

# NINLARO®

## 1. NAME OF THE MEDICINAL PRODUCT

NINLARO 2.3 mg hard capsules

NINLARO 3 mg hard capsules

NINLARO 4 mg hard capsules

## 2. QUALITATIVE AND QUANTITATIVE COMPOSITION

NINLARO 2.3 mg hard capsules

Each capsule contains 2.3 mg of ixazomib (as 3.3 mg of ixazomib citrate)

NINLARO 3 mg hard capsules

Each capsule contains 3 mg of ixazomib (as 4.3 mg of ixazomib citrate)

NINLARO 4 mg hard capsules

Each capsule contains 4 mg of ixazomib (as 5.7 mg of ixazomib citrate)

For the full list of excipients, see section 6.1.

## 3. PHARMACEUTICAL FORM

Hard capsule.

NINLARO 2.3 mg hard capsules

Light pink, size 4 gelatin hard capsule, marked “Takeda” on the cap and “2.3 mg” on the body with black ink.

NINLARO 3 mg hard capsules

Light grey, size 4 gelatin hard capsule, marked “Takeda” on the cap and “3 mg” on the body with black ink.

NINLARO 4 mg hard capsules

Light orange, size 3 gelatin hard capsule, marked “Takeda” on the cap and “4 mg” on the body with black ink.

## 4. CLINICAL PARTICULARS

### 4.1 Therapeutic indications

NINLARO is indicated:

- for the treatment of adult patients with multiple myeloma who have received at least one prior therapy, in combination with lenalidomide and dexamethasone
- for maintenance therapy in adult patients with multiple myeloma following autologous stem cell transplantation.
- for maintenance therapy in adult patients with multiple myeloma not treated with stem cell transplantation

## 4.2 Posology and method of administration

Treatment must be initiated and monitored under the supervision of a physician experienced in the management of multiple myeloma.

### Posology

#### **Recommended Dose**

*1) Treatment of patients with multiple myeloma who have received at least one prior therapy in combination with lenalidomide and dexamethasone*

The recommended starting dose of IXAZOMIB is 4 mg administered orally once a week on Days 1, 8, and 15 of a 28-day treatment cycle.

The recommended starting dose of lenalidomide is 25 mg administered daily on Days 1 to 21 of a 28-day treatment cycle.

The recommended starting dose of dexamethasone is 40 mg administered on Days 1, 8, 15, and 22 of a 28-day treatment cycle.

#### **Dosing schedule: IXAZOMIB taken with lenalidomide and dexamethasone**

28-day cycle (a 4-week cycle)								
	Week 1		Week 2		Week 3		Week 4	
	Day 1	Days 2 to 7	Day 8	Days 9 to 14	Day 15	Days 16 to 21	Day 22	Days 23 to 28
IXAZOMIB	✓		✓		✓			
Lenalidomide	✓	✓ Daily	✓	✓ Daily	✓	✓ Daily		
Dexamethasone	✓		✓		✓		✓	

✓ = intake of medicinal product

For additional information regarding lenalidomide and dexamethasone, refer to the Summary of Product Characteristics (SmPC) for these medicinal products.

Treatment should be continued until disease progression or unacceptable toxicity. Treatment with IXAZOMIB in combination with lenalidomide and dexamethasone for longer than 24 cycles should be based on an individual benefit risk assessment, as the data on the tolerability and toxicity beyond 24 cycles are limited (see section 5.1).

*2) Maintenance therapy in patients with multiple myeloma following autologous stem cell transplantation and in patients with multiple myeloma not treated with stem cell transplantation*

*The recommended dose of ixazomib maintenance therapy is one 4 mg capsule administered orally once a week on Days 1, 8, and 15 of a 28-day treatment cycle. Treatment should be initiated at 3 mg and should be escalated to 4 mg on Day 1 of cycle 5, if tolerated during the first 4 cycles. Treatment should be continued for 24 months, or until disease progression, or unacceptable toxicity, whichever comes first*

### Dose modifications

*1) Treatment of patients with multiple myeloma who have received at least one prior therapy in combination with lenalidomide and dexamethasone*

The IXAZOMIB dose reduction steps in combination with lenalidomide and dexamethasone are presented in Table 1 and the dose modification guidelines are provided in Table 2.

**Table 1: IXAZOMIB dose reduction steps due to adverse reactions when used in combination with Lenalidomide and Dexamethasone**

Recommended starting dose*	First reduction to	Second reduction to	Discontinue
4 mg	3 mg	2.3 mg	

\*Recommended reduced dose of 3 mg in the presence of moderate or severe hepatic impairment, severe renal impairment or end-stage renal disease (ESRD) requiring dialysis.

An alternating dose modification approach is recommended for IXAZOMIB and lenalidomide for overlapping toxicities of thrombocytopenia, neutropenia and rash. For these toxicities, the first dose modification step is to withhold/reduce lenalidomide. Refer to the lenalidomide SmPC, section 4.2 for the dose reduction steps for these toxicities.

**Table 2: Dose modifications guidelines for IXAZOMIB in combination with lenalidomide and dexamethasone**

Haematological toxicities	Recommended actions
<b>Thrombocytopenia (platelet count)</b>	
Platelet count < 30,000/mm <sup>3</sup>	<ul style="list-style-type: none"> <li>Withhold IXAZOMIB and lenalidomide until platelet count ≥ 30,000/mm<sup>3</sup>.</li> <li>Following recovery, resume lenalidomide at the next lower dose according to its SmPC and resume IXAZOMIB at its most recent dose.</li> <li>If platelet count falls to &lt; 30,000/mm<sup>3</sup> again, withhold IXAZOMIB and lenalidomide until platelet count ≥ 30,000/mm<sup>3</sup>.</li> <li>Following recovery, resume IXAZOMIB at the next lower dose and resume lenalidomide at its most recent dose.*</li> </ul>
<b>Neutropenia (absolute neutrophil count)</b>	
Absolute neutrophil count < 500/mm <sup>3</sup>	<ul style="list-style-type: none"> <li>Withhold IXAZOMIB and lenalidomide until absolute neutrophil count is ≥ 500/mm<sup>3</sup>. Consider adding G-CSF as per clinical guidelines.</li> <li>Following recovery, resume lenalidomide at the next lower dose according to its prescribing information and resume IXAZOMIB at its most recent dose.</li> <li>If absolute neutrophil count falls to &lt; 500/mm<sup>3</sup> again, withhold IXAZOMIB and lenalidomide until absolute neutrophil count is ≥ 500/mm<sup>3</sup>.</li> <li>Following recovery, resume IXAZOMIB at the next lower dose and resume lenalidomide at its most recent dose.*</li> </ul>
<b>Non-haematological toxicities</b>	
<b>Rash</b>	
Grade <sup>†</sup> 2 or 3	<ul style="list-style-type: none"> <li>Withhold lenalidomide until rash recovers to ≤ Grade 1.</li> </ul>

	<ul style="list-style-type: none"> <li>Following recovery, resume lenalidomide at the next lower dose according to its SmPC.</li> <li>If Grade 2 or 3 rash occurs again, withhold IXAZOMIB and lenalidomide until rash recovers to ≤ Grade 1.</li> <li>Following recovery, resume IXAZOMIB at the next lower dose and resume lenalidomide at its most recent dose.*</li> </ul>
Grade 4	Discontinue treatment regimen
<b>Peripheral neuropathy</b>	
Grade 1 peripheral neuropathy with pain or Grade 2 peripheral neuropathy	<ul style="list-style-type: none"> <li>Withhold IXAZOMIB until peripheral neuropathy recovers to ≤ Grade 1 without pain or patient's baseline.</li> <li>Following recovery, resume IXAZOMIB at its most recent dose.</li> </ul>
Grade 2 peripheral neuropathy with pain or Grade 3 peripheral neuropathy	<ul style="list-style-type: none"> <li>Withhold IXAZOMIB. Toxicities should, at the physician's discretion, generally recover to patient's baseline condition or ≤ Grade 1 prior to resuming IXAZOMIB.</li> <li>Following recovery, resume IXAZOMIB at the next lower dose.</li> </ul>
Grade 4 peripheral neuropathy	Discontinue treatment regimen.
<b>Other non-haematological toxicities</b>	
Grade 3 or 4 non-hematological toxicities	<ul style="list-style-type: none"> <li>Withhold IXAZOMIB. Toxicities should, at the physician's discretion, generally recover to patient's baseline condition or at most Grade 1 prior to resuming IXAZOMIB.</li> <li>If attributable to IXAZOMIB, resume IXAZOMIB at the next lower dose following recovery.</li> </ul>

\*For additional occurrences, alternate dose modification of lenalidomide and IXAZOMIB

†Grading based on National Cancer Institute Common Terminology Criteria (CTCAE) Version 4.03

2) Maintenance therapy in patients with multiple myeloma following autologous stem cell transplantation and in patients with multiple myeloma not treated with stem cell transplantation  
The dose reduction steps are presented in Table 3 and the dose modification guidelines are provided in Table 4.

**Table 3: Dose Reductions of ixazomib due to Adverse Reactions**

	Recommended starting dose*	First reduction to	Second reduction to	Discontinue
Cycle 1~4	3mg	2.3mg	Discontinue	
Cycle 5 ~	4mg	3mg	2.3mg	

\*Recommended lower dose of one 2.3 mg capsule for Cycles 1-4 with an escalation to 3 mg for Cycle 5 or higher in patients with moderate or severe hepatic impairment, severe renal impairment or end-stage renal disease requiring dialysis.

