

1. NAME OF THE MEDICINAL PRODUCT

Abraxane for Injectable Suspension 100mg

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

Each vial contains 100 mg of paclitaxel formulated as albumin bound nanoparticles.

After reconstitution, each ml of suspension contains 5 mg of paclitaxel formulated as albumin bound nanoparticles.

For the full list of excipients, see section 6.1.

3. PHARMACEUTICAL FORM

Powder for suspension for infusion.

The reconstituted suspension has a pH of 6-7.5 and an osmolality of 300-360 mOsm/kg.

The powder is white to yellow.

4. CLINICAL PARTICULARS

4.1 Therapeutic indications

Abraxane monotherapy is indicated for the treatment of metastatic breast cancer in adult patients who have failed first-line treatment for metastatic disease and for whom standard, anthracycline containing therapy is not indicated (see section 4.4).

Abraxane in combination with gemcitabine is indicated for the first-line treatment of adult patients with metastatic adenocarcinoma of the pancreas.

Abraxane in combination with carboplatin is indicated as first-line treatment of locally advanced or metastatic non-small cell lung cancer, in patients who are not candidates for curative surgery or radiation therapy.

4.2 Posology and method of administration

Abraxane should only be administered under the supervision of a qualified oncologist in units specialised in the administration of cytotoxic agents. It should not be substituted for or with other paclitaxel formulations.

Posology

Breast cancer

The recommended dose of Abraxane is 260 mg/m² administered intravenously over 30 minutes every 3 weeks.

Dose adjustments during treatment of breast cancer

Patients who experience severe neutropenia (neutrophil count < 500 cells/mm³ for a week or longer) or severe sensory neuropathy during Abraxane therapy should have the dose reduced to 220 mg/m² for subsequent courses. Following recurrence of severe neutropenia or severe sensory neuropathy, additional dose reduction should be made to 180 mg/m². Abraxane should not be administered until

neutrophil counts recover to > 1500 cells/mm³. For Grade 3 sensory neuropathy withhold treatment until resolution to Grade 1 or 2, followed by a dose reduction for all subsequent courses.

Pancreatic adenocarcinoma

The recommended dose of Abraxane in combination with gemcitabine is 125 mg/m² administered intravenously over 30 minutes on Days 1, 8 and 15 of each 28-day cycle. The concurrent recommended dose of gemcitabine is 1000 mg/m² administered intravenously over 30 minutes immediately after the completion of Abraxane administration on Days 1, 8 and 15 of each 28-day cycle.

Dose adjustments during treatment of pancreatic adenocarcinoma

Table 1: Dose level reductions for patients with pancreatic adenocarcinoma

Dose Level	Abraxane Dose (mg/m ²)	Gemcitabine Dose (mg/m ²)
Full dose	125	1000
1 st dose level reduction	100	800
2 nd dose level reduction	75	600
If additional dose reduction required	Discontinue treatment	Discontinue treatment

Table 2: Dose modifications for neutropenia and/or thrombocytopenia at the start of a cycle or within a cycle for patients with pancreatic adenocarcinoma

Cycle Day	ANC count (cells/mm ³)		Platelet count (cells/mm ³)	Abraxane Dose	Gemcitabine Dose
Day 1	< 1500	OR	< 100,000	Delay doses until recovery	
Day 8	≥ 500 but < 1000	OR	≥ 50,000 but < 75,000	Reduce doses 1 dose level	
	< 500	OR	< 50,000	Withhold doses	
Day 15: If Day 8 doses were given without modification:					
Day 15	≥ 500 but < 1000	OR	≥ 50,000 but < 75,000	Treat with Day 8 dose level and follow with WBC Growth Factors OR Reduce doses 1 dose level from Day 8 doses	
	< 500	OR	< 50,000	Withhold doses	
Day 15: If Day 8 doses were reduced:					
Day 15	≥ 1000	AND	≥ 75,000	Return to the Day 1 dose levels and follow with WBC Growth Factors OR Treat with same doses as Day 8	
	≥ 500 but < 1000	OR	≥ 50,000 but < 75,000	Treat with Day 8 dose levels and follow with WBC Growth Factors OR Reduce doses 1 dose level from Day 8 doses	
	< 500	OR	< 50,000	Withhold doses	
Day 15: If Day 8 doses were withheld:					
Day 15	≥ 1000	AND	≥ 75,000	Return to Day 1 dose levels and follow with WBC Growth Factors OR Reduce doses 1 dose level from	

				Day 1 doses
	≥ 500 but < 1000	OR	$\geq 50,000$ but $< 75,000$	Reduce 1 dose level and follow with WBC Growth Factors OR Reduce doses 2 dose levels from Day 1 doses
	< 500	OR	$< 50,000$	Withhold doses

Abbreviations: ANC=Absolute Neutrophil Count; WBC=white blood cell

Table 3: Dose modifications for other adverse drug reactions in patients with pancreatic adenocarcinoma

Adverse Drug Reaction (ADR)	Abraxane Dose	Gemcitabine Dose
Febrile Neutropenia: Grade 3 or 4	Withhold doses until fever resolves and ANC ≥ 1500 ; resume at next lower dose level ^a	
Peripheral Neuropathy: Grade 3 or 4	Withhold dose until improves to $\leq$ Grade 1; resume at next lower dose level ^a	Treat with same dose
Cutaneous Toxicity: Grade 2 or 3	Reduce to next lower dose level ^a ; discontinue treatment if ADR persists	
Gastrointestinal Toxicity: Grade 3 mucositis or diarrhoea	Withhold doses until improves to $\leq$ Grade 1; resume at next lower dose level ^a	

^aSee Table 1 for dose level reductions

Non-Small Cell Lung Cancer

The recommended dose of ABRAXANE is 100 mg/m² administered as an intravenous infusion over 30 minutes on Days 1, 8, and 15 of each 21-day cycle. Administer carboplatin on Day 1 of each 21 day cycle immediately after ABRAXANE.

Dose adjustments during treatment of non-small cell lung cancer

Do not administer ABRAXANE on Day 1 of a cycle until absolute neutrophil count (ANC) is at least 1500 cells/mm³ and platelet count is at least 100,000 cells/mm³.

In patients who develop severe neutropenia or thrombocytopenia withhold treatment until counts recover to an absolute neutrophil count of at least 1500 cells/mm³ and platelet count of at least 100,000 cells/mm³ on Day 1 or to an absolute neutrophil count of at least 500 cells/mm³ and platelet count of at least 50,000 cells/mm³ on Days 8 or 15 of the cycle. Upon resumption of dosing, permanently reduce ABRAXANE and carboplatin doses as outlined in Table 4.

Withhold ABRAXANE for Grade 3-4 peripheral neuropathy. Resume ABRAXANE and carboplatin at reduced doses (see Table 4) when peripheral neuropathy improves to Grade 1 or completely resolves.

Table 4: Permanent Dose Reductions for Hematologic and Neurologic Adverse Drug Reactions in NSCLC

Adverse Drug Reaction	Occurrence	Weekly ABRAXANE Dose (mg/m ²)	Every 3-Week Carboplatin Dose (AUC mg•min/mL)
Neutropenic Fever (ANC less than 500/mm ³ with fever $>38^{\circ}\text{C}$)	First	75	4.5

OR Delay of next cycle by more than 7 days for ANC less than 1500/mm ³ OR ANC less than 500/mm ³ for more than 7 days	Second	50	3
	Third	Discontinue Treatment	
Platelet count less than 50,000/mm ³	First	75	4.5
	Second	Discontinue Treatment	
Severe sensory Neuropathy – Grade 3 or 4	First	75	4.5
	Second	50	3
	Third	Discontinue Treatment	

Special populations

Hepatic impairment

For patients with mild hepatic impairment (total bilirubin > 1 to ≤ 1.5 x ULN and aspartate aminotransferase [AST] ≤ 10 x ULN), no dose adjustments are required, regardless of indication. Treat with same doses as patients with normal hepatic function.

For metastatic breast cancer patients and non small cell lung cancer patients with moderate to severe hepatic impairment (total bilirubin > 1.5 to ≤ 5 x ULN and AST ≤ 10 x ULN), a 20% reduction in dose is recommended. The reduced dose may be escalated to the dose for patients with normal hepatic function if the patient is tolerating the treatment for at least two cycles (see sections 4.4 and 5.2).

For patients with metastatic adenocarcinoma of the pancreas have moderate to severe hepatic impairment, there are insufficient data to permit dosage recommendations (see sections 4.4 and 5.2).

For patients with total bilirubin > 5 x ULN or AST > 10 x ULN, there are insufficient data to permit dosage recommendations regardless of indication (see sections 4.4 and 5.2).

Renal impairment

Adjustment of the starting Abraxane dose is not required for patients with mild to moderate renal impairment (estimated creatinine clearance ≥ 30 to < 90 ml/min). There are insufficient data available to recommend dose modifications of Abraxane in patients with severe renal impairment or end stage renal disease (estimated creatinine clearance < 30 ml/min) (see section 5.2).

Elderly

No additional dosage reductions, other than those for all patients, are recommended for patients 65 years and older.

Of the 229 patients in the randomized study who received Abraxane monotherapy for breast cancer, 13% were at least 65 years of age and $< 2\%$ were 75 years or older. No toxicities occurred notably more frequently among patients at least 65 years of age who received Abraxane. However, a subsequent analysis in 981 patients receiving Abraxane monotherapy for metastatic breast cancer, of which 15% were ≥ 65 years old and 2% were ≥ 75 years old, showed a higher incidence of epistaxis, diarrhoea, dehydration, fatigue and peripheral oedema in patients ≥ 65 years.

