

SUMMARY OF PRODUCT CHARACTERISTICS

1 NAME OF THE MEDICINAL PRODUCT

Ebetaxel 6mg/ml Concentrate for Solution for Infusion

2 QUALITATIVE AND QUANTITATIVE COMPOSITION

1ml contains 6mg of the active ingredient, paclitaxel

1 vial of 5ml contains 30mg of paclitaxel

1 vial of 16.7ml contains 100mg of paclitaxel

1 vial of 25ml contains 150mg of paclitaxel

1 vial of 50ml contains 300mg of paclitaxel

1 vial of 100ml contains 600mg of paclitaxel

1ml contains 522.4mg of the excipient, polyoxyl castor oil (macrogol glycerol ricinolate)

For full list of excipients, see 6.1

3 PHARMACEUTICAL FORM

Concentrate for solution for infusion

A clear, colourless to pale yellow solution

4 CLINICAL PARTICULARS

4.1 Therapeutic indications

- Paclitaxel is indicated alone or in combination, for the treatment of advanced carcinoma of the ovary.
- For the treatment of metastatic breast cancer after failure of combination chemotherapy. Prior therapy should have included an anthracycline unless clinically contraindicated.
- Paclitaxel is indicated for the adjuvant treatment of node-positive breast cancer administered sequentially to standard doxorubicin-containing combination chemotherapy.
- Advanced non small cell lung cancer: paclitaxel associated with cisplatin is indicated for the treatment of non small cell lung cancer in patients who are not candidates for potentially curative surgery and/or radiation therapy.
- Kaposi's sarcoma: paclitaxel is indicated in the second-line treatment of AIDS related Kaposi's sarcoma.

4.2 Dosage and Method of Administration

First-line chemotherapy of ovarian cancer

Since other dosage regimens have not yet been evaluated, the recommended first-line treatment of ovarian cancer is 135 mg/m² of paclitaxel as an infusion over 24 hours, followed by 75 mg/m² of cisplatin and a therapy-free interval of three weeks (see “*Interactions with Other Medicinal Products*”).

Second-line chemotherapy of ovarian and metastatic breast cancer

The recommended dosage is 175 mg/m² of paclitaxel, given as an intravenous infusion. Paclitaxel should be administered as a three-hour infusion, with an interval of three weeks between therapy courses.

Adjuvant therapy of node-positive breast cancer

Paclitaxel 175 mg/m² administered intravenously over 3 hours every 3 weeks for 4 courses sequentially to standard combination therapy containing doxorubicin.

Advanced non-small cell lung cancer

The recommended regimen, given every 3 weeks, is paclitaxel administered intravenously over 24 hours at a dose of 135 mg/m² followed by cisplatin 75 mg/m².

Kaposi's sarcoma

Paclitaxel administered at a dose of 135 mg/m² given intravenously over 3 hours every 3 weeks or at a dose of 100 mg/m² given intravenously over 3 hours every 2 weeks is recommended (dose intensity 45-50 mg/m²/week).

In two clinical trials evaluating these schedules, the former schedule (135 mg/m² every 3 weeks) was more toxic than the latter. In addition, all patients with low performance status were treated with the latter schedule (100 mg/m² every 2 weeks).

Dose adjustment during treatment

Treatment courses with paclitaxel may be repeated only if blood counts with at least 1,000/mm³ of neutrophils and at least 75,000/mm³ of platelets have been reached. In patients who exhibit severe neutropenia (neutrophils <500/mm³ over a one-week period or longer) or severe peripheral neuropathies during paclitaxel therapy, subsequent dosing should be reduced by 25% to 75 mg/m².

Special therapeutic groups

Patients with hepatic insufficiency

- Studies in patients with hepatic dysfunction have not been performed. The available data are insufficient to recommend a dose adjustment for these patients (see “*Pharmacokinetic Properties*”). Paclitaxel should not be administered to patients with severe hepatic dysfunction.