**Table 4: Dose Modifications Guidelines for ixazomib in Maintenance**

Hematological Toxicities	Recommended Actions
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<b>Thrombocytopenia (Platelet Count)</b>	
Platelet count less than 50,000/mm <sup>3</sup>	<ul style="list-style-type: none"> <li>• Withhold ixazomib until platelet count is at least 75,000/mm<sup>3</sup>.</li> <li>• Following recovery, resume ixazomib at the next lower dose</li> </ul>
<b>Neutropenia (Absolute Neutrophil Count)</b>	
Absolute neutrophil count less than 750/mm <sup>3</sup>	<ul style="list-style-type: none"> <li>• Withhold ixazomib until absolute neutrophil count is at least 1,000/mm<sup>3</sup>.</li> <li>• Following recovery, resume ixazomib at the next lower dose.</li> </ul>
<b>Non-Hematological Toxicities</b>	<b>Recommended Actions</b>
<b>Rash</b>	
Grade <sup>†</sup> 2	<ul style="list-style-type: none"> <li>• Institute oral or topical symptomatic measures. If not effective, reduce ixazomib to the next lower dose.</li> </ul>
Grade 3	<ul style="list-style-type: none"> <li>• Withhold ixazomib until rash recovers to ≤ Grade 1.</li> <li>• Following recovery, resume ixazomib at the next lower dose.</li> </ul>
Grade 4	Discontinue treatment regimen.
<b>Peripheral Neuropathy</b>	
Grade 1 Peripheral Neuropathy with Pain or Grade 2 Peripheral Neuropathy	<ul style="list-style-type: none"> <li>• Withhold ixazomib until peripheral neuropathy recovers to ≤ Grade 1 or lower without pain or patient's baseline.</li> <li>• Following recovery, resume ixazomib at its most recent dose.</li> </ul>
Grade 2 Peripheral Neuropathy with Pain or Grade 3 Peripheral Neuropathy	<ul style="list-style-type: none"> <li>• Withhold ixazomib. Toxicities should, at the physician's discretion, generally recover to patient's baseline condition or ≤ Grade 1 or lower prior to resuming ixazomib.</li> <li>• Following recovery, resume ixazomib at the next lower dose.</li> </ul>
Grade 4 Peripheral Neuropathy	Discontinue treatment regimen.
<b>Other Non-Hematological Toxicities</b>	
Other Grade 2, 3 Non Hematological Toxicities	<ul style="list-style-type: none"> <li>• Withhold ixazomib. Toxicities should, at the physician's discretion, generally recover to patient's baseline condition or ≤ Grade 1 or lower prior to resuming ixazomib.</li> <li>• Following recovery, resume ixazomib at the next lower dose.</li> </ul>
Other Grade 4 Non Hematological Toxicities	<ul style="list-style-type: none"> <li>• Consider permanently discontinuing ixazomib unless, at the physician's discretion, the patient is obtaining a clinical benefit. In such cases, resume ixazomib at the next lower dose following recovery.</li> </ul>

<sup>†</sup>Grading based on National Cancer Institute Common Terminology Criteria (CTCAE)

#### Concomitant medicinal products

Antiviral prophylaxis should be considered in patients being treated with IXAZOMIB to decrease the risk of herpes zoster reactivation. Patients included in studies with IXAZOMIB who received antiviral prophylaxis had a lower incidence of herpes zoster infection compared to patients who did not receive prophylaxis.

Thromboprophylaxis is recommended in patients being treated with IXAZOMIB in combination with lenalidomide and dexamethasone, and should be based on an assessment of the patient’s underlying risks and clinical status.

For other concomitant medicinal products that may be required, refer to the current lenalidomide and dexamethasone SmPC.

Special patient populations

*Elderly*

No dose adjustment of IXAZOMIB is required for patients over 65 years of age.

Discontinuations in patients > 75 years of age were reported in 13 patients (28%) in the IXAZOMIB regimen and 10 patients (16%) in the placebo regimen. Cardiac arrhythmias in patients > 75 years of age were observed in 10 patients (21%) in the IXAZOMIB regimen and 9 patients (15%) in the placebo regimen.

*Hepatic impairment*

The ixazomib starting dose adjustments for patients with impaired hepatic function (see Specific Populations) are provided in Error! Reference source not found.5.

**Table 5. Starting Dose Adjustments for Patients with Impaired Hepatic Function**

<b>Hepatic Function Category</b>	<b>Maintenance Therapy for MM</b>	<b>Combination Therapy for MM After at Least One Prior Therapy</b>
Mild (total bilirubin ≤ ULN and AST > ULN or total bilirubin > 1-1.5 x ULN and any AST)	No dose adjustment	No dose adjustment
Moderate (total bilirubin > 1.5-3x ULN) or Severe (total bilirubin > 3x ULN)	Initiate at 2.3 mg followed by escalation to 3 mg on Day 1 of cycle 5, if tolerated during the first 4 cycles	3 mg

\*ULN = Upper Limit of Normal , AST = Aspartate Aminotransferase

*Renal impairment*

The ixazomib starting dose adjustments for patients with impaired renal function are provided in Table 6.

**Table 6 Starting Dose Adjustments for Patients with Impaired Renal Function**

<b>Renal Function Category</b>	<b>Maintenance Therapy for MM</b>	<b>Combination Therapy for MM After at Least One Prior Therapy</b>
Mild or moderate (creatinine clearance ≥ 30 mL/min)	No dose adjustment	No dose adjustment

Severe (creatinine clearance < 30 mL/min) or ESRD requiring dialysis	Initiate at 2.3 mg followed by escalation to 3 mg on Day 1 of cycle 5, if tolerated during the first 4 cycles	3 mg
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\*ESRD = End-stage Renal Disease

IXAZOMIB is not dialyzable and, therefore, can be administered without regard to the timing of dialysis (see section 5.2).

Refer to the lenalidomide SmPC for dosing recommendations in patients with renal impairment.

#### *Paediatric population*

The safety and efficacy of IXAZOMIB in children below 18 years of age have not been established. No data are available.

#### Method of administration

IXAZOMIB is for oral use.

IXAZOMIB should be taken at approximately the same time on days 1, 8, and 15 of each treatment cycle at least 1 hour before or at least 2 hours after food (see section 5.2). The capsule should be swallowed whole with water. It should not be crushed, chewed, or opened (see section 6.6).

Prior to initiating a new cycle of therapy:

- Absolute neutrophil count should be  $\geq 1,000/\text{mm}^3$
- Platelet count should be  $\geq 75,000/\text{mm}^3$
- Non-haematologic toxicities should, at the physician's discretion, generally be recovered to patient's baseline condition or  $\leq$  Grade 1

#### Delayed or missed doses

In the event that a ixazomib dose is delayed or missed, the dose should be taken only if the next scheduled dose is  $\geq 72$  hours away. A missed dose should not be taken within 72 hours of the next scheduled dose. A double dose should not be taken to make up for a missed dose.

If a patient vomits after taking a dose, the patient should not repeat the dose but should resume dosing at the time of the next scheduled dose.

### **4.3 Contraindications**

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

As IXAZOMIB is administered in combination with lenalidomide and dexamethasone, refer to the SmPC for these medicinal products for additional contraindications.

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

As IXAZOMIB is administered in combination with lenalidomide and dexamethasone, refer to the SmPC for these medicinal products for additional special warnings and precautions for use.

#### Thrombocytopenia

Thrombocytopenia has been reported with IXAZOMIB (see section 4.8) with platelet nadirs typically occurring between Days 14-21 of each 28-day cycle and recovery to baseline by the start of the next cycle (see section 4.8).

Platelet counts should be monitored at least monthly during IXAZOMIB treatment. More frequent monitoring should be considered during the first three cycles as per the lenalidomide SmPC. Thrombocytopenia can be managed with dose modifications (see section 4.2) and platelet transfusions as per standard medical guidelines.

#### Gastrointestinal toxicities

Diarrhoea, constipation, nausea and vomiting have been reported with IXAZOMIB, occasionally requiring use of antiemetic and antidiarrhoeal medicinal products and supportive care (see section 4.8). The dose should be adjusted for severe (Grade 3-4) symptoms (see section 4.2). In case of severe gastrointestinal events, monitoring of serum potassium level is recommended.

#### Peripheral neuropathy

Peripheral neuropathy has been reported with IXAZOMIB (see section 4.8). The patient should be monitored for symptoms of peripheral neuropathy. Patients experiencing new or worsening peripheral neuropathy may require dose modification (see section 4.2).

#### Peripheral oedema

Peripheral oedema has been reported with IXAZOMIB (see section 4.8). The patient should be evaluated for underlying causes and provide supportive care, as necessary. The dose of dexamethasone should be adjusted per its prescribing information or IXAZOMIB for Grade 3 or 4 symptoms (see section 4.2).

#### Cutaneous reactions

Rash has been reported with IXAZOMIB (see section 4.8). Rash should be managed with supportive care or with dose modification if Grade 2 or higher (see section 4.2). Severe cutaneous adverse reactions (SCARs) including Toxic epidermal necrolysis (TEN) and Steven-Johnson syndrome (SJS), which can be life-threatening or fatal, have also been rarely reported in association with IXAZOMIB treatment (see section 4.8).

At the time of prescription patients should be advised of the signs and symptoms and monitored closely for skin reactions. If signs and symptoms suggestive of these reactions appear, ixazomib should be withdrawn immediately and an alternative treatment considered (as appropriate).

If the patient has developed a serious reaction such as SJS or TEN with the use of ixazomib, treatment with ixazomib must not be restarted in this patient at any time.

#### Thrombotic microangiopathy

Cases of thrombotic microangiopathy (TMA), including thrombotic thrombocytopenic purpura (TTP), have been reported in patients who received IXAZOMIB. Some of these events have been fatal. Signs and symptoms of TMA should be monitored for. If the diagnosis is suspected, stop IXAZOMIB and evaluate patients for possible TMA. If the diagnosis of TMA is excluded, ixazomib can be restarted. The safety of reinitiating IXAZOMIB therapy in patients previously experiencing TMA is not known.