Of the 421 patients with pancreatic adenocarcinoma in the randomized study who received Abraxane in combination with gemcitabine, 41% were 65 years and older and 10% were 75 years and older. In patients aged 75 years and older who received Abraxane and gemcitabine, there was a higher incidence of serious adverse reactions and adverse reactions that led to treatment discontinuation (see section 4.4). Patients with pancreatic adenocarcinoma aged 75 years and older should be carefully assessed before treatment is considered (see section 4.4).

Of the 514 patients in the randomized study who received ABRAXANE and carboplatin for the first-line treatment of non-small cell lung cancer, 31% were 65 years or older and 3.5% were 75 years or older. Myelosuppression, peripheral neuropathy, and arthralgia were more frequent in patients 65

years or older compared to patients younger than 65 years old. No overall difference in effectiveness, as measured by response rates, was observed between patients 65 years or older compared to patients younger than 65 years old.

Pharmacokinetic/pharmacodynamic modelling using data from 125 patients with advanced solid tumours indicates that patients ≥ 65 years of age may be more susceptible to development of neutropenia within the first treatment cycle.

Paediatric population

The safety and efficacy of Abraxane in children and adolescents aged 0 to less than 18 years has not been established. Currently available data are described in sections 4.8, 5.1 and 5.2 but no recommendation on a posology can be made. There is no relevant use of Abraxane in the paediatric population for the indication of metastatic breast cancer, pancreatic adenocarcinoma or non-small cell lung cancer.

Method of administration

Administer reconstituted Abraxane suspension intravenously using an infusion set incorporating a 15 μm filter. Following administration, it is recommended that the intravenous line be flushed with sodium chloride 9 mg/ml (0.9%) solution for injection to ensure administration of the complete dose.

For instructions on reconstitution of the medicinal product before administration, see section 6.5.

4.3 Contraindications

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

Lactation (see section 4.6).

Patients who have baseline neutrophil counts < 1500 cells/ mm^3 .

4.4 Special warnings and precautions for use

Abraxane is an albumin-bound nanoparticle formulation of paclitaxel, which may have substantially different pharmacological properties compared to other formulations of paclitaxel (see sections 5.1 and 5.2). It should not be substituted for or with other paclitaxel formulations.

Hypersensitivity

Rare occurrences of severe hypersensitivity reactions, including very rare events of anaphylactic reactions with fatal outcome, have been reported. If a hypersensitivity reaction occurs, the medicinal product should be discontinued immediately, symptomatic treatment should be initiated, and the patient should not be rechallenged with paclitaxel.

Haematology

Bone marrow suppression (primarily neutropenia) occurs frequently with Abraxane. Neutropenia is dose-dependent and a dose-limiting toxicity. Frequent monitoring of blood cell counts should be performed during Abraxane therapy. Patients with breast cancer or pancreatic adenocarcinoma should not be retreated with subsequent cycles of Abraxane until neutrophils recover to > 1500 cells/ mm^3 and platelets recover to $> 100,000$ cells/ mm^3 (see section 4.2).

In patients with NSCLC, resume treatment if recommended (see Table 4) at permanently reduced doses for both weekly ABRAXANE and every-3-week carboplatin after ANC recovers to at least 1500 cells/ mm^3 and platelet count of at least 100,000 cells/ mm^3 on Day 1 or to an ANC of at least 500 cells/ mm^3 and platelet count of at least 50,000 cells/ mm^3 on Days 8 or 15 of the cycle.

Neuropathy

Sensory neuropathy occurs frequently with Abraxane, although development of severe symptoms is less common. The occurrence of Grade 1 or 2 sensory neuropathy does not generally require dose reduction.

When Abraxane is used as monotherapy in breast cancer, if Grade 3 sensory neuropathy develops, treatment should be withheld until resolution to Grade 1 or 2 followed by a dose reduction for all subsequent courses of Abraxane is recommended (see section 4.2).

For combination use of Abraxane and gemcitabine in pancreatic adenocarcinoma, if Grade 3 or higher peripheral neuropathy develops, withhold Abraxane; continue treatment with gemcitabine at the same dose. Resume Abraxane at reduced dose when peripheral neuropathy improves to Grade 0 or 1 (see section 4.2).

For combination use of Abraxane and carboplatin in non-small cell lung cancer, withhold Abraxane for Grade 3 – 4 peripheral neuropathy. Resume Abraxane and carboplatin at reduced doses when peripheral neuropathy improves to Grade 1 or completely resolves (see section 4.2).

Sepsis

Sepsis was reported at a rate of 5% in patients with or without neutropenia who received Abraxane in combination with gemcitabine. Complications due to the underlying pancreatic cancer, especially biliary obstruction or presence of biliary stent, were identified as significant contributing factors. If a patient becomes febrile (regardless of neutrophil count), initiate treatment with broad spectrum antibiotics. For febrile neutropenia, withhold Abraxane and gemcitabine until fever resolves and ANC ≥ 1500 cells/mm³, then resume treatment at reduced dose levels (see section 4.2).

Pneumonitis

Pneumonitis occurred in 1% of patients when Abraxane was used as monotherapy and in 4% of patients when Abraxane was used in combination with gemcitabine. Closely monitor all patients for signs and symptoms of pneumonitis. After ruling out infectious etiology and upon making a diagnosis of pneumonitis, permanently discontinue treatment with Abraxane and gemcitabine and promptly initiate appropriate treatment and supportive measures (see section 4.2).

Hepatic impairment

Because the toxicity of paclitaxel can be increased with hepatic impairment, administration of Abraxane in patients with hepatic impairment should be performed with caution. Patients with hepatic impairment may be at increased risk of toxicity, particularly from myelosuppression; such patients should be closely monitored for development of profound myelosuppression.

Abraxane is not recommended in patients that have total bilirubin $> 5 \times \text{ULN}$ or AST $> 10 \times \text{ULN}$. In addition, Abraxane is not recommended in patients with metastatic adenocarcinoma of the pancreas that have moderate to severe hepatic impairment (total bilirubin $> 1.5 \times \text{ULN}$ and AST $\leq 10 \times \text{ULN}$) (see section 5.2).

Cardiotoxicity

Rare reports of congestive heart failure and left ventricular dysfunction have been observed among individuals receiving Abraxane. Most of the individuals were previously exposed to cardiotoxic medicinal products such as anthracyclines, or had underlying cardiac history. Thus, patients receiving Abraxane should be vigilantly monitored by physicians for the occurrence of cardiac events.

CNS metastases

The effectiveness and safety of Abraxane in patients with central nervous system (CNS) metastases has not been established. CNS metastases are generally not well controlled by systemic chemotherapy.

Gastrointestinal symptoms

If patients experience nausea, vomiting and diarrhoea following the administration of Abraxane, they may be treated with commonly used anti-emetics and constipating agents.

Eye disorders

Cystoid macular oedema (CMO) has been reported in patients treated with Abraxane. Patients with impaired vision should undergo a prompt and complete ophthalmologic examination. In case CMO is diagnosed, Abraxane treatment should be discontinued and appropriate treatment initiated (see section 4.8).

Patients 75 years and older

For patients of 75 years and older, no benefit for the combination treatment of Abraxane and gemcitabine in comparison to gemcitabine monotherapy has been demonstrated. In the very elderly (≥ 75 years) who received Abraxane and gemcitabine, there was a higher incidence of serious adverse reactions and adverse reactions that led to treatment discontinuation including haematologic toxicities, peripheral neuropathy, decreased appetite and dehydration. Patients with pancreatic adenocarcinoma aged 75 years and older should be carefully assessed for their ability to tolerate Abraxane in combination with gemcitabine with special consideration to performance status, co-morbidities and increased risk of infections (see section 4.2 and 4.8)

Other

Although limited data is available, no clear benefit in terms of prolonged overall survival has been demonstrated in pancreatic adenocarcinoma patients with normal CA 19-9 levels prior to start of treatment with Abraxane and gemcitabine (see section 5.1).

Erlotinib should not be coadministered with Abraxane plus gemcitabine (see section 4.5).

Excipients

This medicine contains less than 1 mmol sodium (23 mg) per 100 mg, that is to say essentially 'sodium free'.

4.5 Interactions with other medicinal products and other forms of interaction

The metabolism of paclitaxel is catalysed, in part, by cytochrome P450 isoenzymes CYP2C8 and CYP3A4 (see section 5.2). Therefore, in the absence of a PK drug-drug interaction study, caution should be exercised when administering paclitaxel concomitantly with medicines known to inhibit either CYP2C8 or CYP3A4 (e.g. ketoconazole and other imidazole antifungals, erythromycin, fluoxetine, gemfibrozil, clopidogrel, cimetidine, ritonavir, saquinavir, indinavir, and nelfinavir) because toxicity of paclitaxel may be increased due to higher paclitaxel exposure. Administering paclitaxel concomitantly with medicines known to induce either CYP2C8 or CYP3A4 (e.g. rifampicin, carbamazepine, phenytoin, efavirenz, nevirapine) is not recommended because efficacy may be compromised because of lower paclitaxel exposures.