- *Patients with renal insufficiency*

- Studies in patients with renal impairment have not been performed. There are no sufficient data for dosage recommendations (see “*Pharmacokinetic Properties*”).

- *Paediatric use*

- Studies demonstrating the safety and efficacy of paclitaxel in children and adolescents (below 18 years of age) have not been performed. Paclitaxel is therefore not recommended for paediatric use.

- *Elderly patients*

- Studies demonstrating the safety and efficacy of paclitaxel in elderly patients (over 65 years of age) have not been performed. Paclitaxel is therefore not recommended for use in elderly patients.

Subsequent dosing of paclitaxel depends on individual patient tolerance levels. Treatment with paclitaxel should only be continued after blood counts with at least 1,500/mm³ of neutrophils and at least 100,000/mm³ of platelets have been achieved. If patients develop severe neutropenia (with neutrophils <500/mm³ for 7 days or longer) or severe peripheral neuropathy, dosage should be reduced by 20% in subsequent courses (see “*Special Warnings and Precautions for Use*”).

All patients must receive premedication treatment with corticosteroids, antihistaminic agents and H₂ antagonists prior to paclitaxel therapy:

Active ingredient	Dosage	Interval prior to paclitaxel administration
Dexamethasone	20 mg orally	approx. 12 and 6 hours
Diphenhydramine	50 mg IV	30-60 minutes
Cimetidine or Ranitidine	300 mg IV 50 mg IV	30-60 minutes

Paclitaxel should be administered using a microporous filter with a pore size ≤0.22 µm (in-line filter) - see “*Instructions for Use and Handling*”.

4.3 Contraindications

Paclitaxel is contra-indicated in patients with severe hypersensitivity to paclitaxel or to any ingredient, especially Polyoxyl castor oil (macrogol glycerol ricinolate) (see 4.4).

Paclitaxel is contraindicated during pregnancy and lactation (see 4.6) and should not be used in patients with baseline neutrophils $< 1,500/\text{mm}^3$ ($< 1,000/\text{mm}^3$ for Kaposi's Sarcoma (KS) patients).

In Kaposi's Sarcoma (KS), paclitaxel is also contraindicated in patients with concurrent, serious, uncontrolled infections.

4.4 Special warnings and precautions for use

Paclitaxel should be administered under the supervision of a physician experienced in the use of cancer chemotherapeutic agents. Since significant hypersensitivity reactions may occur, appropriate supportive equipment should be available.

Patients must be pretreated with corticosteroids, antihistamines and H_2 antagonists (see 4.2).

Paclitaxel should be given *before* cisplatin when used in combination (see 4.5).

Significant hypersensitivity reactions characterised by dyspnoea and hypotension requiring treatment, angioedema and generalised urticaria have occurred in $< 1\%$ of patients receiving paclitaxel after adequate premedication. These reactions are probably histamine-mediated. In the case of severe hypersensitivity reactions, paclitaxel should be discontinued immediately, symptomatic therapy should be initiated and the patient should not be rechallenged with the drug.

Bone marrow suppression (primarily neutropenia) is the dose-limiting toxicity. Frequent monitoring of blood counts should be instituted. Patients should not be retreated until neutrophils recover to $1,500/\text{mm}^3$ ($1,000/\text{mm}^3$ for KS patients) and platelets recover to $100,000/\text{mm}^3$ ($75,000/\text{mm}^3$ for KS patients). In the KS clinical study, the majority of patients were receiving granulocyte colony stimulating factor (G-CSF).

Severe cardiac conduction abnormalities have been reported rarely with single agent paclitaxel. If patients develop significant conduction abnormalities during paclitaxel administration, appropriate therapy should be administered and continuous cardiac monitoring should be performed during subsequent therapy with paclitaxel. Hypotension, hypertension, and bradycardia have been observed during paclitaxel administration; patients are usually asymptomatic and generally do not require treatment. Frequent vital sign monitoring, particularly during the first hour of paclitaxel infusion, is recommended. Severe cardiovascular events were observed more frequently in patients with NSCLC than in those with breast or ovarian

carcinoma. A single case of heart failure related to paclitaxel was seen in the AIDS-KS clinical study.