#### Hepatotoxicity

Drug-induced liver injury, hepatocellular injury, hepatic steatosis, hepatitis cholestatic and hepatotoxicity have been uncommonly reported with IXAZOMIB (see section 4.8). Hepatic enzymes should be monitored regularly and the dose should be adjusted for Grade 3 or 4 symptoms (see section 4.2).



### Pregnancy

Women should avoid becoming pregnant while being treated with IXAZOMIB. If IXAZOMIB is used during pregnancy or if the patient becomes pregnant while taking IXAZOMIB, the patient should be apprised of the potential hazard to the foetus.

Women of childbearing potential must use highly effective contraception while taking IXAZOMIB and for 90 days after stopping treatment (see sections 4.5 and 4.6). Women using hormonal contraceptives should additionally use a barrier method of contraception.

### Posterior reversible encephalopathy syndrome

Posterior reversible encephalopathy syndrome (PRES) has occurred in patients receiving IXAZOMIB. PRES is a rare, reversible, neurological disorder which can present with seizure, hypertension, headache, altered consciousness, and visual disturbances. Brain imaging, preferably Magnetic Resonance Imaging, is used to confirm the diagnosis. In patients developing PRES, discontinue IXAZOMIB.

### Strong CYP3A inducers

Strong inducers may reduce the efficacy of IXAZOMIB, therefore the concomitant use of strong CYP3A inducers such as carbamazepine, phenytoin, rifampicin and St. John's Wort (*Hypericum perforatum*), should be avoided (see sections 4.5 and 5.2). Closely monitor patients for disease control if co-administration with a strong CYP3A inducer cannot be avoided.

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

### Pharmacokinetic interactions

#### CYP inhibitors

Co-administration of ixazomib with clarithromycin, a strong CYP3A inhibitor, did not result in a clinically meaningful change in the systemic exposure of ixazomib. Ixazomib  $C_{max}$  was decreased by 4% and AUC was increased by 11%. Therefore, no dose modification is required for ixazomib with co-administration of strong CYP3A inhibitors.

Co-administration of ixazomib with strong CYP1A2 inhibitors did not result in a clinically meaningful change in the systemic exposure of ixazomib based on the results of a population pharmacokinetic (PK) analysis. Therefore, no dose modification is required for ixazomib with co-administration of strong CYP1A2 inhibitors.

#### CYP inducers

Co-administration of ixazomib with rifampicin decreased ixazomib  $C_{max}$  by 54% and AUC by 74%. Therefore, co-administration of strong CYP3A inducers with ixazomib is not recommended (see section 4.4).

#### Effect of ixazomib on other medicinal products

Ixazomib is not a reversible or a time-dependent inhibitor of CYPs 1A2, 2B6, 2C8, 2C9, 2C19, 2D6, or 3A4/5. Ixazomib did not induce CYP1A2, CYP2B6, and CYP3A4/5 activity or corresponding immunoreactive protein levels. Ixazomib is not expected to produce drug-drug interactions via CYP inhibition or induction.

#### Transporter-based interactions

Ixazomib is a low affinity substrate of P-gp. Ixazomib is not a substrate of BCRP, MRP2 or hepatic OATPs. Ixazomib is not an inhibitor of P-gp, BCRP, MRP2, OATP1B1, OATP1B3, OCT2, OAT1, OAT3, MATE1, or MATE2-K. Ixazomib is not expected to cause transporter-mediated drug-drug interactions.

#### Oral contraceptives

When IXAZOMIB is administered together with dexamethasone, which is known to be a weak to moderate inducer of CYP3A4 as well as other enzymes and transporters, the risk for reduced efficacy of oral contraceptives needs to be considered. Women using hormonal contraceptives should additionally use a barrier method of contraception.

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

As IXAZOMIB is administered in combination with lenalidomide and dexamethasone, refer to the SmPC for these medicinal products for additional information on fertility, pregnancy and lactation.

#### Women of childbearing potential/Contraception in males and females

Male and female patients who are able to have children must use effective contraceptive measures during and for 90 days following treatment. IXAZOMIB is not recommended in women of childbearing potential not using contraception.

When IXAZOMIB is administered together with dexamethasone, which is known to be a weak to moderate inducer of CYP3A4 as well as other enzymes and transporters, the risk for reduced efficacy of oral contraceptives needs to be considered. Therefore, women using oral hormonal contraceptives should additionally use a barrier method of contraception.

#### Pregnancy

IXAZOMIB is not recommended during pregnancy as it can cause foetal harm when administered to a pregnant woman. Therefore, women should avoid becoming pregnant while being treated with IXAZOMIB.

There are no data for the use of IXAZOMIB in pregnant women. Studies in animals have shown reproductive toxicity (see section 5.3).

IXAZOMIB is given in combination with lenalidomide, Lenalidomide is structurally related to thalidomide. Thalidomide is a known human teratogenic active substance that causes severe life-threatening birth defects. If lenalidomide is taken during pregnancy, a teratogenic effect in humans is expected. The conditions of the Pregnancy Prevention Programme for lenalidomide must be fulfilled for all patients unless there is reliable evidence that the patient does not have childbearing potential. Please refer to the current lenalidomide SmPC.

#### Breast-feeding

It is unknown whether IXAZOMIB or its metabolites are excreted in human milk. No animal data are available. A risk to newborns/infants cannot be excluded and therefore breast-feeding should be discontinued.

IXAZOMIB will be given in combination with lenalidomide and breast-feeding should be stopped because of the use of lenalidomide.

#### Fertility

Fertility studies have not been conducted with IXAZOMIB (see section 5.3).

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

IXAZOMIB has minor influence on the ability to drive or use machines. Fatigue and dizziness have been observed in clinical trials. Patients should be advised not to drive or operate machines if they experience any of these symptoms.

#### 4.8 Undesirable effects

As IXAZOMIB is administered in combination with lenalidomide and dexamethasone, refer to the SmPC for these medicinal products for additional undesirable effects.

##### Summary of the safety profile

The safety profile of NINLARO is based on available clinical trial data and post-marketing experience to date. Frequencies of adverse reactions described below and in Table 7 have been determined based on data generated from clinical studies.

(1) Treatment of patients with multiple myeloma who have received at least one prior therapy in combination with lenalidomide and dexamethasone (TOURMALINE MM1 - Study C16010 - NCT01564537)

Unless otherwise noted, the data presented below is the pooled safety data from the pivotal, Phase 3, global C16010 study (n=720) and the double-blind, placebo-controlled C16010 China Continuation Study (n=115). The most frequently reported adverse reactions ( $\geq 20\%$ ) across 417 patients treated within the IXAZOMIB regimen and 418 patients within the placebo regimen were diarrhoea (39% vs. 32%), thrombocytopenia (33% vs. 21%), neutropenia (33% vs. 30%), constipation (30% vs. 22%), peripheral neuropathy (25% vs. 20%), nausea (23% vs. 18%), peripheral oedema (23% vs. 17%), vomiting (20% vs. 10%) and upper respiratory tract infection (21% vs. 16%). Serious adverse reactions reported in  $\geq 2\%$  of patients included thrombocytopenia (2%) and diarrhoea (2%).

##### Tabulated list of adverse reactions

The following convention is used for the classification of the frequency of an adverse drug reaction (ADR): 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 system organ class, the adverse drug reactions are ranked by frequency, with the most frequent reactions first. Within each frequency grouping, adverse reactions are presented in order of decreasing seriousness.

**Table 7: Adverse reactions in patients treated with IXAZOMIB in combination with lenalidomide and dexamethasone in TOURMALINE MM1 - Study C16010 (all grades, grade 3 and grade 4)**

System organ class / Adverse reaction	Adverse reactions (all grades)	Grade 3 adverse reactions	Grade 4 adverse reactions
<b>Infection and infestation</b>			
Upper respiratory tract infection	Very common	Uncommon	
Bronchitis	Very common	Common	
Herpes zoster	Common	Common	
<b>Blood and lymphatic system disorders</b>			
Thrombocytopenia*	Very common	Very common	Common
Neutropenia*	Very common	Very common	Common
Thrombotic microangiopathy	Rare		Rare

Thrombotic thrombocytopenic purpura <sup>†</sup>	Rare	Rare	Rare
Immune system disorders			
Anaphylactic reaction <sup>†</sup>	Rare	Very rare	Very rare
Angioedema <sup>†</sup>	Rare	Rare	
<b>Metabolism and nutrition disorders</b>			
Tumour lysis syndrome <sup>†</sup>	Rare	Rare	Rare
<b>Nervous system disorders</b>			
Peripheral neuropathies*	Very common	Common	
Posterior reversible encephalopathy disorders* <sup>†</sup>	Rare	Rare	Rare
Transverse myelitis <sup>†</sup>	Rare	Rare	
<b>Gastrointestinal disorders</b>			
Diarrhoea	Very common	Common	
Nausea	Very common	Common	
Vomiting	Very common	Uncommon	
Constipation	Very common	Uncommon	
<b>Skin and subcutaneous tissue disorders</b>			
Rash*	Very common	Common	
Stevens-Johnson syndrome <sup>†</sup>	Rare	Rare	
Acute febrile neutrophilic dermatosis	Rare	Rare	
Toxic epidermal necrolysis <sup>†</sup>	Rare		Rare
<b>Musculoskeletal and connective tissue disorders</b>			
Back pain	Very common	Uncommon	
<b>General disorders and administration site conditions</b>			
Oedema peripheral	Very common	Common	

\*Represents a pooling of preferred terms

<sup>†</sup>Reported outside of the Phase 3 Studies

*(2) Maintenance therapy with multiple myeloma following autologous stem cell transplantation (TOURMALINE-MM3 - Study C16019 – NCT02181413)*

Frequencies of adverse reactions described below have been determined based on the safety data from several Phase 3 randomized, double-blind, placebo-controlled studies. Safety data on maintenance therapy is from TOURMALINE-MM3 which included 653 patients with multiple myeloma following ASCT, who received NINLARO (N = 394) or placebo (N = 259).