Paclitaxel and gemcitabine do not share a common metabolic pathway. Paclitaxel clearance is primarily determined by CYP2C8 and CYP3A4 mediated metabolism followed by biliary excretion, while gemcitabine is inactivated by cytidine deaminase followed by urinary excretion. Pharmacokinetic interactions between Abraxane and gemcitabine have not been evaluated in humans.

Abraxane is indicated as mono-therapy for breast cancer, in combination with gemcitabine for pancreatic adenocarcinoma, or in combination with carboplatin for non-small cell lung cancer (see section 4.1). Abraxane should not be used in combination with other anticancer agents.

Paediatric population

Interaction studies have only been performed in adults.

4.6 Fertility, pregnancy and lactation

Contraception in males and females

Women of childbearing potential should use effective contraception during treatment and for at least six months after the last dose of Abraxane. Male patients with female partners of reproductive potential are advised to use effective contraception and to avoid fathering a child during treatment with Abraxane and for at least three months after the last dose of Abraxane.

Pregnancy

There are very limited data on the use of paclitaxel in human pregnancy. Paclitaxel is suspected to cause serious birth defects when administered during pregnancy. Studies in animals have shown reproductive toxicity (see section 5.3). Women of childbearing potential should have a pregnancy test prior to starting treatment with Abraxane. Abraxane should not be used in pregnancy, and in women of childbearing potential not using effective contraception, unless the clinical condition of the mother requires treatment with paclitaxel.

Breast-feeding

Paclitaxel and/or its metabolites were excreted into the milk of lactating rats (see section 5.3). It is not known if paclitaxel is excreted in human milk. Because of potential serious adverse reactions in breast-feeding infants, Abraxane is contraindicated during lactation. Breast-feeding must be discontinued for the duration of therapy.

Fertility

Abraxane induced infertility in male rats (see section 5.3). Based on findings in animals, male and female fertility may be compromised. Male patients should seek advice on conservation of sperm prior to treatment because of the possibility of irreversible infertility due to therapy with Abraxane.

4.7 Effects on ability to drive and use machines

Abraxane has minor or moderate influence on the ability to drive and use machines. Abraxane may cause adverse reactions such as tiredness (very common) and dizziness (common) that may affect the ability to drive and use machinery. Patients should be advised not to drive and use machines if they feel tired or dizzy.

4.8 Undesirable effects

Summary of the safety profile

The most common clinically significant adverse reactions associated with the use of Abraxane have been neutropenia, peripheral neuropathy, arthralgia/myalgia and gastrointestinal disorders.

Tabulated list of adverse reactions

Table 5 lists adverse reactions associated with Abraxane monotherapy at any dose in any indication (N = 789), Abraxane in combination with gemcitabine for pancreatic adenocarcinoma from the phase III clinical trial (N = 421), Abraxane in combination with carboplatin for non-small cell lung cancer from the phase III clinical trial (N = 514) and from post-marketing use.

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 $< 1/1,000$), very rare ($< 1/10,000$), not known (cannot be estimated from the available data). Within each frequency grouping, adverse reactions are presented in order of decreasing seriousness.

Table 5: Adverse reactions reported with Abraxane

	Monotherapy (N=789)	Combination therapy with gemcitabine (N =421)	Combination therapy with carboplatin (N = 514)
Infections and infestations			
<i>Common:</i>	Infection, urinary tract infection, folliculitis, upper respiratory tract infection, candidiasis, sinusitis	Sepsis, pneumonia, oral candidiasis	Pneumonia, bronchitis, upper respiratory tract infection, urinary tract infection

	Monotherapy (N=789)	Combination therapy with gemcitabine (N =421)	Combination therapy with carboplatin (N = 514)
<i>Uncommon:</i>	Sepsis ¹ , neutropenic sepsis ¹ , pneumonia, oral candidiasis, nasopharyngitis, cellulitis, herpes simplex, viral infection, herpes zoster, fungal infection, catheter-related infection, injection site infection		Sepsis, oral candidiasis
Neoplasms benign, malignant and unspecified (including cysts and polyps)			
<i>Uncommon:</i>	Tumour necrosis, metastatic pain		
Blood and lymphatic system disorders			
<i>Very common:</i>	Bone marrow suppression, neutropenia, thrombocytopenia, anaemia, leukopenia, lymphopenia	Neutropenia, thrombocytopenia, anaemia	Neutropenia ³ , thrombocytopenia ³ , anaemia ³ , leukopenia ³
<i>Common:</i>	Febrile neutropenia	Pancytopenia	Febrile neutropenia, lymphopenia
<i>Uncommon:</i>		Thrombotic thrombocytopenic purpura	Pancytopenia
<i>Rare:</i>	Pancytopenia		
Immune system disorders			
<i>Uncommon:</i>	Hypersensitivity		Drug hypersensitivity, hypersensitivity
<i>Rare:</i>	Severe hypersensitivity ¹		
Metabolism and nutrition disorders			
<i>Very common:</i>	Anorexia	Dehydration, decreased appetite, hypokalaemia	Decreased appetite
<i>Common:</i>	Dehydration, decreased appetite, hypokalaemia		Dehydration
<i>Uncommon:</i>	Hypophosphataemia, fluid retention, hypoalbuminaemia, polydipsia, hyperglycaemia, hypocalcaemia, hypoglycaemia, hyponatraemia		
<i>Not known:</i>	Tumour lysis syndrome ¹		
Psychiatric disorders			
<i>Very common:</i>		Depression, insomnia	
<i>Common:</i>	Depression, insomnia, anxiety	Anxiety	Insomnia
<i>Uncommon:</i>	Restlessness		
Nervous system disorders			

	Monotherapy (N=789)	Combination therapy with gemcitabine (N =421)	Combination therapy with carboplatin (N = 514)
<i>Very common:</i>	Peripheral neuropathy, neuropathy, hypoaesthesia, paraesthesia	Peripheral neuropathy, dizziness, headache, dysgeusia	Peripheral neuropathy
<i>Common:</i>	Peripheral sensory neuropathy, dizziness, peripheral motor neuropathy, ataxia, headache, sensory disturbance, somnolence, dysgeusia		Dizziness, headache, dysgeusia
<i>Uncommon:</i>	Polyneuropathy, areflexia, syncope, postural dizziness, dyskinesia, hyporeflexia, neuralgia, neuropathic pain, tremor, sensory loss	VII th nerve paralysis	
<i>Not known:</i>	Cranial nerve palsies multiple ¹		
Eye disorders			
<i>Common:</i>	Vision blurred, lacrimation increased, dry eye, keratoconjunctivitis sicca, madarosis	Lacrimation increased	Vision blurred
<i>Uncommon:</i>	Reduced visual acuity, abnormal vision, eye irritation, eye pain, conjunctivitis, visual disturbance, eye pruritus, keratitis	Cystoid macular oedema	
<i>Rare:</i>	Cystoid macular oedema ¹		
Ear and labyrinth disorders			
<i>Common:</i>	Vertigo		
<i>Uncommon:</i>	Tinnitus, ear pain		
Cardiac disorders			
<i>Common:</i>	Arrhythmia, tachycardia, supraventricular tachycardia	Cardiac failure congestive, tachycardia	
<i>Rare:</i>	Cardiac arrest, cardiac failure congestive, left ventricular dysfunction, atrioventricular block ¹ , bradycardia		
Vascular disorders			
<i>Common:</i>	Hypertension, lymphoedema, flushing, hot flushes	Hypotension, hypertension	Hypotension, hypertension
<i>Uncommon:</i>	Hypotension, orthostatic hypotension, peripheral coldness	Flushing	Flushing
<i>Rare:</i>	Thrombosis		
Respiratory, thoracic and mediastinal disorders			
<i>Very common:</i>		Dyspnoea, epistaxis, cough	Dyspnoea
<i>Common:</i>	Interstitial pneumonitis ² , dyspnoea, epistaxis, pharyngolaryngeal pain, cough, rhinitis, rhinorrhoea	Pneumonitis, nasal congestion	Haemoptysis, epistaxis, cough

	Monotherapy (N=789)	Combination therapy with gemcitabine (N =421)	Combination therapy with carboplatin (N = 514)
<i>Uncommon:</i>	Pulmonary emboli, pulmonary thromboembolism, pleural effusion, exertional dyspnoea, sinus congestion, decreased breath sounds, productive cough, allergic rhinitis, hoarseness, nasal congestion, nasal dryness, wheezing	Dry throat, nasal dryness	Pneumonitis
<i>Not known:</i>	Vocal cord paresis ¹		
Gastrointestinal disorders			
<i>Very common:</i>	Diarrhoea, vomiting, nausea, constipation, stomatitis	Diarrhoea, vomiting, nausea, constipation, abdominal pain, abdominal pain upper	Diarrhoea, vomiting, nausea, constipation
<i>Common:</i>	Gastroesophageal reflux disease, dyspepsia, abdominal pain, abdominal distension, abdominal pain upper, oral hypoesthesia	Intestinal obstruction, colitis, stomatitis, dry mouth	Stomatitis, dyspepsia, dysphagia, abdominal pain
<i>Uncommon:</i>	Rectal haemorrhage, dysphagia, flatulence, glossodynia, dry mouth, gingival pain, loose stools, oesophagitis, abdominal pain lower, mouth ulceration, oral pain		
Hepatobiliary disorders			
<i>Common:</i>		Cholangitis	Hyperbilirubinaemia
<i>Uncommon:</i>	Hepatomegaly		
Skin and subcutaneous tissue disorders			
<i>Very common:</i>	Alopecia, rash	Alopecia, rash	Alopecia, rash
<i>Common:</i>	Pruritus, dry skin, nail disorder, erythema, nail pigmentation/discolouration, skin hyperpigmentation, onycholysis, nail changes	Pruritus, dry skin, nail disorder	Pruritus, nail disorder
<i>Uncommon:</i>	Photosensitivity reaction, urticaria, skin pain, generalised pruritus, pruritic rash, skin disorder, pigmentation disorder, hyperhidrosis, onychomadesis, erythematous rash, generalised rash, dermatitis, night sweats, maculo-papular rash, vitiligo, hypotrichosis, nail bed tenderness, nail discomfort, macular rash, papular rash, skin lesion, swollen face		Skin exfoliation, dermatitis allergic, urticaria
<i>Very rare:</i>	Stevens-Johnson syndrome ¹ , toxic epidermal necrolysis ¹		
<i>Not known:</i>	Palmar-plantar erythrodysesthesia syndrome ^{1, 4} , scleroderma ¹		