When paclitaxel is used in combination with doxorubicin or trastuzumab for initial treatment of metastatic breast cancer, attention should be placed on the monitoring of cardiac function. When patients are candidates for treatment with paclitaxel in these combinations, they should undergo baseline cardiac assessment including history, physical examination, ECG, echocardiogram, and/or MUGA scan. Cardiac function should be further monitored during treatment (e.g. every three months). Monitoring may help to identify patients who develop cardiac dysfunction and treating physicians should carefully assess the cumulative dose (mg/m^2) of anthracycline administered when making decisions regarding frequency of ventricular function assessment. When testing indicates deterioration in cardiac function, even asymptomatic, treating physicians should carefully assess the clinical benefits of further therapy against the potential for producing cardiac damage, including potentially irreversible damage. If further treatment is administered, monitoring of cardiac function should be more frequent (e.g. every 1-2 cycles). For more details see Summary of Product Characteristics of trastuzumab or doxorubicin.

Although the occurrence of *peripheral neuropathy* is frequent, the development of severe symptoms is rare. In severe cases, a dose reduction of 20% (25% for KS patients) for all subsequent courses of paclitaxel is recommended. In NSCLC patients and in ovarian cancer patients treated in the first-line setting, the administration of paclitaxel as a three hour infusion in combination with cisplatin, resulted in a greater incidence of severe neurotoxicity than both single agent paclitaxel and cyclophosphamide followed by cisplatin.

Patients with hepatic impairment may be at increased risk of toxicity, particularly grade III-IV myelosuppression. There is no evidence that the toxicity of paclitaxel is increased when given as a three-hour infusion to patients with mildly abnormal liver function. When paclitaxel is given as a longer infusion, increased myelosuppression may be seen in patients with moderate to severe hepatic impairment. Patients should be monitored closely for the development of profound myelosuppression (see 4.2). Inadequate data are available to recommend dosage alterations in patients with mild to moderate hepatic impairments (see 5.2).

No data are available for patients with severe baseline cholestasis. Patients with severe hepatic impairment should not be treated with paclitaxel.

Since paclitaxel 6mg/ml infusion contains ethanol anhydrous (401.66 mg/ml), consideration should be given to possible CNS and other effects.

Special care should be taken to avoid intra-arterial application of paclitaxel, since in animal studies testing for local tolerance severe tissue reactions were observed after intra-arterial application.

Pseudomembranous colitis has been rarely reported including cases in patients who have not been concomitantly treated with antibiotics. This reaction should be considered in the differential diagnosis of cases of severe or persistent diarrhoea occurring during or shortly after treatment with paclitaxel.

Paclitaxel in combination with radiation of the lung, irrespective of their chronological order, may contribute to the development of *interstitial pneumonitis*.

In KS patients, severe mucositis is rare. If severe reactions occur, the paclitaxel dose should be reduced by 25%.

This product contains polyxolyl castor oil (macrogol glycerol ricinolate) which may cause severe allergic reactions.

4.5 Interaction with other medicinal products and other forms of interaction

Cimetidine

Paclitaxel clearance is not affected by cimetidine premedication.

Cisplatin

The recommended regimen of paclitaxel administration for the first-line chemotherapy of ovarian carcinoma is for paclitaxel to be given before cisplatin. When paclitaxel is given before cisplatin, the safety profile of paclitaxel is consistent with that reported for single-agent use. When paclitaxel was given after cisplatin, patients showed a more profound myelosuppression and an approximately 20% decrease in paclitaxel clearance. Patients treated with paclitaxel and cisplatin may have an increased risk of renal failure as compared to cisplatin alone in gynaecological cancers.