For maintenance therapy with multiple myeloma following autologous stem cell transplantation (TOURMALINE-MM3), the most frequently reported adverse reactions ( $\geq 20\%$ ) in patients receiving were nausea (ixazomib 39% vs. placebo 15%), diarrhea (ixazomib 35% vs. placebo 24%), vomiting (ixazomib 27% vs. placebo 11%), upper respiratory tract infection (ixazomib 26% vs. placebo 21%), arthralgia (ixazomib 22% vs. placebo 12%), and rash (ixazomib 21% vs. placebo 14%). Serious adverse reactions reported in  $\geq 2\%$  of patients included pneumonia (6%). For each adverse reaction, ixazomib was discontinued in  $< 1\%$  of patients.

The following convention is used for the classification of the frequency of an adverse drug reaction (ADR) and is based on the Council for International Organizations of Medical Sciences (CIOMS) guidelines: 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).

**Table 8. Adverse Reactions in Patients Treated with Ixazomib as Maintenance Therapy following autologous stem cell transplantation in TOURMALINE-MM3 (All Grades, Grade 3 and Grade 4)**

<b>System Organ Class / Adverse Reactions</b>	<b>Adverse Reactions (All Grades)</b>	<b>Grade 3 Adverse Reactions</b>	<b>Grade 4 Adverse Reactions</b>
<b>Infections and infestations</b>			
Upper respiratory tract infection	Very common	Uncommon	
Pneumonia	Very common	Common	Uncommon
Herpes zoster	Very common	Uncommon	
<b>Blood and lymphatic system disorders</b>			
Thrombocytopenia*	Very common	Common	Common
<b>Nervous system disorders</b>			
Peripheral neuropathies*	Very common	Uncommon	
<b>Gastrointestinal disorders</b>			
Diarrhea	Very common	Common	
Nausea	Very common	Uncommon	
Vomiting	Very common	Common	
<b>Skin and subcutaneous tissue disorders</b>			
Rash*	Very common	Common	
<b>Musculoskeletal and connective tissue disorders</b>			
Arthralgia	Very common	Uncommon	
<b>General disorders and administration site conditions</b>			
Edema peripheral	Common	Uncommon	

Note: Adverse reactions included as preferred terms are based on MedDRA version 20.0.

\*Represents a pooling of preferred terms.

*(3) Maintenance therapy with multiple myeloma not treated with stem cell transplantation (TOURMALINE-MM4 - Study C16021 – NCT02312258)*

Safety data on maintenance therapy in patients with multiple myeloma not treated with stem cell transplantation is from TOURMALINE-MM4, which included 702 patients who received NINLARO (N = 426) or placebo (N = 276).

For maintenance therapy with multiple myeloma not treated with stem cell transplantation (TOURMALINE MM4, the most frequently reported adverse reactions ( $\geq 20\%$ ) in patients receiving were nausea (ixazomib 27% vs. placebo 8%), vomiting (ixazomib 24% vs. placebo

4%), and diarrhea (ixazomib 23% vs. placebo 12%). Serious adverse reactions reported in  $\geq$  2% of patients included pneumonia (4%). For each adverse reaction, ixazomib was discontinued in  $<$  1% of patients.

**Table 9. Adverse Reactions in Patients Treated with Ixazomib as Maintenance Therapy for Multiple Myeloma Not Treated with stem cell transplantation in TOURMALINE-MM4 (All Grades, Grade 3 and Grade 4)**

System Organ Class / Adverse Reactions	Adverse Reactions (All Grades)	Grade 3 Adverse Reactions	Grade 4 Adverse Reactions
<u>Infections and infestations</u>			
Upper respiratory tract infection	Very common	Uncommon	
Pneumonia	Common	Common	
Herpes zoster	Common	Uncommon	
<u>Blood and lymphatic system disorders</u>			
Thrombocytopenia*	Common	Common	
<u>Nervous system disorders</u>			
Peripheral neuropathies*	Very common	Common	
<u>Gastrointestinal disorders</u>			
Diarrhea	Very common	Common	
Nausea	Very common	Uncommon	
Vomiting	Very common	Common	
<u>Skin and subcutaneous tissue disorders</u>			
Rash*	Very common	Common	
<u>Musculoskeletal and connective tissue disorders</u>			
Arthralgia	Very common	Uncommon	
<u>General disorders and administration site conditions</u>			
Edema peripheral	Common		

**Note: Adverse reactions included as preferred terms are based on MedDRA version 22.0.**

\* Represents a pooling of preferred terms

#### Description of selected adverse reactions

##### Discontinuations

##### ***Combination Therapy with Lenalidomide and Dexamethasone (TOURMALINE MM1)***

For each adverse reaction, one or more of the three medicinal products was discontinued in  $\leq$  3% of patients in the IXAZOMIB regimen.

##### ***Maintenance Therapy following autologous stem cell transplantation (TOURMALINE MM3)***

For each adverse reaction, ixazomib was discontinued in  $<$ 1% of patients.

***Maintenance Therapy not treated with stem cell transplantation (TOURMALINE MM4)***

For each adverse reaction, ixazomib was discontinued in <1% of patients.

***Thrombocytopenia******Combination Therapy with Lenalidomide and Dexamethasone (TOURMALINE MM1)***

Two percent of patients in both the IXAZOMIB regimen and the placebo regimen had a platelet count  $\leq 10,000/\text{mm}^3$  during treatment. Less than 1% of patients in both regimens had a platelet count  $\leq 5,000/\text{mm}^3$  during treatment. Thrombocytopenia resulted in discontinuation of one or more of the three medicinal products in < 2% of patients in the IXAZOMIB regimen and 3% of patients in the placebo regimen. Thrombocytopenia did not result in an increase in haemorrhagic events or platelet transfusions.

***Maintenance Therapy following autologous stem cell transplantation (TOURMALINE MM3)***

Grade 3 thrombocytopenia was reported in 4% of patients receiving ixazomib. There were no reports of Grade 3 thrombocytopenia in patients receiving placebo. Grade 4 thrombocytopenia was reported in 1% of patients receiving ixazomib and < 1% of patients receiving placebo. Serious adverse reactions of thrombocytopenia were reported in < 1% of patients receiving either ixazomib or placebo.

***Maintenance Therapy not treated with stem cell transplantation (TOURMALINE MM4)***

Grade 3 thrombocytopenia was reported in 2% of patients receiving ixazomib. There were no reports of Grade 3 thrombocytopenia in patients receiving placebo. No serious adverse reactions of thrombocytopenia were reported in patients receiving ixazomib or placebo.

***Gastrointestinal toxicities******Combination Therapy with Lenalidomide and Dexamethasone (TOURMALINE MM1)***

Diarrhoea resulted in discontinuation of one or more of the three medicinal products in 2% of patients in the IXAZOMIB regimen and 1% of patients in the placebo regimen.

***Maintenance Therapy following autologous stem cell transplantation (TOURMALINE MM3)***

Diarrhoea resulted in discontinuation of ixazomib in <1% of patients; no patients in the placebo arm discontinued due to diarrhoea.

***Maintenance Therapy not treated with stem cell transplantation (TOURMALINE MM4)***

Nausea and vomiting resulted in discontinuation of ixazomib in <1% of patients; no patients in the placebo arm discontinued due to nausea or vomiting.

***Rash******Combination Therapy with Lenalidomide and Dexamethasone (TOURMALINE MM1)***

Rash occurred in 25% of patients in the IXAZOMIB regimen compared to 15% of patients in the placebo regimen. The most common type of rash reported in both regimens was maculo-papular and macular rash. Grade 3 rash was reported in 3% of patients in the IXAZOMIB regimen compared to 2% of patients in the placebo regimen. Rash resulted in discontinuation of one or more of the three medicinal products in < 1% of patients in both regimens.

***Maintenance Therapy following autologous stem cell transplantation (TOURMALINE MM3)***

The most common types of rash reported in patients receiving ixazomib or placebo included maculopapular and macular rash. Grade 3 rash was reported in 1% of patients receiving ixazomib; no patients receiving placebo reported Grade 3 rash. Serious adverse reactions of rash were reported in < 1% of patients receiving ixazomib; no patients receiving placebo reported a serious adverse reaction of rash.

***Maintenance Therapy not treated with stem cell transplantation (TOURMALINE MM4)***

The most common types of rash reported in patients receiving ixazomib or placebo included maculopapular and macular rash. Grade 3 rash was reported in 2% of patients receiving ixazomib; no patients receiving placebo reported Grade 3 rash. Serious adverse reactions of rash were reported in < 1% of patients receiving ixazomib; no patients receiving placebo reported a serious adverse reaction of rash.

***Peripheral neuropathy***

***Combination Therapy with Lenalidomide and Dexamethasone (TOURMALINE MM1)***

Peripheral neuropathy occurred in 28% of patients in the IXAZOMIB regimen compared to 22% of patients in the placebo regimen. Grade 3 adverse reactions of peripheral neuropathy were reported in 2% of patients in the IXAZOMIB regimen compared to 1% in the placebo regimens. The most commonly reported reaction was peripheral sensory neuropathy (21% and 15% in the IXAZOMIB and placebo regimen, respectively). Peripheral motor neuropathy was not commonly reported in either regimen (< 1%). Peripheral neuropathy resulted in discontinuation of one or more of the three medicinal products in 3% of patients in the IXAZOMIB regimen compared to <1% of patients in the placebo regimen.

***Maintenance Therapy following autologous stem cell transplantation (TOURMALINE MM3)***

Grade 3 adverse reactions of peripheral neuropathy were reported in < 1% of patients receiving ixazomib; no patients receiving placebo reported Grade 3 adverse reaction of peripheral neuropathy. No serious adverse reactions of peripheral neuropathy were reported in patients receiving ixazomib or placebo. The most commonly reported reaction was peripheral neuropathy unspecified (10% and 8% in patients receiving ixazomib and placebo, respectively). No patients receiving ixazomib reported peripheral motor neuropathy; < 1% of patients receiving placebo reported peripheral motor neuropathy.

