collected and placed in hazardous waste containers. The contaminated surfaces should be properly rinsed with abundant amounts of cold water and thoroughly cleaned. The materials used for cleaning should be disposed of as hazardous waste

In case of Irinotecan Hikma come into contact with the skin, the area should be rinsed profusely with running water and then washed with soap and water. In case of contact with mucous membranes, wash thoroughly the affected area contacted with water. If you feel some unease, contact a doctor.

In case of eye contact with Irinotecan Hikma, wash them thoroughly with plenty of water. Contact an ophthalmologist immediately.

Disposal:

All materials used for dilution and administration should be disposed of according to hospital standard procedures applicable to cytotoxic agents.

## **7      MARKETING AUTHORISATION HOLDER**

Hikma Farmacêutica (Portugal), S.A.  
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