Doxorubicin

Since the elimination of doxorubicin and its active metabolites can be reduced when paclitaxel and doxorubicin are given closer in time, paclitaxel for initial treatment of metastatic breast cancer should be administered 24 hours after doxorubicin (see 5.2).

Cytochrome P450 isoenzyme substrates

The metabolism of paclitaxel is catalysed, in part, by cytochrome P450 isoenzymes CYP2C8 and CYP3A4. 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.

Protease inhibitors

Studies in KS patients, who were taking multiple concomitant medications, suggest that the systemic clearance of paclitaxel was significantly lower in the presence of nelfinavir and ritonavir, but not with indinavir. Insufficient information is available on interactions with other protease inhibitors. Consequently, paclitaxel should be administered with caution in patients receiving protease inhibitors as concomitant therapy.

4.6 Pregnancy and lactation

Paclitaxel has been shown to be embryotoxic and foetotoxic in rabbits, and to decrease fertility in rats.

There is no information on the use of paclitaxel in pregnant women. As with other cytotoxic drugs, paclitaxel may cause foetal harm, and is therefore contraindicated during pregnancy. Women should be advised to avoid becoming pregnant during therapy with paclitaxel, and to inform the treating physician immediately should this occur.

It is not known whether paclitaxel is excreted in human milk. Paclitaxel is contraindicated during lactation. Breastfeeding should be discontinued for the duration of paclitaxel therapy.

4.7 Effects on ability to drive and use machines

Paclitaxel has not been demonstrated to interfere with this ability. However, it should be noted that the formulation contains alcohol (see 4.4 and 6.1).

4.8 Undesirable effects

The frequency and severity of undesirable effects, unless otherwise mentioned, are generally similar between patients receiving paclitaxel for the treatment of ovarian carcinoma, breast carcinoma, or NSCLC. None of the observed toxicities were clearly influenced by age.

The most frequent significant undesirable effect was **bone marrow suppression**. Severe neutropenia (< 500 cells/mm³) occurred in 28% of patients, but was not associated with febrile episodes. Only 1% of patients experienced severe neutropenia for 7 days. Thrombocytopenia was reported in 11% of patients. Three percent of patients had a platelet count nadir $<$

50,000/mm³ at least once while on study. Anaemia was observed in 64% of patients, but was severe (Hb < 5 mmol/l) in only 6% of patients. Incidence and severity of anaemia is related to baseline haemoglobin status.

Neurotoxicity, mainly **peripheral neuropathy***, appeared to be more frequent and severe with a 175 mg/m² 3-hour infusion (85% neurotoxicity, 15% severe) than with a 135 mg/m² 24-hour infusion (25% peripheral neuropathy, 3% severe) when paclitaxel was combined with cisplatin. In NSCLC patients and in ovarian cancer patients treated with paclitaxel over three hours followed by cisplatin, there is an apparent increase in the incidence of severe neurotoxicity. Peripheral neuropathy can occur following the first course and can worsen with increasing exposure to paclitaxel. Peripheral neuropathy was the cause of paclitaxel discontinuation in a few cases. Sensory symptoms have usually improved or resolved within several months of paclitaxel discontinuation. Pre-existing neuropathies resulting from prior therapies are not a contraindication for paclitaxel therapy.

* can persist beyond 6 months of paclitaxel discontinuation.

Arthralgia or myalgia affected 60% of patients and was severe in 13% of patients.

A significant hypersensitivity reaction with possible fatal outcome (defined as hypotension requiring therapy, angioedema, respiratory distress requiring bronchodilator therapy, or generalised urticaria) occurred in two (< 1%) of patients. Thirty-four percent of patients (17% of all courses) experienced minor hypersensitivity reactions. These minor reactions, mainly flushing and rash, did not require therapeutic intervention nor did they prevent continuation of paclitaxel therapy.