***Maintenance Therapy not treated with stem cell transplantation (TOURMALINE MM4)***

Grade 3 adverse reactions of peripheral neuropathy were reported in 2% of patients receiving ixazomib; no patients receiving placebo reported Grade 3 adverse reaction of peripheral neuropathy. No serious adverse reactions of peripheral neuropathy were reported in patients receiving ixazomib or placebo. The most commonly reported reaction was peripheral sensory neuropathy (15% and 9% in patients receiving ixazomib and placebo, respectively). Peripheral motor neuropathy was reported in <1% of patients receiving ixazomib; no patients receiving placebo reported peripheral motor neuropathy.

***Peripheral Edema***

***Combination Therapy with Lenalidomide and Dexamethasone (TOURMALINE MM1)***

Peripheral edema was reported in 25% and 18% of patients in ixazomib and placebo regimens, respectively. The majority of peripheral edema adverse reactions were Grade 1 (16% in ixazomib regimen and 13% in the placebo regimen) and Grade 2 (7% in ixazomib regimen and 4% in the placebo regimen).

Grade 3 peripheral edema was reported in 2% and 1% of patients in ixazomib and placebo regimens, respectively. There was no Grade 4 peripheral edema reported. There were no discontinuations reported due to peripheral edema.



***Maintenance Therapy following autologous stem cell transplantation (TOURMALINE MM3)***

Grade 3 peripheral edema was reported in < 1% of patients receiving ixazomib; no patients receiving placebo reported Grade 3 peripheral edema. There were no serious adverse reactions of peripheral edema reported in patients receiving ixazomib or placebo

***Maintenance Therapy not treated with stem cell transplantation (TOURMALINE MM4)***

There were no serious adverse reactions of peripheral edema reported in patients receiving ixazomib or placebo.

***Pneumonia******Maintenance Therapy following autologous stem cell transplantation (TOURMALINE MM3)***

Grade 3 pneumonia was reported in 6% of patients receiving ixazomib and 4% of patients receiving placebo. Grade 4 pneumonia was reported in < 1% of patients receiving ixazomib, and in no patients receiving placebo. Serious adverse reactions of pneumonia were reported in 6% of patients receiving ixazomib and 4% of patients receiving placebo. There was one case of fatal pneumonia in a patient receiving ixazomib. Pyrexia, which commonly occurred in association with infections, including pneumonia, was reported in 21% and 15% of patients receiving ixazomib and placebo, respectively.

***Maintenance Therapy not treated with stem cell transplantation (TOURMALINE MM4)***

Grade 3 pneumonia was reported in 4% of patients receiving ixazomib and 1% of patients receiving placebo. Serious adverse reactions of pneumonia were reported in 4% of patients receiving ixazomib and <1% of patients receiving placebo. Pyrexia, which commonly occurred in association with infections, including pneumonia, was reported in 11% and 5% of patients receiving ixazomib and placebo, respectively.

***Eye Disorders******Combination Therapy with Lenalidomide and Dexamethasone (TOURMALINE MM1)***

Eye disorders were reported with many different preferred terms but in aggregate, the frequency was 34% in patients in the IXAZOMIB regimen and 28% of patients in the placebo regimen. The most common adverse reactions were blurred vision (6% in the IXAZOMIB regimen and 5% in the placebo regimen), dry eye (6% in the IXAZOMIB regimen and 1% in the placebo regimen), conjunctivitis (8% in the IXAZOMIB regimen and 2% in the placebo regimen) and cataract (13% in the IXAZOMIB regimen and 17% in the placebo regimen). Grade 3 adverse reactions were reported in 6% of patients in the IXAZOMIB regimen and 8% of patients in the placebo regimens.

***Other adverse reactions***

In the pooled dataset from the pivotal, Phase 3, global C16010 study (n=720) and the double-blind, placebo-controlled, C16010 China Continuation Study (n=115), the following adverse reactions occurred with a similar rate between the IXAZOMIB and placebo regimens: fatigue (28% vs. 26%), decreased appetite (13% vs. 11%), hypotension (5% vs. 4%), heart failure<sup>†</sup> (5% each), arrhythmia<sup>†</sup> (17% vs. 16%), and liver impairment including enzyme changes<sup>†</sup> (11% vs. 9%).

The frequency of severe (Grade 3-4) events of hypokalaemia was higher in the IXAZOMIB regimen (7%) than the placebo regimen (2%).

Fungal and viral pneumonia resulting in fatal outcome were rarely reported in patients given the IXAZOMIB, lenalidomide and dexamethasone combination.

† Standardised MedDRA Queries (SMQs)

#### 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.

### **4.9 Overdose**

Overdose has been reported in patients taking NINLARO. Symptoms of overdose are generally consistent with the known risks of NINLARO (see section 4.8). Overdose of 12 mg (taken at one time) has resulted in serious adverse events, such as severe nausea, aspiration pneumonia, multiple organ failure and death.

There is no known specific antidote for IXAZOMIB overdose. In the event of an overdose, monitor the patient closely for adverse reactions (section 4.8) and provide appropriate supportive care. Ixazomib is not dialyzable (see section 5.2).

Overdoses were most common in patients starting treatment with NINLARO. The importance of carefully following all dosage instructions should be discussed with patients starting treatment. Instruct patients to take the recommended dosage as directed because overdose has led to deaths.

## **5. PHARMACOLOGICAL PROPERTIES**

### **5.1 Pharmacodynamic properties**

Pharmacotherapeutic group: Antineoplastic agents, other antineoplastic agents, ATC code: L01XG03

#### Mechanism of action

Ixazomib citrate, a prodrug, is a substance that rapidly hydrolyses under physiological conditions to its biologically active form, ixazomib.

Ixazomib is an oral, highly selective and reversible proteasome inhibitor. Ixazomib preferentially binds and inhibits the chymotrypsin-like activity of the beta 5 subunit of the 20S proteasome.

Ixazomib induced apoptosis of several tumour cell types *in vitro*. Ixazomib demonstrated *in vitro* cytotoxicity against myeloma cells from patients who had relapsed after multiple prior therapies, including bortezomib, lenalidomide, and dexamethasone. The combination of ixazomib and lenalidomide demonstrated synergistic cytotoxic effects in multiple myeloma cell lines. *In vivo*, ixazomib demonstrated antitumour activity in various tumour xenograft models, including models of multiple myeloma. *In vitro*, ixazomib affected cell types found in the bone marrow microenvironment including vascular endothelial cells, osteoclasts and osteoblasts.

#### Cardiac electrophysiology

Ixazomib did not prolong the QTc interval at clinically relevant exposures based on the results of a pharmacokinetic-pharmacodynamic analysis of data from 245 patients. At the 4 mg dose, mean change from baseline in QTcF was estimated to be 0.07 msec (90% CI; -0.22, 0.36) from the model

based analysis. There was no discernible relationship between ixazomib concentration and the RR interval suggesting no clinically meaningful effect of ixazomib on heart rate.

#### Clinical efficacy and safety

##### 1) Treatment of patients with multiple myeloma who have received at least one prior therapy in combination with lenalidomide and dexamethasone (TOURMALINE-MM1 Study C16010)

The efficacy and safety of IXAZOMIB in combination with lenalidomide and dexamethasone was evaluated in an international randomized, double-blind, placebo-controlled, multicenter Phase 3 superiority study (C16010) in patients with relapsed and/or refractory multiple myeloma who had received at least one prior therapy. A total of 722 patients (intent-to-treat [ITT] population) were randomized in a 1:1 ratio to receive either the combination of IXAZOMIB, lenalidomide, and dexamethasone (N=360; IXAZOMIB regimen) or placebo, lenalidomide and dexamethasone (N=362; placebo regimen) until disease progression or unacceptable toxicity. Patients enrolled in the trial had multiple myeloma that was refractory, including primary refractory, had relapsed after prior therapy, or had relapsed and was refractory to any prior therapy. Patients that changed therapies prior to disease progression were eligible for enrolment, as well as those with controlled cardiovascular conditions. The Phase 3 study excluded patients who were refractory to lenalidomide or proteasome inhibitors and patients who received more than three prior therapies. For the purposes of this study, refractory disease was defined as disease progression on treatment or progression within 60 days after the last dose of lenalidomide or a proteasome inhibitor. As data are limited in these patients, a careful risk-benefit assessment is recommended before initiating the IXAZOMIB regimen.

Thromboprophylaxis was recommended for all patients in both treatment groups according to the lenalidomide SmPC. Concomitant medications, such as antiemetic, antiviral, and antihistamine medications were given to patients at the physician's discretion as prophylaxis and/or management of symptoms.

Patients received IXAZOMIB 4 mg or placebo on Days 1, 8, and 15 plus lenalidomide (25 mg) on Days 1 through 21 and dexamethasone (40 mg) on Days 1, 8, 15, and 22 of a 28-day cycle. Patients with renal impairment received a starting dose of lenalidomide according to its SmPC. Treatment continued until disease progression or unacceptable toxicities.

The baseline demographics and disease characteristics were balanced and comparable between the study regimens. The median age was 66 years, range 38-91 years; 58% of patients were older than 65 years. Fifty seven percent of patients were male. Eighty five percent of the population was White, 9% Asian and 2% Black. Ninety three percent of patients had an ECOG performance status of 0-1 and 12% had baseline ISS stage III disease (N=90). Twenty five percent of patients had a creatinine clearance of < 60 mL/min. Twenty three percent of patients had light chain disease and 12% of patients had measurable disease by free light chain assay only. Nineteen percent had high-risk cytogenetic abnormalities (del[17], t[4;14], t[14;16]) (N=137), 10% had del(17) (N=69) and 34% had 1q amplification (1q21) (N=247). Patients received one to three prior therapies (median of 1) including prior treatment with bortezomib (69%), carfilzomib (<1%), thalidomide (45%), lenalidomide (12%), melphalan (81%). Fifty seven percent of patients had undergone prior stem cell transplantation. Seventy seven percent of patients relapsed after prior therapies and 11% were refractory to prior therapies. Primary refractory, defined as best response of stable disease or disease progression on all prior therapies, was documented in 6% of patients.