	Monotherapy (N=789)	Combination therapy with gemcitabine (N =421)	Combination therapy with carboplatin (N = 514)
Musculoskeletal and connective tissue disorders			
<i>Very common:</i>	Arthralgia, myalgia	Arthralgia, myalgia, pain in extremity	Arthralgia, myalgia
<i>Common:</i>	Back pain, pain in extremity, bone pain, muscle cramps, limb pain	Muscular weakness, bone pain	Back pain, pain in extremity, musculoskeletal pain
<i>Uncommon:</i>	Chest wall pain, muscular weakness, neck pain, groin pain, muscle spasms, musculoskeletal pain, flank pain, limb discomfort, muscle weakness		
Renal and urinary disorders			
<i>Common:</i>		Acute renal failure	
<i>Uncommon:</i>	Haematuria, dysuria, pollakiuria, nocturia, polyuria, urinary incontinence	Haemolytic uraemic syndrome	
Reproductive system and breast disorders			
<i>Uncommon:</i>	Breast pain		
General disorders and administration site conditions			
<i>Very common:</i>	Fatigue, asthenia, pyrexia	Fatigue, asthenia, pyrexia, oedema peripheral, chills	Fatigue, asthenia, oedema peripheral
<i>Common:</i>	Malaise, lethargy, weakness, peripheral oedema, mucosal inflammation, pain, rigors, oedema, decreased performance status, chest pain, influenza-like illness, hyperpyrexia	Infusion site reaction	Pyrexia, chest pain
<i>Uncommon:</i>	Chest discomfort, abnormal gait, swelling, injection site reaction		Mucosal inflammation, infusion site extravasation, infusion site inflammation, infusion site rash
<i>Rare:</i>	Extravasation		
Investigations			
<i>Very common:</i>		Weight decreased, alanine aminotransferase increased	

	Monotherapy (N=789)	Combination therapy with gemcitabine (N =421)	Combination therapy with carboplatin (N = 514)
<i>Common:</i>	Decreased weight, increased alanine aminotransferase, increased aspartate aminotransferase, decreased haematocrit, decreased red blood cell count, increased body temperature, increased gamma-glutamyltransferase, increased blood alkaline phosphatase	Aspartate aminotransferase increased, blood bilirubin increased, blood creatinine increased	Weight decreased, alanine aminotransferase increased, aspartate aminotransferase increased, blood alkaline phosphatase increased
<i>Uncommon:</i>	Increased blood pressure, increased weight, increased blood lactate dehydrogenase, increased blood creatinine, increased blood glucose, increased blood phosphorus, decreased blood potassium, increased bilirubin		
Injury, poisoning and procedural complications			
<i>Uncommon:</i>	Contusion		
<i>Rare:</i>	Radiation recall phenomenon, radiation pneumonitis		

¹ As reported in the post-marketing surveillance of Abraxane.

² The frequency of pneumonitis is calculated based on pooled data in 1310 patients in clinical trials receiving Abraxane monotherapy for breast cancer and for other indications.

³ Based on laboratory assessments: maximal degree of myelosuppression (treated population).

⁴ In some patients previously exposed to capecitabine.

Description of selected adverse reactions

This section contains the most common and clinically relevant adverse reactions related to Abraxane.

Adverse reactions were assessed in 229 patients with metastatic breast cancer who were treated with 260 mg/m² Abraxane once every three weeks in the pivotal phase III clinical study (Abraxane monotherapy).

Adverse reactions were assessed in 421 patients treated with Abraxane in combination with gemcitabine (125 mg/m² Abraxane in combination with gemcitabine at a dose of 1000 mg/m² given on Days 1, 8 and 15 of each 28-day cycle) and 402 gemcitabine monotherapy-treated patients receiving first-line systemic treatment for metastatic adenocarcinoma of the pancreas (Abraxane/gemcitabine).

Adverse reactions were assessed in 514 patients with non-small cell lung cancer who were treated with Abraxane in combination with carboplatin (100mg/m² Abraxane given on Days 1, 8 and 15 of each 21-day cycle in combination with carboplatin given on Day 1 of each cycle) in the phase III randomized, controlled clinical trial (Abraxane/carboplatin). Patient-reported taxane toxicity was assessed using the 4 subscales of the Functional Assessment of Cancer Therapy (FACT)-Taxane questionnaire. Using repeated measure analysis, 3 of the 4 subscales (peripheral neuropathy, pain hands/feet and hearing) favored Abraxane and carboplatin ($p \leq 0.002$). For the other subscale (oedema), there was no difference in the treatment arms.

Infections and infestations

Abraxane/gemcitabine

Sepsis was reported at a rate of 5% in patients with or without neutropenia who received Abraxane in combination with gemcitabine during the conduct of a trial in pancreatic adenocarcinoma.

Complications due to the underlying pancreatic cancer, especially biliary obstruction or presence of biliary stent, were identified as significant contributing factors. If a patient becomes febrile (regardless

of neutrophil count), initiate treatment with broad spectrum antibiotics. For febrile neutropenia, withhold Abraxane and gemcitabine until fever resolves and ANC ≥ 1500 cells/mm³, then resume treatment at reduced dose levels (see section 4.2).

Blood and lymphatic system disorders

Abraxane monotherapy-metastatic breast cancer

In patients with metastatic breast cancer, neutropenia was the most notable important haematological toxicity (reported in 79% of patients), and was rapidly reversible and dose-dependent; leukopenia was reported in 71% of patients. Grade 4 neutropenia (<500 cells/mm³) occurred in 9% of patients treated with Abraxane. Febrile neutropenia occurred in four patients on Abraxane. Anaemia (Hb < 10 g/dl) was observed in 46% of patients on Abraxane, and was severe (Hb < 8 g/dl) in three cases. Lymphopenia was observed in 45% of the patients.

Abraxane/gemcitabine

Table 6 provides the frequency and severity of haematologic laboratory-detected abnormalities for patients treated with Abraxane in combination with gemcitabine or with gemcitabine.

Table 6: Haematologic laboratory-detected abnormalities in pancreatic adenocarcinoma trial

	Abraxane (125 mg/m ²)/ Gemcitabine		Gemcitabine	
	Grades 1-4 (%)	Grade 3-4 (%)	Grades 1-4 (%)	Grade 3-4 (%)
Anaemia ^{a,b}	97	13	96	12
Neutropenia ^{a,b}	73	38	58	27
Thrombocytopenia ^{b,c}	74	13	70	9

^a 405 patients assessed in Abraxane/gemcitabine-treated group

^b 388 patients assessed in gemcitabine-treated group

^c 404 patients assessed in Abraxane/gemcitabine-treated group

Abraxane/carboplatin

Anaemia and thrombocytopenia were more commonly reported in the Abraxane and carboplatin arm than in the Taxol and carboplatin arm (54% versus 28% and 45% versus 27% respectively).

Nervous system disorders

Abraxane monotherapy-metastatic breast cancer

In general, the frequency and severity of neurotoxicity was dose-dependent in patients receiving Abraxane. Peripheral neuropathy (mostly Grade 1 or 2 sensory neuropathy) was observed in 68% of patients on Abraxane with 10% being Grade 3, and no cases of Grade 4.

Abraxane/gemcitabine

For patients treated with Abraxane in combination with gemcitabine, the median time to first occurrence of Grade 3 peripheral neuropathy was 140 days. The median time to improvement by at least 1 grade was 21 days, and the median time to improvement from Grade 3 peripheral neuropathy to Grade 0 or 1 was 29 days. Of the patients with treatment interrupted due to peripheral neuropathy, 44% (31/70 patients) were able to resume Abraxane at a reduced dose. No patients treated with Abraxane in combination with gemcitabine had Grade 4 peripheral neuropathy.

Abraxane/carboplatin

For non-small cell lung cancer patients treated with Abraxane and carboplatin, the median time to first occurrence of Grade 3 treatment-related peripheral neuropathy was 121 days, and the median time to improvement from Grade 3 treatment related peripheral neuropathy to Grade 1 was 38 days. No patients treated with Abraxane and carboplatin experienced Grade 4 peripheral neuropathy.

Eye disorders

There have been rare reports during post-marketing surveillance of reduced visual acuity due to cystoid macular oedema during treatment with Abraxane (see section 4.4).