Injection site reactions during intravenous administration may lead to localised oedema, pain, erythema, and induration; on occasion, extravasation can result in cellulitis. Skin sloughing and/or peeling has been reported, sometimes related to extravasation. Skin discoloration may also occur. Recurrence of skin reactions at a site of previous extravasation following administration of paclitaxel at a different site, i.e. “recall”, has been reported rarely. A specific treatment for extravasation reactions is unknown at this time.

Disseminated intravascular coagulation (DIC), often in association with sepsis or multi-organ failure, has been reported.

Tabulated summary of undesirable effects

The table below lists undesirable effects regardless of severity associated with the administration of single agent paclitaxel administered as a three hour infusion in the metastatic setting and adverse reactions from post-marketing experience. The latter ones may be attributed to paclitaxel regardless of the treatment regimen..

The frequency of undesirable effects listed below is defined using the following convention:

very common ($\geq 1/10$); common ($\geq 1/100, < 1/10$); uncommon ($\geq 1/1,000, < 1/100$); rare ($\geq 1/10,000, < 1/1,000$); very rare ($< 1/10,000$).

Infections and infestations:	<p><i>Very common</i> : infection (mainly urinary tract and upper respiratory tract infections), with reported cases of fatal outcome</p> <p><i>Uncommon</i>: septic shock</p> <p><i>Rare</i>: pneumonia, peritonitis, sepsis</p>
Blood and the lymphatic system disorders:	<p><i>Very common</i> : myelosuppression, neutropenia, anaemia, thrombocytopenia, leucopenia, bleeding</p> <p><i>Rare</i>: febrile neutropenia</p> <p><i>Very rare</i>: acute myeloid leukaemia, myelodysplastic syndrome</p>
Immune system disorders:	<p><i>Very common</i> : minor hypersensitivity reactions (mainly flushing and rash)</p> <p><i>Uncommon</i> : significant hypersensitivity reactions requiring therapy (e.g., hypotension, angioneurotic oedema, respiratory distress, generalised urticaria, chills, back pain, chest pain, tachycardia, abdominal pain, pain in extremities, diaphoresis and hypertension)</p> <p><i>Rare</i>: anaphylactic reactions</p> <p><i>Very rare</i> : anaphylatic shock</p>
Metabolism and nutrition disorders:	<p><i>Very rare</i> : anorexia</p>
Psychiatric disorders:	<p><i>Very rare</i> : confusional state</p>
Nervous system disorders:	<p><i>Very common</i> : neurotoxicity (mainly: peripheral neuropathy)</p> <p><i>Rare</i>: motor neuropathy (with resultant minor distal weakness)</p> <p><i>Very rare</i> : autonomic neuropathy (resulting in paralytic ileus and orthostatic hypotension), grand mal seizures, convulsions, encephalopathy,</p>

	<p>dizziness, headache, ataxia</p> <p>Further, it has been demonstrated that peripheral neuropathies can persist beyond 6 months of paclitaxel discontinuation.</p>
Eye disorders:	<p><i>Very rare:</i> optic nerve and/or visual disturbances (scintillating scotomata), particularly in patients who have received higher doses than recommended</p>
Ear and labyrinth disorders:	<p><i>Very rare :</i> ototoxicity, hearing loss, tinnitus, vertigo</p>
Cardiac disorders:	<p><i>Common:</i> bradycardia</p> <p><i>Uncommon :</i> cardiomyopathy, asymptomatic ventricular tachycardia, tachycardia with bigeminy, AV block and syncope, myocardial infarction</p> <p><i>Very rare :</i> atrial fibrillation, supraventricular tachycardia</p>
Vascular disorders:	<p><i>Very common :</i> hypotension</p> <p><i>Uncommon:</i> hypertension, thrombosis, thrombophlebitis</p> <p><i>Very rare:</i> shock</p>
Respiratory, thoracic and mediastinal disorders:	<p><i>Rare:</i> dyspnoea, pleural effusion, interstitial pneumonia, lung fibrosis, pulmonary embolism, respiratory failure</p> <p><i>Very rare:</i> cough</p>
Gastrointestinal disorders:	<p><i>Very common :</i> nausea, vomiting, diarrhoea, mucosal inflammation</p> <p><i>Rare*:</i> bowel obstruction, bowel perforation, ischaemic colitis, pancreatitis</p> <p><i>Very rare :</i> mesenteric thrombosis, pseudomembranous colitis, oesophagitis, constipation, ascites, neutropenic colitis</p>
Hepato-biliary disorders:	<p><i>Very rare:</i> hepatic necrosis, hepatic encephalopathy (both with reported cases of fatal outcome)</p>
Skin and subcutaneous tissue disorders:	<p><i>Very common :</i> alopecia : alopecia was observed in 87% of patients and was abrupt in onset. Pronounced hair loss of $\geq 50\%$ is expected for the majority of patients who experience alopecia.</p>