The primary endpoint was progression-free survival (PFS) according to the 2011 International Myeloma Working Group (IMWG) Consensus Uniform Response Criteria as assessed by a blinded independent review committee (IRC) based on central laboratory results. Response was assessed every 4 weeks until disease progression. At the primary analysis (median follow up of 14.7 months and a median of 13 cycles), PFS was statistically significantly different between the treatment arms. PFS results are summarized in Table 10 and Figure 1. The improvement in PFS in the IXAZOMIB regimen was supported by improvements in overall response rate.

**Table 10: Progression Free Survival and Response Results in Multiple Myeloma Patients Treated with IXAZOMIB or Placebo in Combination with Lenalidomide and Dexamethasone TOURMALINE MM1 Study C16010 (Intent-to-Treat Population)**

	IXAZOMIB + Lenalidomide and Dexamethasone (N = 360)	Placebo + Lenalidomide and Dexamethasone (N = 362)
<b>Progression-Free Survival</b>		
Events, n (%)	129 (36)	157 (43)
Median (months)	20.6	14.7
p-value*	0.012	
Hazard Ratio† (95% CI)	0.74 (0.59, 0.94)	
<b>Overall Response Rate‡, n (%)</b>	282 (78.3)	259 (71.5)
<b>Response Category, n (%)</b>		
Complete Response	42 (11.7)	24 (6.6)
Very Good Partial Response	131 (36.4)	117 (32.3)
Partial Response	109 (30.3)	118 (32.6)
<b>Time to Response, months</b>		
Median	1.1	1.9
<b>Duration of Response§, months</b>		
Median	20.5	15.0

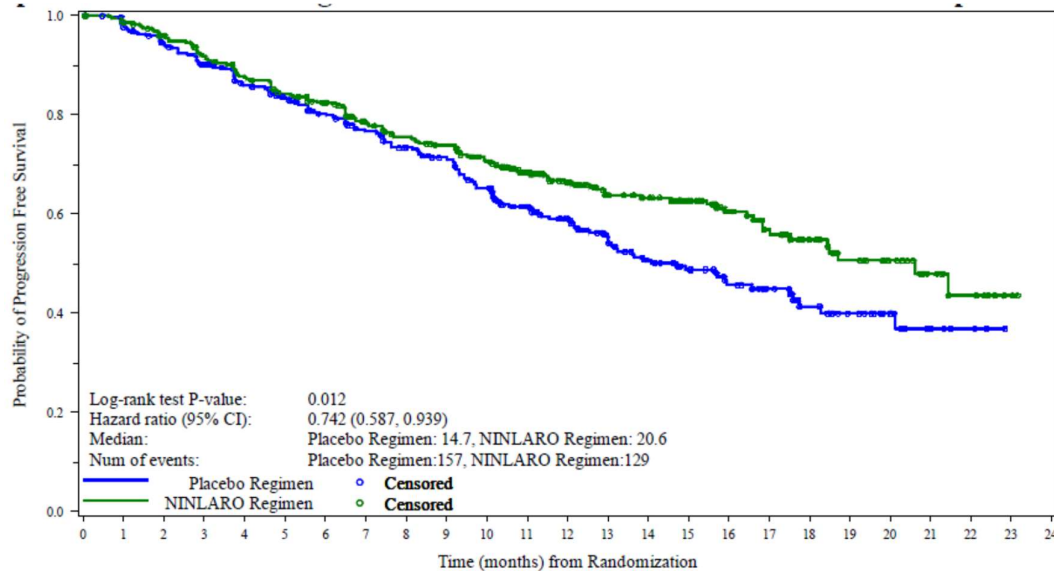
\*P-value is based on the stratified log-rank test.

†Hazard ratio is based on a stratified Cox’s proportional hazard regression model. A hazard ratio less than 1 indicates an advantage for the IXAZOMIB regimen.

‡ORR = CR+VGPR+PR

§Based on responders in the response-evaluable population

**Figure 1: Kaplan-Meier Plot of Progression-Free Survival in the Intent-to-Treat Population**



**Number of Patients at Risk**

Placebo Regimen	362	340	325	308	288	274	254	237	218	208	188	157	130	101	85	71	58	46	31	22	15	5	3	0	0
NINLARO Regimen	360	345	332	315	298	283	270	248	233	224	206	182	145	119	111	95	72	58	44	34	26	14	9	1	0

A second, non-inferential, PFS analysis was conducted with a median follow up of 23 months. At this analysis, estimated median PFS was 20 months in the ixazomib regimen and 15.9 months in the

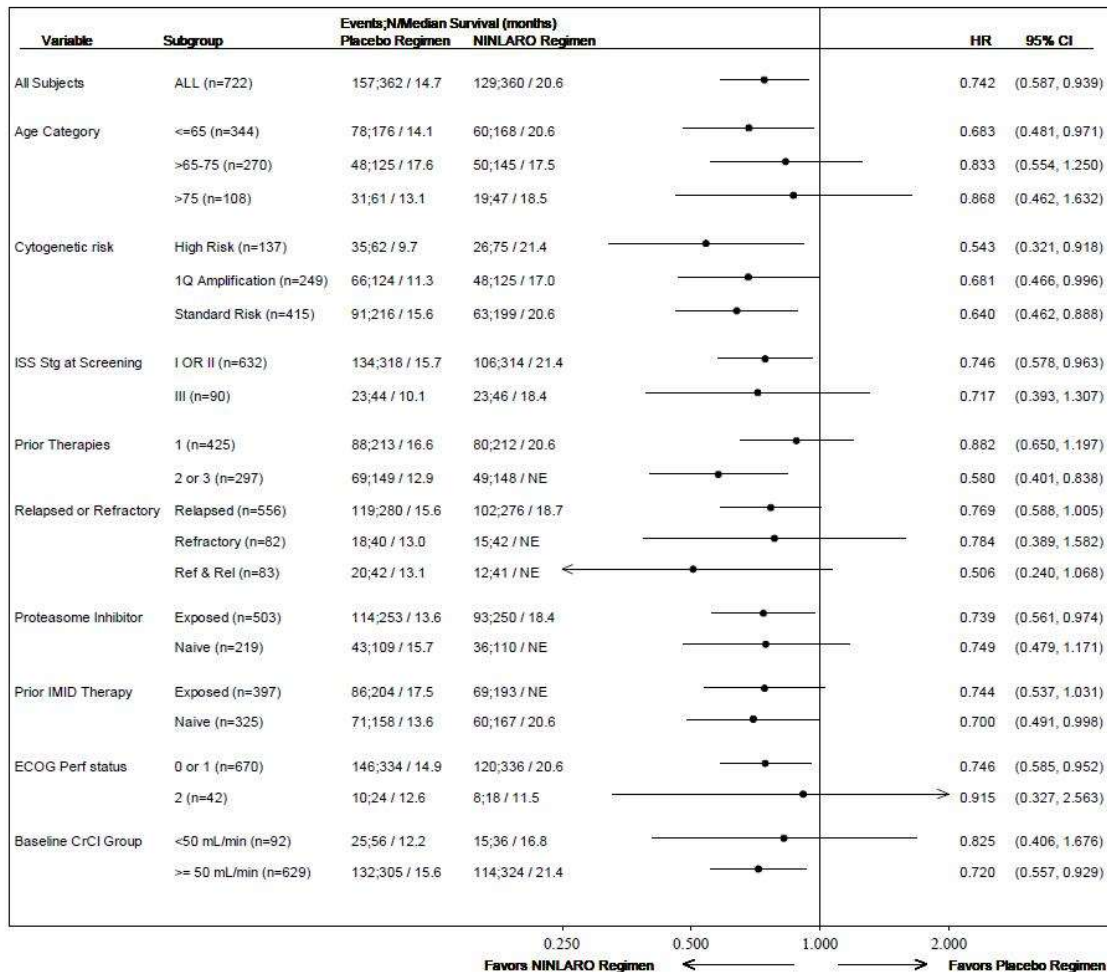
placebo regimen (HR = 0.82 [95% CI (0.67, 1.0)]) in the ITT population. For patients with one prior therapy, the median PFS was 18.7 months in the ixazomib regimen and 17.6 months in the placebo regimen (HR = 0.99). For patients with 2 or 3 prior therapies, PFS was 22.0 months in the ixazomib regimen and 13.0 months in the placebo regimen (HR = 0.62).

At the final analysis for OS at a median duration of follow up of approximately 85 months, median OS in the ITT population was 53.6 months for patients in the ixazomib regimen and 51.6 months for patients in the placebo regimen (HR = 0.94 [95% CI: 0.78, 1.13; p = 0.495]). For patients with one prior therapy, the median OS was 54.3 months in the ixazomib regimen and 58.3 months in the placebo regimen (HR = 1.02 [95% CI: 0.80, 1.29]). For patients with 2 or 3 prior therapies, the median OS was 53.0 months in the ixazomib regimen and 43.0 months in the placebo regimen (HR = 0.85 [95% CI: 0.64, 1.11]).

A randomized, double-blind, placebo-controlled Phase 3 study was conducted in China (N=115) with a similar study design and eligibility criteria. Many of the patients enrolled in the study had advanced disease with Durie-Salmon Stage III (69%) at initial diagnosis and a treatment history of receiving at least 2 prior therapies (60%) and being thalidomide refractory (63%). At the primary analysis (median follow up of 8 months and a median of 6 cycles), the median PFS was 6.7 months in the IXAZOMIB regimen compared to 4 months in the placebo regimen (p-value=0.035, HR=0.60). At the final analysis for OS at a median follow up of 19.8 months, OS was improved for patients treated in the IXAZOMIB regimen compared with placebo [p-value=0.0014, HR=0.42, 95% CI: 0.242, 0.726 ].