Respiratory, thoracic and mediastinal disorders

Abraxane/gemcitabine

Pneumonitis has been reported at a rate of 4% with the use of Abraxane in combination with gemcitabine. Of the 17 cases of pneumonitis reported in patients treated with Abraxane in combination with gemcitabine, 2 had a fatal outcome. Monitor patients closely for signs and symptoms of pneumonitis. After ruling out infectious etiology and upon making a diagnosis of pneumonitis, permanently discontinue treatment with Abraxane and gemcitabine and promptly initiate appropriate treatment and supportive measures (see section 4.2).

Gastrointestinal disorders

Abraxane monotherapy-metastatic breast cancer

Nausea occurred in 29% of the patients and diarrhoea in 25% of the patients.

Skin and subcutaneous tissue disorders

Abraxane monotherapy-metastatic breast cancer

Alopecia was observed in >80% of the patients treated with Abraxane. The majority of alopecia events occurred less than one month after initiation of Abraxane. Pronounced hair loss $\geq 50\%$ is expected for the majority of patients who experience alopecia.

Musculoskeletal and connective tissue disorders

Abraxane monotherapy-metastatic breast cancer

Arthralgia occurred in 32% of patients on Abraxane and was severe in 6% of cases. Myalgia occurred in 24% of patients on Abraxane and was severe in 7% of cases. The symptoms were usually transient, typically occurred three days after Abraxane administration and resolved within a week.

General disorders and administration site conditions

Abraxane monotherapy-metastatic breast cancer

Asthenia/Fatigue was reported in 40% of the patients.

Clinical Trials Experience in Non-Small Cell Lung Cancer

Adverse reactions were assessed in 514 ABRAXANE/ carboplatin-treated patients and 524 paclitaxel injection/ carboplatin-treated patients receiving first-line systemic treatment for locally advanced (stage IIIB) or metastatic (IV) non-small cell lung cancer (NSCLC) in a multicenter, randomized, open-label trial. ABRAXANE was administered as an intravenous infusion over 30 minutes at a dose of 100 mg/m^2 on Days 1, 8, and 15 of each 21-day cycle. Paclitaxel injection was administered as an intravenous infusion over 3 hours at a dose of 200 mg/m^2 , following premedication. In both treatment arms carboplatin at a dose of $\text{AUC} = 6 \text{ mg} \cdot \text{min/mL}$ was administered intravenously on Day 1 of each 21-day cycle after completion of ABRAXANE/paclitaxel infusion. The differences in paclitaxel dose and schedule between the two arms limit direct comparison of dose-and schedule-dependent adverse reactions. Among patients evaluable for adverse reactions, the median age was 60 years, 75% were men, 81% were White, 49% had adenocarcinoma, 43% had squamous cell lung cancer, 76% were ECOG PS 1. Patients in both treatment arms received a median of 6 cycles of treatment.

The following common ($\geq 10\%$ incidence) adverse reactions were observed at a similar incidence in ABRAXANE plus carboplatin-treated and paclitaxel injection plus carboplatin-treated patients: alopecia 56%, nausea 27%, fatigue 25%, decreased appetite 17%, asthenia 16%, constipation 16%, diarrhea 15%, vomiting 12%, dyspnea 12%, and rash 10% (incidence rates are for the ABRAXANE plus carboplatin treatment group).

Table 7 provides the frequency and severity laboratory-detected abnormalities which occurred with a difference of $\geq 5\%$ for all grades (1-4) or $\geq 2\%$ for Grade 3-4 toxicity between ABRAXANE plus carboplatin-treated patients or paclitaxel injection plus carboplatin-treated patients.

Table 7: Selected Hematologic Laboratory-Detected Abnormalities with a Difference of $\geq 5\%$ for grades (1-4) or $\geq 2\%$ for Grade 3-4 Toxicity Between Treatment Groups

	ABRAXANE (100 mg/m ² weekly) plus carboplatin		Paclitaxel Injection (200 mg/m ² every 3 weeks) plus carboplatin	
	Grades 1-4 (%)	Grade 3-4 (%)	Grades 1-4 (%)	Grade 3-4 (%)
Anemia ^{1,2}	98	28	91	7
Neutropenia ^{1,3}	85	47	83	58
Thrombocytopenia ^{1,3}	68	18	55	9

¹ 508 patients assessed in ABRAXANE/carboplatin-treated group

² 514 patients assessed in paclitaxel injection/carboplatin-treated group

³ 513 patients assessed in paclitaxel injection/carboplatin-treated group

Table 8 provides the frequency and severity of adverse reactions, which occurred with a difference of $\geq 5\%$ for all grades (1-4) or $\geq 2\%$ for Grade 3-4 between either treatment group for the 514 ABRAXANE plus carboplatin-treated patients compared with the 524 patients who received paclitaxel injection plus carboplatin.

Table 8: Selected Adverse Reactions with a Difference of $\geq 5\%$ for All Grade Toxicity or $\geq 2\%$ for Grade 3-4 Toxicity Between Treatment Groups

System Organ Class	MedDRA v 12.1 Preferred Term	ABRAXANE (100 mg/m ² weekly) + carboplatin (N=514)		Paclitaxel Injection (200 mg/m ² every 3 weeks) + carboplatin (N=524)	
		Grade 1-4 Toxicity (%)	Grade 3-4 Toxicity (%)	Grades 1-4 Toxicity (%)	Grade 3-4 Toxicity (%)
Nervous system disorders	Peripheral neuropathy ^a	48	3	64	12
General disorders and administration site conditions	Edema peripheral	10	0	4	<1
Respiratory thoracic and mediastinal disorders	Epistaxis	7	0	2	0
Musculoskeletal and connective tissue disorders	Arthralgia	13	<1	25	2
	Myalgia	10	<1	19	2

^a Peripheral neuropathy is defined by the MedDRA Version 14.0 SMQ neuropathy (broad scope).

For the ABRAXANE plus carboplatin treated group, 17/514 (3%) patients developed Grade 3 peripheral neuropathy and no patients developed Grade 4 peripheral neuropathy. Grade 3 neuropathy improved to Grade 1 or resolved in 10/17 patients (59%) following interruption or discontinuation of ABRAXANE.

Paediatric population

The study consisted of 106 patients, 104 of whom were paediatric patients aged from 6 months to less than 18 years (see section 5.1). Every patient experienced at least 1 adverse reaction. The most frequently reported adverse reactions were neutropenia, anaemia, leukopenia and pyrexia. Serious adverse reactions reported in more than 2 patients were pyrexia, back pain, peripheral oedema and vomiting. No new safety signals were identified in the limited number of paediatric patients treated with Abraxane and the safety profile was similar to that of the adult population.

4.9 Overdose

There is no known antidote for paclitaxel overdose. In the event of an overdose, the patient should be closely monitored. Treatment should be directed at the major anticipated toxicities, which are bone marrow suppression, mucositis and peripheral neuropathy.

5. PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: Antineoplastic agents, plant alkaloids and other natural products, taxanes, ATC Code: L01CD01

Mechanism of action

Paclitaxel is an antimicrotubule agent that promotes the assembly of microtubules from tubulin dimers and stabilises microtubules by preventing depolymerisation. This stability results in the inhibition of the normal dynamic reorganisation of the microtubule network that is essential for vital interphase and mitotic cellular functions. In addition, paclitaxel induces abnormal arrays or “bundles” of microtubules throughout the cell cycle and multiple asters of microtubules during mitosis.

Abraxane contains human serum albumin-paclitaxel nanoparticles of approximately 130 nm in size, where the paclitaxel is present in a non-crystalline, amorphous state. Upon intravenous administration, the nanoparticles dissociate rapidly into soluble, albumin bound paclitaxel complexes of approximately 10 nm in size. Albumin is known to mediate endothelial caveolar transcytosis of plasma constituents, and *in vitro* studies demonstrated that the presence of albumin in Abraxane enhances transport of paclitaxel across endothelial cells. It is hypothesised that this enhanced transendothelial caveolar transport is mediated by the gp-60 albumin receptor, and that there is enhanced accumulation of paclitaxel in the area of tumour due to the albumin-binding protein Secreted Protein Acidic Rich in Cysteine (SPARC).

Clinical efficacy and safety

Breast cancer

Data from 106 patients accrued in two single-arm open-label studies and from 454 patients treated in a randomised Phase III comparative study are available to support the use of Abraxane in metastatic breast cancer. This information is presented below.

Single-arm open-label studies

In one study, Abraxane was administered as a 30-minute infusion at a dose of 175 mg/m² to 43 patients with metastatic breast cancer. The second trial utilised a dose of 300 mg/m² as a 30 minute infusion in 63 patients with metastatic breast cancer. Patients were treated without steroid pre-treatment or planned G-CSF support. Cycles were administered at 3 week intervals. The response rates in all patients were 39.5% (95% CI: 24.9%-54.2%) and 47.6% (95% CI: 35.3%-60.0%), respectively.

The median time to disease progression was 5.3 months (175 mg/m²; 95% CI: 4.6-6.2 months) and 6.1 months (300 mg/m²; 95% CI: 4.2-9.8 months).

Randomised comparative study

This multi-centre trial was conducted in patients with metastatic breast cancer, who were treated every 3 weeks with single-agent paclitaxel, either as solvent-based paclitaxel 175 mg/m² given as a 3-hour infusion with premedication to prevent hypersensitivity (N = 225), or as Abraxane 260 mg/m² given as a 30 minute infusion without premedication (N = 229).