	<p><i>Common:</i> transient and mild nail and skin changes</p> <p><i>Rare:</i> pruritus, rash, erythema</p> <p><i>Very rare :</i> Stevens-Johnson syndrome, epidermal necrolysis, erythema multiforme, exfoliative dermatitis, urticaria, onycholysis (patients on therapy should wear sun protection on hands and feet)</p> <p><i>Unknown :</i> Palmar-plantar erythrodysesthesia syndrome *</p>
Musculoskeletal, connective tissue and bone disorders :	<p><i>Very common:</i> arthralgia, myalgia</p>
General disorders and administration site conditions:	<p><i>Common :</i> injection site reactions (including localised oedema, pain, erythema, induration, on occasion extravasation can result in cellulitis)</p> <p><i>Rare:</i> asthenia, pyrexia, dehydration, oedema, malaise</p>
Investigations:	<p><i>Common :</i> severe elevation in AST (SGOT), severe elevation in alkaline phosphatase</p> <p><i>Uncommon:</i> severe elevation in bilirubin</p> <p><i>Rare:</i> increase in blood creatinine</p>

* As reported in the post marketing surveillance of paclitaxel

Breast cancer patients who received paclitaxel in the adjuvant setting following AC experienced more neurosensory toxicity, hypersensitivity reactions, arthralgia/myalgia, anaemia, infection, fever, nausea/vomiting and diarrhoea than patients who received AC alone. However, the frequency of these events was consistent with the use of single agent paclitaxel, as reported above.

Combination treatment

When administered as a three hour infusion for the first-line chemotherapy of ovarian cancer, neurotoxicity, arthralgia/myalgia, and hypersensitivity were reported as more frequent and severe by patients treated with paclitaxel followed by cisplatin than patients treated with cyclophosphamide followed by cisplatin. Myelosuppression appeared to be less frequent and severe with paclitaxel as a three hour infusion followed by cisplatin compared with cyclophosphamide followed by cisplatin.

For the first line chemotherapy of metastatic breast cancer, neutropenia, anaemia, peripheral neuropathy, arthralgia/myalgia, asthenia, fever, and diarrhoea were reported more frequently and with greater severity when paclitaxel (220 mg/m²) was administered as a three-hour infusion 24 hours following doxorubicin (50 mg/m²) when compared to standard FAC therapy (5-FU 500 mg/m², doxorubicin 50 mg/m², cyclophosphamide 500 mg/m²). Nausea and vomiting appeared to be less frequent and severe with the paclitaxel (220 mg/m²) / doxorubicin (50 mg/m²) regimen as compared to the standard FAC regimen. The use of corticosteroids may have contributed to the lower frequency and severity of nausea and vomiting in the paclitaxel/doxorubicin arm.