As multiple myeloma is a heterogeneous disease, benefit may vary across subgroups in the Phase 3 study (C16010) (see Figure 2).

**Figure 2: Forest plot of progression-free survival in subgroups**



In the Phase 3 study (C16010), 10 patients (5 in each treatment regimen) had severe renal impairment at baseline. Of the 5 patients in the IXAZOMIB regimen, one patient had a confirmed partial response and 3 confirmed stable disease (however 2 were unconfirmed partial response and 1 was an unconfirmed very good partial response). Of the 5 patients in the placebo regimen, 2 had a confirmed very good partial response.

Quality of life as assessed by global health scores (EORTC QLQ-C30 and MY-20) was maintained during treatment and was similar in both treatment regimens in the Phase 3 study (C16010).

2) Maintenance therapy with multiple myeloma following autologous stem cell transplant (TOURMALINE-MM3)

A total of 656 patients with newly diagnosed multiple myeloma who have had partial response (PR) or better following induction therapy and conditioning regimen conditioning regimen containing high-dose melphalan with autologous stem cell transplantation (ASCT) were randomized in a 3:2 fashion to ixazomib maintenance:placebo. Dosing for ixazomib or matching placebo was 3 mg PO once daily on Days 1, 8, and 15 of a 28-day cycle for the first 4 cycles. If tolerated in the first 4 cycles, the dose was escalated to 4 mg beginning at Cycle 5 Day 1 and administered on the same schedule for the duration of therapy. Therapy continued to approximately 24 months, disease progression, or intolerable toxicity, whichever came first.

Table 11 summarizes the baseline patient and disease characteristics in the study. The baseline demographics and disease characteristics were balanced and comparable between the study regimens.

**Table 11 : Baseline Patient and Disease Characteristics (TOURMALINE MM3)**

	Ixazomib (N = 395)	Placebo (N = 261)
<i>Patient Characteristics</i>		
Median age in years (range)	58 (24, 73)	60 (37, 73)
Gender (%) Male/ Female	64/36	62/38
Age Group (% [ $< 60$ / $\geq 60$ to $< 75$ years])	58/42	49/51
Race (%)		
White	80	82
Black	2	1
Asian	15	14
Other or Not Specified	4	3
ECOG performance status, (%)		
0	66	69
1	32	28
2	3	2
Missing	0	<1
<i>Disease Characteristics</i>		
Myeloma ISS stage at initial diagnosis, n (%)		
Stage I	37	37
Stage II or III	63	63
Type of Induction Therapy pre-ASCT (%)		
PI and IMiD	30	30
Any immunomodulatory agent (IMiD)*	11	11
Any proteasome inhibitor*	59	59

Response after transplantation†, %		
CR or VGPR	77	78
PR	23	22
Cytogenetics		
High risk (deletion del[17], t[4:14] and/or t[14:16])	15	21
del(17)	7	8
Minimal Residual Disease (MRD) Status at Study Entry		
MRD-negative	30	29
MRD-positive	57	53

\*Subject counts once for each type of treatment

†As assessed by investigator

The primary endpoint was progression-free survival (PFS) as assessed by a blinded independent review committee (IRC), and the ixazomib arm demonstrated significant improvement in PFS.

PFS results are summarized in Table 12 and shown in Figure 3.

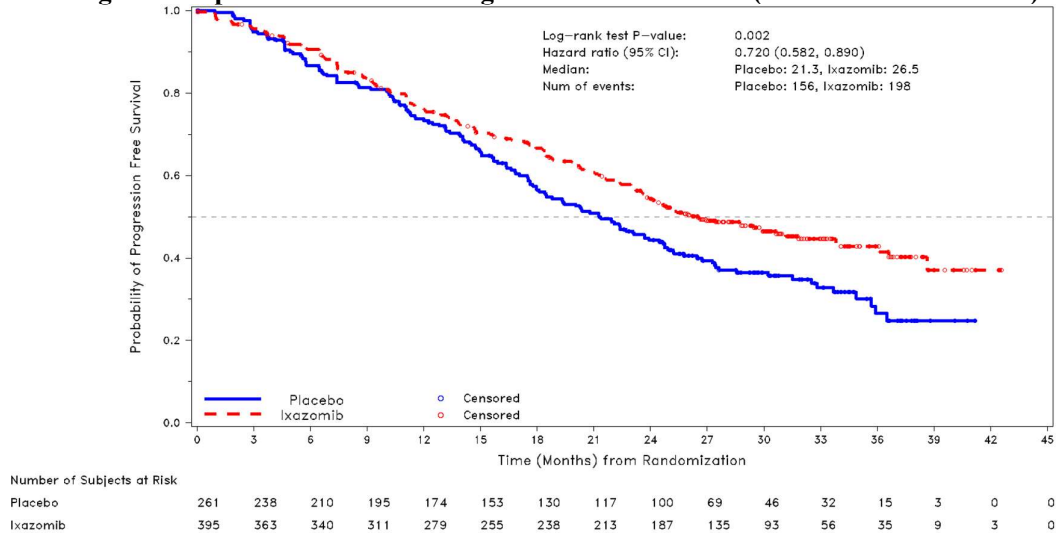
**Table 12: Progression-Free Survival (TOURMALINE-MM3)**

	Ixazomib (n = 395)	Placebo (n = 261)
PFS events, n (%)	198 (50%)	156 (60%)
Median PFS, months (95% CI)	26.5 (23.69~33.81)	21.3 (17.97~24.67)
P-value <sup>1)</sup>	0.002	
Hazard ratio (95% CI) <sup>2)</sup>	0.720 (0.582~0.890)	

1) P-value is based on the stratified log-rank test.

2) Hazard ratio is based on a stratified Cox’s proportional hazard regression model. A hazard ratio less than 1 indicates an advantage for the NINLARO regimen.

**Figure 3. Kaplan-Meier Plot of Progression-Free Survival (TOURMALINE-MM3)**



3) Maintenance therapy with multiple myeloma not treated with stem cell transplantation (TOURMALINE-MM4)

A total of 706 patients with newly diagnosed multiple myeloma who have had partial response (PR) or better following induction therapy and not treated with stem cell transplantation (SCT) were randomized in a 3:2 fashion to ixazomib maintenance:placebo. Dosing for ixazomib or matching placebo was 3 mg PO once daily on Days 1, 8, and 15 of a 28-day cycle for the first 4 cycles. If tolerated in the first 4 cycles, the dose was escalated to 4 mg beginning at Cycle 5 Day 1 and administered on the same schedule for the duration of therapy. Therapy continued to approximately 24 months, disease progression, or intolerable toxicity, whichever came first.

Table 13 summarizes the baseline patient and disease characteristics in the study. The baseline demographics and disease characteristics were balanced and comparable between the study regimens.

**Table 13: Baseline Patient and Disease Characteristics (TOURMALINE MM4)**

	Ixazomib (N = 425)	Placebo (N = 281)
Patient Characteristics		
Median age in years (range)	72 (42, 89)	73 (52, 90)
Gender (%) Male/ Female	52/48	55/45
Age Group (%) [< 65/ ≥ 65 to < 75 years] [≥ 75/ ≥ 85]	9/53 38/3	10/51 39/3
Race (%)		
White	78	81
Black	4	2
Asian	15	14
Other or Not Specified	3	3
ECOG performance status at study entry, (%)		
0	50	52
1	45	43
2	4	5
Missing	<1	0
Disease Characteristics		
ISS stage before initial therapy (%)		
Stage I or II	66	65
Stage III	34	35
Initial therapy included Proteasome Inhibitor (PI) (%)	80	80
Yes	20	20
No		
Response to initial therapy (%)		
CR or VGPR	62	62
PR	38	38
Cytogenetics (%)		
High risk (deletion del[17], t[4:14] and/or t[14:16])	17	17
del(17)	10	7
Minimal Residual Disease (MRD) Status at Study Entry (%)		
MRD-negative	10	9
MRD-positive	40	44



The primary endpoint was progression-free survival (PFS) as assessed by a blinded independent review committee (IRC), and the ixazomib arm demonstrated significant improvement in PFS. PFS results are summarized in Table 14 and shown in Figure 4.

**Table 14: Progression-Free Survival (TOURMALINE MM4)**

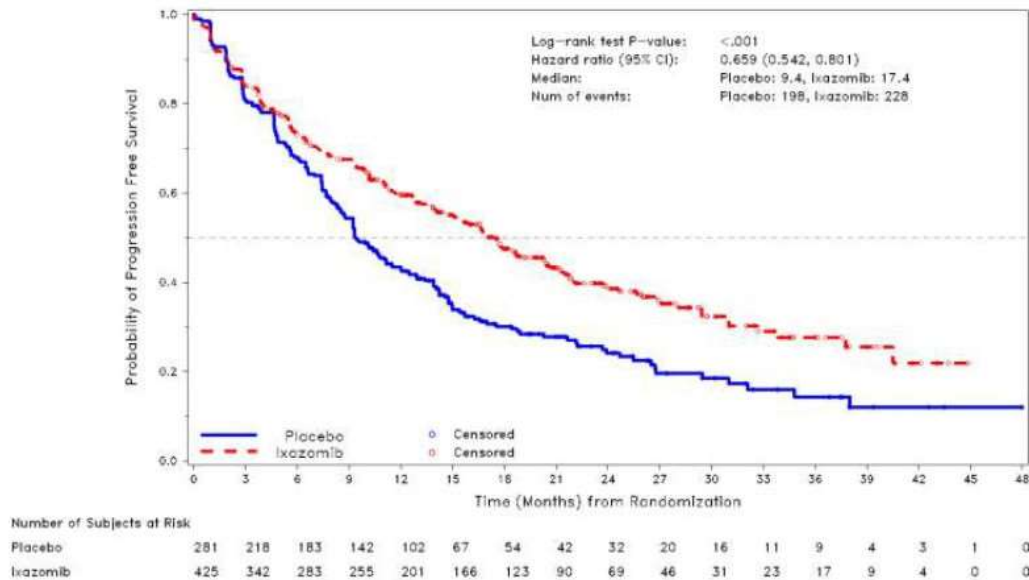
	Ixazomib (n = 425)	Placebo (n = 281)
PFS events, n (%)	228 (54%)	198 (70%)
Median PFS, months (95% CI)	17.4 (14.78~20.30)	9.4 (8.51~11.47)
P-value <sup>1)</sup> (assigned alpha)	<0.001 (0.04)	
Hazard ratio (95% CI) <sup>2)</sup>	0.659 (0.542~0.801)	

1) P-value is based on the stratified log-rank test with stratification factors.