Sixty-four percent of patients had impaired performance status (ECOG 1 or 2) at study entry; 79% had visceral metastases; and 76% had > 3 sites of metastases. Fourteen percent of the patients had not received prior chemotherapy; 27% had received chemotherapy in the adjuvant setting only, 40% in the metastatic setting only, and 19% in both metastatic and adjuvant settings. Fifty-nine percent received study medicinal product as second or greater than second-line therapy. Seventy-seven percent of the patients had been previously exposed to anthracyclines.

Results for overall response rate and time to disease progression, and progression-free survival and survival for patients receiving > 1st-line therapy, are shown below.

Table 9: Results for overall response rate, median time to disease progression, and progression-free survival as assessed by the investigator

Efficacy variable	Abraxane (260 mg/m ²)	Solvent-based paclitaxel (175 mg/m ²)	p-value
<i>Response rate [95% CI] (%)</i>			
> 1 st -line therapy	26.5 [18.98, 34.05] (n = 132)	13.2 [7.54, 18.93] (n = 136)	0.006 ^a
<i>*Median time to disease progression [95% CI] (weeks)</i>			
> 1 st -line therapy	20.9 [15.7, 25.9] (n = 131)	16.1 [15.0, 19.3] (n = 135)	0.011 ^b
<i>*Median progression free survival [95% CI] (weeks)</i>			
> 1 st -line therapy	20.6 [15.6, 25.9] (n = 131)	16.1 [15.0, 18.3] (n = 135)	0.010 ^b
<i>*Survival [95% CI] (weeks)</i>			
> 1 st -line therapy	56.4 [45.1, 76.9] (n = 131)	46.7 [39.0, 55.3] (n = 136)	0.020 ^b

*This data is based on Clinical Study Report: CA012-0 Addendum dated Final (23 March-2005)

^a Chi-squared test

^b Log-rank test

Two hundred and twenty-nine patients treated with Abraxane in the randomized, controlled clinical trial were evaluated for safety. Neurotoxicity to paclitaxel was evaluated through improvement by one grade for patients experiencing Grade 3 peripheral neuropathy at any time during therapy. The natural

course of peripheral neuropathy to resolution to baseline due to cumulative toxicity of Abraxane after > 6 courses of treatment was not evaluated and remains unknown.

Pancreatic adenocarcinoma

A multicenter, multinational, randomized, open-label study was conducted in 861 patients to compare Abraxane/gemcitabine versus gemcitabine monotherapy as first-line treatment in patients with metastatic adenocarcinoma of the pancreas. Abraxane was administered to patients (N = 431) as an intravenous infusion over 30-40 minutes at a dose of 125 mg/m² followed by gemcitabine as an intravenous infusion over 30-40 minutes at a dose of 1000 mg/m² given on Days 1, 8 and 15 of each 28-day cycle. In the comparator treatment arm, gemcitabine monotherapy was administered to patients (N = 430) in accordance with the recommended dose and regimen. Treatment was administered until disease progression or development of an unacceptable toxicity. Of the 431 patients with pancreatic adenocarcinoma who were randomized to receive Abraxane in combination with gemcitabine, the majority (93%) were white, 4% were black and 2% were Asian. 16% had a Karnofsky Performance Status of 100; 42% had a KPS of 90; 35% had a KPS of 80; 7% had a KPS of 70; and <1% of patients had a KPS of below 70. Patients with high cardiovascular risk, history of peripheral artery disease and/or of connective tissue disorders and/or interstitial lung disease were excluded from the study.

Patients received a median treatment duration of 3.9 months in the Abraxane/gemcitabine arm and 2.8 months in the gemcitabine arm. 32% of patients in the Abraxane/gemcitabine arm compared with 15% of patients in the gemcitabine arm received 6 or more months of treatment. For the treated population, the median relative dose intensity for gemcitabine was 75% in the Abraxane/gemcitabine arm and 85% in the gemcitabine arm. The median relative dose intensity of Abraxane was 81%. A higher median cumulative dose of gemcitabine was delivered in the Abraxane/gemcitabine arm (11400 mg/m²) when compared with the gemcitabine arm (9000 mg/m²).

The primary efficacy endpoint was overall survival (OS). The key secondary endpoints were progression-free survival (PFS) and overall response rate (ORR), both assessed by independent, central, blinded radiological review using RECIST guidelines (Version 1.0).

Table 10: Efficacy results from randomized study in patients with pancreatic adenocarcinoma (Intent-to-treat population)

	Abraxane (125 mg/m ²)/ gemcitabine (N=431)	Gemcitabine (N=430)
Overall Survival		
Number of deaths (%)	333 (77)	359 (83)
Median Overall Survival, months (95% CI)	8.5 (7.89, 9.53)	6.7 (6.01, 7.23)
HR _{A+G/G} (95% CI) ^a	0.72 (0.617, 0.835)	
P-value ^b	<0.0001	
Survival Rate % (95% CI) at		
1 Year	35% (29.7, 39.5)	22% (18.1, 26.7)
2 Year	9% (6.2, 13.1)	4% (2.3, 7.2)
75 th Percentile Overall Survival (months)	14.8	11.4
Progression-free Survival		
Death or progression, n (%)	277 (64)	265 (62)
Median Progression-free Survival, months (95% CI)	5.5 (4.47, 5.95)	3.7 (3.61, 4.04)
HR _{A+G/G} (95% CI) ^a	0.69 (0.581, 0.821)	
P-value ^b	<0.0001	
Overall Response Rate		
Confirmed complete or partial overall response, n (%)	99 (23)	31 (7)

95% CI	19.1, 27.2	5.0, 10.1
p _{A+G/pG} (95% CI)	3.19 (2.178, 4.662)	
P-value (chi-square test)	<0.0001	

CI = confidence interval, HRA+G/G = hazard ratio of Abraxane+gemcitabine/gemcitabine,

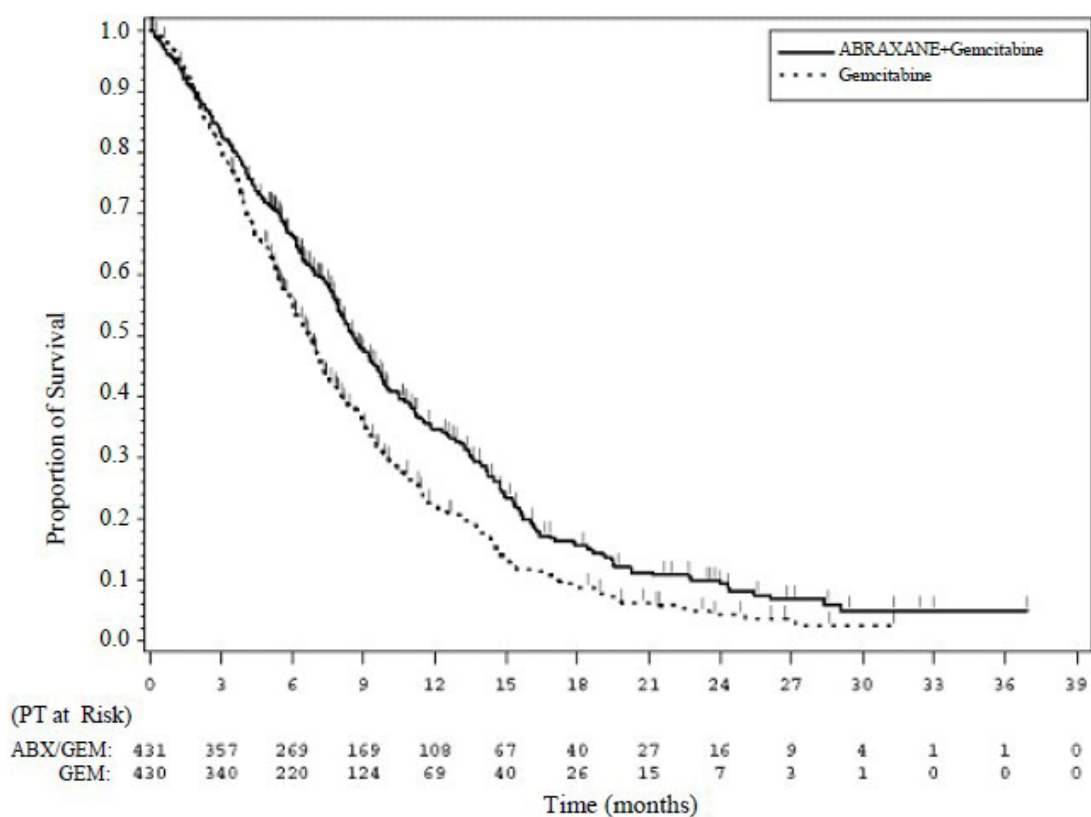
p_{A+G/pG}=response rate ratio of Abraxane+gemcitabine/gemcitabine

^a stratified Cox proportional hazard model

^b stratified log-rank test, stratified by geographic region (North America versus others), KPS (70 to 80 versus 90 to 100), and presence of liver metastasis (yes versus no).

There was a statistically significant improvement in OS for patients treated with Abraxane/gemcitabine versus gemcitabine alone, with 1.8 months increase in median OS, 28% overall reduction in risk of death, 59% improvement in 1-year survival, and 125% improvement in 2-year survival rates.