Paclitaxel and trastuzumab

When paclitaxel was administered as a three-hour infusion in combination with trastuzumab for the first line treatment of patients with metastatic breast cancer, the following events (regardless of relationship to paclitaxel or trastuzumab) were reported more frequently than with single agent paclitaxel: heart failure (8% vs 1%), infection (46% vs 27%), chills (42% vs 4%), fever (47% vs 23%), cough (42% vs 22%), rash (39% vs 18%), arthralgia (37% vs 21%), tachycardia (12% vs 4%), diarrhoea (45% vs 30%), hypertonia (11% vs 3%), epistaxis (18% vs 4%), acne (11% vs 3%), herpes simplex (12% vs 3%), accidental injury (13% vs 3%), insomnia (25% vs 13%), rhinitis (22% vs 5%), sinusitis (21% vs 7%), and injection site reaction (7% vs 1%). Some of these frequency differences may be due to the increased number and duration of treatments with paclitaxel /trastuzumab combination vs single agent paclitaxel. Severe events were reported at similar rates for paclitaxel /trastuzumab and single agent paclitaxel.

Paclitaxel and doxorubicin

When doxorubicin was administered in combination with paclitaxel in metastatic breast cancer, **cardiac contraction abnormalities** (20% reduction of left ventricular ejection fraction) were observed in 15% of patients vs. 10% with standard FAC regimen. **Congestive heart failure** was observed in < 1% in both paclitaxel /doxorubicin and standard FAC arms. Administration of trastuzumab in combination with paclitaxel in patients previously treated with anthracyclines resulted in an increased frequency and severity of **cardiac dysfunction** in comparison with patients treated with paclitaxel single agent (NYHA Class I/II 10% vs. 0%; NYHA Class III/IV 2% vs. 1%) and rarely has been associated with death (see trastuzumab Summary of Product Characteristics). In all but these rare cases, patients responded to appropriate medical treatment.

Radiation pneumonitis has been reported in patients receiving concurrent radiotherapy.

AIDS-related Kaposi's sarcoma

Except for haematologic and hepatic undesirable effects (see below), the frequency and severity of undesirable effects are generally similar between KS patients and patients treated with paclitaxel monotherapy for other solid tumours, based on a clinical study including 107 patients.

Blood and the lymphatic system disorders: bone marrow suppression was the major dose-limiting toxicity. Neutropenia is the most important haematological toxicity. During the first course of treatment, severe neutropenia (< 500 cells/mm³) occurred in 20% of patients. During the entire treatment period, severe neutropenia was observed in 39% of patients. Neutropenia was present for > 7 days in 41% and for 30-35 days in 8% of patients. It resolved within 35 days in all patients who were followed. The incidence of Grade 4 neutropenia lasting > 7 days was 22%.

Neutropenic fever related to paclitaxel was reported in 14% of patients and in 1.3% of treatment cycles. There were three septic episodes (2.8%) during paclitaxel administration related to the medicinal product that proved fatal.

Thrombocytopenia was observed in 50% of patients, and was severe ($< 50,000$ cells/mm³) in 9%. Only 14% experienced a drop in their platelet count $< 75,000$ cells/mm³, at least once while on treatment. Bleeding episodes related to paclitaxel were reported in $< 3\%$ of patients, but the haemorrhagic episodes were localised.

Anaemia (Hb < 11 g/dL) was observed in 61% of patients and was severe (Hb < 8 g/dL) in 10%. Red cell transfusions were required in 21% of patients.

Hepato-biliary disorders : Among patients ($> 50\%$ on protease inhibitors) with normal baseline liver function, 28%, 43% and 44% had elevations in bilirubin, alkaline phosphatase and AST (SGOT), respectively. For each of these parameters, the increases were severe in 1% of cases.