2) Hazard ratio is based on a stratified Cox's proportional hazard regression model test with stratification factors.

A hazard ratio less than 1 indicates an advantage for the NINLARO regimen.

**Figure 4. Kaplan-Meier Plot of Progression-Free Survival (TOURMALINE MM4)**



Paediatric population

The European Medicines Agency has waived the obligation to submit the results of studies with IXAZOMIB in all subsets of the paediatric population in multiple myeloma (see section 4.2 for information on paediatric use).

**5.2 Pharmacokinetic properties**

Absorption

After oral administration, peak plasma concentrations of ixazomib were achieved at approximately one hour after dosing. The mean absolute oral bioavailability is 58%. Ixazomib AUC increases in a dose proportional manner over a dose range of 0.2-10.6 mg.

Administration with a high-fat meal decreased ixazomib AUC by 28% compared with administration after an overnight fast (see section 4.2).

### Distribution

Ixazomib is 99% bound to plasma proteins and distributes into red blood cells with a blood-to-plasma AUC ratio of 10. The steady-state volume of distribution is 543 L.

### Biotransformation

After oral administration of a radiolabeled dose, 70% of total drug-related material in plasma was accounted for by ixazomib. Metabolism by multiple CYP enzymes and non-CYP proteins is expected to be the major clearance mechanism for ixazomib. At clinically relevant ixazomib concentrations, *in vitro* studies using human cDNA-expressed cytochrome P450 isozymes indicate that no specific CYP isozyme predominantly contributes to ixazomib metabolism and non-CYP proteins contribute to overall metabolism. At concentrations exceeding those observed clinically, ixazomib was metabolized by multiple CYP isoforms with estimated relative contributions of 3A4 (42.3%), 1A2 (26.1%), 2B6 (16.0%), 2C8 (6.0%), 2D6 (4.8%), 2C19 (4.8%) and 2C9 (< 1%).

### Elimination

Ixazomib exhibits a multi-exponential disposition profile. Based on a population PK analysis, systemic clearance (CL) was approximately 1.86 L/hr with inter-individual variability of 44%. The terminal half-life ( $t_{1/2}$ ) of ixazomib was 9.5 days. Approximately 2-fold accumulation in AUC was observed with weekly oral dosing on Day 15.

### Excretion

After administration of a single oral dose of  $^{14}\text{C}$ -ixazomib to 5 patients with advanced cancer, 62% of the administered radioactivity was excreted in urine and 22% in the faeces. Unchanged ixazomib accounted for < 3.5% of the administered dose recovered in urine.

### Special populations

#### Hepatic impairment

The PK of ixazomib is similar in patients with normal hepatic function and in patients with mild hepatic impairment (total bilirubin  $\leq$  ULN and AST  $>$  ULN or total bilirubin  $>$  1-1.5 x ULN and any AST) based on the results of a population PK analysis.

The PK of ixazomib was characterized in patients with normal hepatic function at 4 mg (N=12), moderate hepatic impairment at 2.3 mg (total bilirubin  $>$  1.5-3 x ULN, N=13) or severe hepatic impairment at 1.5 mg (total bilirubin  $>$  3 x ULN, N=18). Unbound dose-normalized AUC was 27% higher in patients with moderate or severe hepatic impairment as compared to patients with normal hepatic function (see section 4.2).

#### Renal impairment

The PK of ixazomib is similar in patients with normal renal function and in patients with mild or moderate renal impairment (creatinine clearance  $\geq$  30 mL/min) based on the results of a population PK analysis.

The PK of ixazomib was characterized at a dose of 3 mg in patients with normal renal function (creatinine clearance  $\geq$  90 mL/min, N=18), severe renal impairment (creatinine clearance  $<$  30 mL/min, N=14), or ESRD requiring dialysis (N=6). Unbound AUC was 38% higher in patients with severe renal impairment or ESRD requiring dialysis as compared to patients with normal renal function. Pre- and post-dialyzer concentrations of ixazomib measured during the haemodialysis session were similar, suggesting that ixazomib is not dialyzable (see section 4.2).

Age, gender, race

There was no clinically meaningful effect of age (23-91 years), sex, body surface area (1.2-2.7 m<sup>2</sup>), or race on the clearance of ixazomib based on the results of a population PK analysis. The mean AUC was 35% higher in Asian patients; however, there was overlap in the AUC of ixazomib across White and Asian patients.

**5.3 Preclinical safety data**Mutagenicity

Ixazomib was not mutagenic in a bacterial reverse mutation assay (Ames assay) or clastogenic in a bone marrow micronucleus assay in mice. Ixazomib was positive in an *in vitro* clastogenicity test in human peripheral blood lymphocytes. However, ixazomib was negative in an *in vivo* comet assay in mice, in which percent tail DNA was assessed in the stomach and liver. Therefore, the weight of evidence indicates that IXAZOMIB is not considered to present a genotoxic risk.

Reproductive and embryo-foetal development

Ixazomib caused embryo-foetal toxicity in pregnant rats and rabbits only at maternally toxic doses and at exposures that were slightly higher than those observed in patients receiving the recommended dose. Studies of fertility and early embryonic development and pre- and post-natal toxicology were not conducted with ixazomib, but evaluation of reproductive tissues was conducted in the general toxicity studies. There were no effects due to ixazomib treatment on male or female reproductive organs in studies up to 6-months duration in rats and up to 9-months duration in dogs.

Animal toxicology and/or pharmacology

In multi-cycle repeated-dose toxicity studies conducted in rats and dogs, the principal target organs included the gastrointestinal tract, lymphoid tissues, and the nervous system. In the 9-month study (10 cycles) in dogs orally administered with a dosing schedule mimicking the clinical regimen (28-day cycle), microscopic neuronal effects were generally minimal in nature and only observed at 0.2 mg/kg (4 mg/m<sup>2</sup>). The majority of target organ findings demonstrated partial to full recovery following discontinuation of treatment, with the exception of neuronal findings in the lumbar dorsal root ganglion and dorsal column.

Following oral administration, a tissue distribution study in rats revealed that the brain and spinal cord were amongst the tissues with the lowest levels, suggesting that the penetration of ixazomib through the blood-brain barrier appears to be limited. However, the relevance to humans is unknown.

Non-clinical safety pharmacology studies both *in vitro* (on hERG channels) and *in vivo* (in telemetered dogs following single oral administration) demonstrated no effects of ixazomib on cardiovascular or respiratory functions at AUC more than 8-fold higher than the clinical value.

**6. PHARMACEUTICAL PARTICULARS****6.1 List of excipients**NINLARO 2.3 mg hard capsulesCapsule contents

Microcrystalline cellulose  
Magnesium stearate  
Talc

Capsule shell

Gelatin  
Titanium dioxide (E171)  
Red iron oxide (E172)

Printing ink

Shellac  
Propylene glycol  
Potassium hydroxide  
Black iron oxide (E172)

NINLARO 3 mg hard capsules

Capsule contents

Microcrystalline cellulose  
Magnesium stearate  
Talc

Capsule shell

Gelatin  
Titanium dioxide (E171)  
Black iron oxide (E172)

Printing ink

Shellac  
Propylene glycol  
Potassium hydroxide  
Black iron oxide (E172)

NINLARO 4 mg hard capsules

Capsule contents

Microcrystalline cellulose  
Magnesium stearate  
Talc

Capsule shell

Gelatin  
Titanium dioxide (E171)  
Yellow iron oxide (E172)  
Red iron oxide (E172)

Printing ink

Shellac  
Propylene glycol  
Potassium hydroxide  
Black iron oxide (E172)

**6.2 Incompatibilities**

Not applicable.

**6.3 Shelf life**

See expiry date on product packaging

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

Do not store above 30°C. Do not freeze.

Store in the original package in order to protect from moisture.

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

PVC-Aluminium /Aluminium blister sealed inside a wallet pack containing one capsule.  
Three single blister wallet packs are packaged in one carton.

#### **6.6 Special precautions for disposal and other handling**

IXAZOMIB is cytotoxic. The capsule should not be removed until just prior to dosing. The capsules should not be opened or crushed. Direct contact with the capsule contents should be avoided. In case of capsule breakage, avoid raising dust during clean-up. If contact occurs, wash thoroughly with soap and water.

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

### **7. MARKETING AUTHORISATION HOLDER**

Imported by: Takeda (Thailand) Ltd., Bangkok, Thailand

### **8. MARKETING AUTHORISATION NUMBER(S)**

Ninlaro (2.3 mg) capsule: 1C 15154/64 (NC)

Ninalro (3 mg) capsule: 1C 15055/61 (NC)

Ninalro (4 mg) capsule: 1C 15056/61 (NC)

### **9. DATE OF AUTHORISATION**

18 July 2018

### **10. DATE OF REVISION OF THE TEXT**

May 2024