Figure 1: Kaplan-Meier curve of overall survival (intent-to-treat population)



Treatment effects on OS favoured the Abraxane/gemcitabine arm across the majority of pre-specified subgroups (including gender, KPS, geographic region, primary location of pancreatic cancer, stage at diagnosis, presence of liver metastases, presence of peritoneal carcinomatosis, prior Whipple procedure, presence of biliary stent at baseline, presence of pulmonary metastases, and number of metastatic sites). For patients ≥ 75 years of age in the Abraxane/gemcitabine and gemcitabine arms the survival Hazard Ratio (HR) was 1.08 (95% CI 0.653, 1.797). For patients with normal baseline CA 19-9 levels the survival HR was 1.07 (95% CI 0.692, 1.661).

There was a statistically significant improvement in PFS for patients treated with Abraxane/gemcitabine versus gemcitabine alone, with 1.8 months increase in median PFS.

Non-Small Cell Lung Cancer

A multicenter, randomized, open-label study was conducted in 1052 chemo-naïve patients with Stage IIIB/ IV non-small cell lung cancer to compare ABRAXANE in combination with carboplatin to paclitaxel injection in combination with carboplatin as first-line treatment in patients with advanced non-small cell lung cancer. ABRAXANE was administered as an intravenous infusion over 30 minutes at a dose of 100 mg/m² on Days 1, 8, and 15 of each 21-day cycle. Paclitaxel injection was administered as an intravenous infusion over 3 hours at a dose of 200 mg/m², following premedication. In both treatment arms carboplatin at a dose of AUC = 6 mg•min/mL was administered intravenously on Day 1 of each 21-day cycle after completion of ABRAXANE/ paclitaxel infusion. Treatment was administered until disease progression or development of an unacceptable toxicity. The major efficacy outcome measure was overall response rate as determined by a central independent review committee using RECIST guidelines (Version 1.0).

In the intent-to-treat (all-randomized) population, the median age was 60 years, 75% were men, 81% were White, 49% had adenocarcinoma, 43% had squamous cell lung cancer, 76% were ECOG PS 1, and 73% were current or former smokers. Patients received a median of 6 cycles of treatment in both study arms.

Patients in the ABRAXANE/ carboplatin arm had a statistically significantly higher overall response rate compared to patients in the paclitaxel injection/ carboplatin arm [(33% versus 25%) see Table 11]. There was no statistically significant difference in overall survival between the two study arms.

Table 11: Efficacy Results from Randomized Non-Small Cell Lung Cancer Trial (Intent-to-Treat Population)

	ABRAXANE (100 mg/m² weekly) + carboplatin (N=521)	Paclitaxel Injection (200 mg/m² every 3 weeks)+ carboplatin (N=531)
Overall Response Rate (ORR)		
Confirmed complete or partial overall response, n (%)	170 (33%)	132 (25%)
95% CI	28.6, 36.7	21.2, 28.5
P-value (Chi-Square test)	0.005	
Median DoR in months (95% CI)	6.9 (5.6, 8.0)	6.0 (5.6, 7.1)
Overall Response Rate by Histology		
Carcinoma/Adenocarcinoma	66/254 (26%)	71/264 (27%)
Squamous Cell Carcinoma	94/229 (41%)	54/221 (24%)
Large Cell Carcinoma	3/9 (33%)	2/13 (15%)
Other	7/29 (24%)	5/33 (15%)

CI = confidence interval; DoR= Duration of response

Paediatric population

Safety and effectiveness in paediatric patients have not been established (see section 4.2).

Study ABI-007-PST-001, a Phase 1/2, multicenter, open-label, dose-finding study to assess the safety, tolerability and preliminary efficacy of weekly Abraxane in paediatric patients with recurrent or refractory solid tumours included a total of 106 patients aged ≥ 6 months to ≤ 24 years.

The Phase 1 portion of the study included a total of 64 patients aged from 6 months to less than 18 years old and determined the maximum tolerated dose (MTD) to be 240 mg/m², administered as an intravenous infusion over 30 minutes, on Days 1, 8, and 15 of each 28-day cycle.

The Phase 2 portion enrolled a total of 42 patients using a Simon two-stage minimax design, aged from 6 months to 24 years with recurrent or refractory Ewing's sarcoma, neuroblastoma or rhabdomyosarcoma for the evaluation of antitumour activity assessed by the overall response rate (ORR). Of the 42 patients, 1 patient was < 2 , 27 were aged ≥ 2 to < 12 , 12 were aged ≥ 12 to < 18 and 2 adult patients were aged ≥ 18 to 24 years old.

Patients were treated for a median of 2 cycles at the MTD. From the 41 patients eligible for efficacy evaluation in stage 1, 1 patient in the rhabdomyosarcoma group (N=14) had a confirmed partial response (PR) resulting in an ORR of 7.1% (95% CI: 0.2, 33.9). No confirmed complete response (CR) or PR was observed in either the Ewing's sarcoma group (N=13) or the neuroblastoma group (N=14). None of the study arms continued into stage 2 because the protocol-defined requirement of ≥ 2 patients to have a confirmed response was not met.

The median overall survival results, including the 1-year follow-up period were 32.1 weeks (95% CI: 21.4, 72.9), 32.0 weeks (95% CI: 12, not established) and 19.6 weeks (95% CI: 4, 25.7) for the Ewing's sarcoma, neuroblastoma and rhabdomyosarcoma groups, respectively.

The overall safety profile of Abraxane in paediatric patients was consistent with the known safety profile of Abraxane in adults (see section 4.8). Based on these results, it was concluded that Abraxane as monotherapy does not have meaningful clinical activity or survival benefit that warrants further development in the paediatric population.

5.2 Pharmacokinetic properties

The pharmacokinetics of total paclitaxel following 30- and 180-minute infusions of Abraxane at dose levels of 80 to 375 mg/m² were determined in clinical studies. The paclitaxel exposure (AUC) increased linearly from 2653 to 16736 ng.hr/ml following dosing from 80 to 300 mg/m².

In a study in patients with advanced solid tumours, the pharmacokinetic characteristics of paclitaxel following Abraxane administered intravenously at 260 mg/m² over 30 minutes were compared with those following 175 mg/m² of the solvent-based paclitaxel injection administered over 3 hours. Based on non-compartmental PK analysis, the plasma clearance of paclitaxel with Abraxane was larger (43%) than that following a solvent-based paclitaxel injection and its volume of distribution was also higher (53%). There were no differences in terminal half-lives.

In a repeat dose study with 12 patients receiving Abraxane administered intravenously at 260 mg/m², inpatient variability in AUC was 19% (range = 3.21%-27.70%). There was no evidence for accumulation of paclitaxel with multiple treatment courses.

Distribution

Following Abraxane administration to patients with solid tumours, paclitaxel is evenly distributed into blood cells and plasma and is highly bound to plasma proteins (94%).

The protein binding of paclitaxel following Abraxane was evaluated by ultrafiltration in a within-patient comparison study. The fraction of free paclitaxel was significantly higher with Abraxane (6.2%) than with solvent-based paclitaxel (2.3%). This resulted in significantly higher exposure to unbound paclitaxel with Abraxane compared with solvent-based paclitaxel, even though the total exposure is comparable. This is possibly due to paclitaxel not being trapped in Cremophor EL micelles as with solvent-based paclitaxel. Based on the published literature, *in vitro* studies of binding to human serum proteins, (using paclitaxel at concentrations ranging from 0.1 to 50 µg/ml), indicate that the presence of cimetidine, ranitidine, dexamethasone, or diphenhydramine did not affect protein binding of paclitaxel.

Based on population pharmacokinetic analysis, the total volume of distribution is approximately 1741 L; the large volume of distribution indicates extensive extravascular distribution and/or tissue binding of paclitaxel.

Biotransformation and elimination

Based on the published literature, *in vitro* studies with human liver microsomes and tissue slices show that paclitaxel is metabolised primarily to 6 α -hydroxypaclitaxel; and to two minor metabolites, 3'-*p*-hydroxypaclitaxel and 6 α -3'-*p*-dihydroxypaclitaxel. The formation of these hydroxylated metabolites is catalysed by CYP2C8, CYP3A4, and both CYP2C8 and CYP3A4 isoenzymes respectively.

In patients with metastatic breast cancer, after a 30-minute infusion of Abraxane at 260 mg/m², the mean value for cumulative urinary excretion of unchanged active substance accounted for 4% of the total administered dose with less than 1% as the metabolites 6 α -hydroxypaclitaxel and 3'-*p*-hydroxypaclitaxel, indicating extensive non-renal clearance. Paclitaxel is principally eliminated by hepatic metabolism and biliary excretion.

At the clinical dose range of 80 to 300 mg/m², the mean plasma clearance of paclitaxel ranges from 13 to 30 L/h/m², and the mean terminal half-life ranges from 13 to 27 hours.

Hepatic impairment

The effect of hepatic impairment on population pharmacokinetics of Abraxane was studied in patients with advanced solid tumours. This analysis included patients with normal hepatic function (n=130), and pre-existing mild (n=8), moderate (n=7), or severe (n=5) hepatic impairment (according to NCI Organ Dysfunction Working Group criteria). The results show that mild hepatic impairment (total bilirubin >1 to ≤1.5 x ULN) has no clinically important effect on pharmacokinetics of paclitaxel. Patients with moderate (total bilirubin >1.5 to ≤3 x ULN) or severe (total bilirubin >3 to ≤5 x ULN) hepatic impairment have a 22% to 26% decrease in the maximum elimination rate of paclitaxel and approximately 20% increase in mean paclitaxel AUC compared with patients with normal hepatic function. Hepatic impairment has no effect on mean paclitaxel C_{max}. In addition, elimination of paclitaxel shows an inverse correlation with total bilirubin and a positive correlation with serum albumin.

Pharmacokinetic/pharmacodynamic modeling indicates that there is no correlation between hepatic function (as indicated by the baseline albumin or total bilirubin level) and neutropenia after adjusting for Abraxane exposure.

Pharmacokinetic data are not available for patients with total bilirubin >5 x ULN or for patients with metastatic adenocarcinoma of the pancreas (see section 4.2).

Renal impairment

Population pharmacokinetic analysis included patients with normal renal function (n=65), and pre-existing mild (n=61), moderate (n=23), or severe (n=1) renal impairment (according to draft FDA guidance criteria 2010). Mild to moderate renal impairment (creatinine clearance ≥30 to <90 ml/min) has no clinically important effect on the maximum elimination rate and systemic exposure (AUC and C_{max}) of paclitaxel. Pharmacokinetic data are insufficient for patients with severe renal impairment and not available for patients with end stage kidney disease.

Elderly

Population pharmacokinetic analysis for Abraxane included patients with ages ranging from 24 to 85 years old and shows that age does not significantly influence the maximum elimination rate and systemic exposure (AUC and $C_{\max}$) of paclitaxel.

Pharmacokinetic/pharmacodynamic modelling using data from 125 patients with advanced solid tumours indicates that patients ≥ 65 years of age may be more susceptible to development of neutropenia within the first treatment cycle, although the plasma paclitaxel exposure is not affected by age.

Paediatric population

The pharmacokinetics of paclitaxel following 30 minutes of intravenous administration at dose levels of 120 mg/m² to 270 mg/m² were determined in 64 patients (2 to ≤ 18 years) in Phase 1 of a Phase 1/2 study in recurrent or refractory paediatric solid tumours. Following dosing increase from 120 to 270 mg/m², the paclitaxel mean AUC_(0-inf) and $C_{\max}$ ranged from 8867 to 14361 ng*hr/ml and from 3488 to 8078 ng/ml, respectively.

Dose normalized peak drug exposure values were comparable across the dose range studied; however, dose-normalized total drug exposure values were only comparable across 120 mg/m² to 240 mg/m²; with lower dose-normalized AUC_∞ at the 270 mg/m² dose level. At the MTD of 240 mg/m², the mean CL was 19.1 L/h and the mean terminal half-life was 13.5 hours.

In children and adolescent patients, exposure to paclitaxel increased with higher dosing and weekly drug exposures were higher than in adult patients.

Other intrinsic factors

Population pharmacokinetic analyses for Abraxane indicate that gender, race (Asian vs. White), and type of solid tumours do not have a clinically important effect on systemic exposure (AUC and $C_{\max}$) of paclitaxel. Patients weighing 50 kg had paclitaxel AUC approximately 25% lower than those weighing 75 kg. The clinical relevance of this finding is uncertain.

Pharmacokinetic Interactions between and ABRAXANE and Carboplatin

Administration of carboplatin immediately after the completion of the ABRAXANE infusion to patients with NSCLC did not cause clinically meaningful changes in paclitaxel exposure. The observed mean AUC_{inf} of free carboplatin was approximately 23% higher than the targeted value (6min*mg/mL), but its mean half-life and clearance were consistent with those reported in the absence of paclitaxel.

5.3 Preclinical safety data

The carcinogenic potential of paclitaxel has not been studied. However, based on the published literature, paclitaxel is a potentially carcinogenic and genotoxic agent at clinical doses, based upon its pharmacodynamic mechanism of action. Paclitaxel has been shown to be clastogenic *in vitro* (chromosome aberrations in human lymphocytes) and *in vivo* (micronucleus test in mice). Paclitaxel has been shown to be genotoxic *in vivo* (micronucleus test in mice), but it did not induce mutagenicity in the Ames test or the Chinese hamster ovary/hypoxanthine-guanine phosphoribosyl transferase (CHO/HGPRT) gene mutation assay.

Paclitaxel at doses below the human therapeutic dose was associated with low fertility when administered prior and during mating in male and female rats and foetal toxicity in rats. Animal studies with Abraxane showed non-reversible, toxic effects on the male reproductive organs at clinically relevant exposure levels.

Paclitaxel and/or its metabolites were excreted into the milk of lactating rats. Following intravenous administration of radiolabelled paclitaxel to rats on days 9 to 10 postpartum, concentrations of radioactivity in milk were higher than in plasma and declined in parallel with the plasma concentrations.

6. PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Human albumin solution (containing sodium caprylate and N-acetyl-L-tryptophan).

6.2 Incompatibilities

This medicinal product must not be mixed with other medicinal products except those mentioned in section 6.5.

6.3 Special precautions for storage

Unopened vials

Store the medicinal product in its original package at below 30°C.

Keep the vial in the outer carton in order to protect from light. Neither freezing nor refrigeration adversely affects the stability of the product.

Stability of reconstituted suspension in the vial

After first reconstitution, the suspension should be filled into an infusion bag immediately. However, chemical and physical in-use stability has been demonstrated for 24 hours at 2°C-8°C in the original carton, and protected from bright light. Alternative light-protection may be used in the clean room.

Stability of the reconstituted suspension in the infusion bag

Chemical and physical in-use stability has been demonstrated for 24 hours at 2°C-8°C followed by 4 hours at 25°C, protected from light.

However, from a microbiological point of view, unless the method of reconstituting and filling of the infusion bags precludes the risks of microbial contamination, the product should be used immediately after reconstitution and filling of the infusion bags.

If not used immediately, in-use storage times and conditions are the responsibility of the user.

The total combined storage time of reconstituted medicinal product in the vial and in the infusion bag when refrigerated and protected from light is 24 hours. This may be followed by storage in the infusion bag for 4 hours below 25°C.

6.4 Nature and contents of container

50 ml vial (type 1 glass) with a stopper (butyl rubber), with an overseal (aluminium), containing 100 mg of paclitaxel formulated as albumin bound nanoparticles.

Pack size of one vial.

6.5 Special precautions for disposal and other handling

Preparation and administration precautions

Paclitaxel is a cytotoxic anticancer medicinal product and, as with other potentially toxic compounds, caution should be exercised in handling Abraxane. The use of gloves, goggles and protective clothing is recommended. If the suspension contacts the skin, the skin should be washed immediately and thoroughly with soap and water. If it contacts mucous membranes, the membranes should be flushed

thoroughly with water. Abraxane should only be prepared and administered by personnel appropriately trained in the handling of cytotoxic agents. Pregnant staff should not handle Abraxane.

Given the possibility of extravasation, it is advisable to closely monitor the infusion site for possible infiltration during administration of the medicinal product. Limiting the infusion of Abraxane to 30 minutes, as directed, reduces the likelihood of infusion-related reactions.

Reconstitution and administration of the product

Abraxane is supplied as a sterile lyophilised powder for reconstitution before use. After reconstitution, each ml of suspension contains 5 mg of paclitaxel formulated as albumin bound nanoparticles.

Using a sterile syringe, 20 ml of sodium chloride 9 mg/ml (0.9%) solution for infusion should slowly be injected into a vial of Abraxane over a minimum of 1 minute. The solution should be directed onto the inside wall of the vial. The solution should not be injected directly onto the powder as this will result in foaming.

Once the addition is complete, the vial should be allowed to stand for a minimum of 5 minutes to ensure proper wetting of the solid. Then, the vial should gently and slowly be swirled and/or inverted for at least 2 minutes until complete resuspension of any powder occurs. The generation of foam must be avoided. If foaming or clumping occurs, the solution must stand for at least 15 minutes until foam subsides.

The reconstituted suspension should be milky and homogenous without visible precipitates. Some settling of the reconstituted suspension may occur. If precipitates or settling are visible, the vial should be gently inverted again to ensure complete resuspension prior to use.

Inspect the suspension in the vial for particulate matter. Do not administer the reconstituted suspension if particulate matter is observed in the vial.

The exact total dosing volume of 5 mg/ml suspension required for the patient should be calculated and the appropriate amount of reconstituted Abraxane should be injected into an empty, sterile, PVC or non-PVC type intravenous bag.

The use of medical devices containing silicone oil as a lubricant (i.e. syringes and IV bags) to reconstitute and administer Abraxane may result in the formation of proteinaceous strands. Administer Abraxane using an infusion set incorporating a 15 µm filter to avoid administration of these strands. Use of a 15 µm filter removes strands and does not change the physical or chemical properties of the reconstituted product.

Use of filters with a pore size less than 15 µm may result in blockage of the filter.

The use of specialized di(2-ethylhexyl)phthalate (DEHP)-free solution containers or administration sets is not necessary to prepare or administer Abraxane infusions.

Following administration, it is recommended that the intravenous line be flushed with sodium chloride 9 mg/ml (0.9%) solution for injection to ensure administration of the complete dose.

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

PRODUCT REGISTRATION HOLDER

DKSH Malaysia Sdn. Bhd.
B-11-01, The Ascent, Paradigm, No. 1,
Jalan SS7/26A, Kelana Jaya, 47301
Petaling Jaya, Selangor, Malaysia.

DATE OF TEXT

Update: 06 Feb 2025

20250206/ABX PI/MY