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. Any suspected adverse events should be reported to the Ministry of Health according to the National Regulation by using an online form <https://sideeffects.health.gov.il/>

4.9 Overdose

There is no known antidote for paclitaxel overdosage. The primary anticipated complications of overdosage would consist of bone marrow suppression, peripheral neurotoxicity and mucositis

5 PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic group/ATC code: cystostatic agent, L01C D01.

Paclitaxel is an antimicrotubule agent that promotes the assembly of microtubules from tubulin dimers and stabilises microtubules by preventing depolymerization. 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.

Ovarian cancer

In the first-line chemotherapy of ovarian carcinoma, the safety and efficacy of paclitaxel were evaluated in two major, randomised, controlled (vs. cyclophosphamide 750 mg/m² / cisplatin 75 mg/m²) trials. In the Intergroup trial (BMS CA139-209), over 650 patients with stage II_{b-c}, III or IV primary ovarian cancer received a maximum of 9 treatment courses of paclitaxel (175 mg/m² over three hr) followed by cisplatin (75 mg/m²) or control. The second major trial (GOG-111/BMS CA139-022) evaluated a maximum of six courses of either paclitaxel (135 mg/m² over 24 hrs) followed by cisplatin (75 mg/m²) or control in over 400 patients with stage III/IV primary ovarian cancer, with a > 1 cm residual disease after staging laparotomy, or with distant metastases. While the two different paclitaxel posologies were not compared with each other directly, in both trials patients treated with paclitaxel in combination with cisplatin had a significantly higher response rate, longer time to progression, and longer survival time when compared with standard therapy. Increased neurotoxicity, arthralgia/myalgia but reduced myelosuppression were observed in advanced ovarian cancer patients administered three-hour infusion paclitaxel/cisplatin as compared to patients who received cyclophosphamide/cisplatin.

Breast cancer

In the adjuvant treatment of breast carcinoma, 3121 patients with node positive breast carcinoma were treated with adjuvant paclitaxel therapy or no chemotherapy following four courses of doxorubicin and cyclophosphamide (CALGB 9344, BMS CA 139-223). Median follow-up was 69 months. Overall, paclitaxel patients had a significant reduction of 18% in the risk of disease recurrence relative to patients receiving AC alone ($p = 0.0014$), and a significant reduction of 19% in the risk of death ($p = 0.0044$) relative to patients receiving AC alone. Retrospective analyses show benefit in all patient subsets. In patients with hormone receptor negative/unknown tumours, reduction in risk of disease recurrence was 28% (95%CI: 0.59-0.86). In the patient subgroup with hormone receptor positive tumours, the risk reduction of disease recurrence was 9% (95%CI: 0.78-1.07). However, the design of the study did not investigate the effect of extended AC therapy beyond four cycles. It cannot be excluded on the basis of this study alone that the observed effects could be partly due to the difference in duration of chemotherapy between the two arms (AC 4 cycles; AC + paclitaxel eight cycles). Therefore, adjuvant treatment with paclitaxel should be regarded as an alternative to extended AC therapy.

In a second large clinical study in adjuvant node positive breast cancer with a similar design, 3060 patients were randomized to receive or not four courses of paclitaxel at a higher dose of 225 mg/m² following four courses of AC (NSABP B-28, BMS CA139-270). At a median follow-up of 64 months, Paclitaxel patients had a significant reduction of 17% in the risk of disease recurrence relative to patients who received AC alone ($p = 0.006$); paclitaxel treatment was associated with a reduction

in the risk of death of 7% (95%CI: 0.78-1.12). All subset analyses favored the paclitaxel arm. In this study patients with hormone receptor positive tumour had a reduction in the risk of disease recurrence of 23% (95%CI: 0.6-0.92); in the patient subgroup with hormone receptor negative tumour the risk reduction of disease recurrence was 10% (95%CI: 0.7-1.11).

In the first-line treatment of metastatic breast cancer, the efficacy and safety of paclitaxel were evaluated in two pivotal, phase III, randomised, controlled open-label trials.

In the first study (BMS CA139-278), the combination of bolus doxorubicin (50 mg/m²) followed after 24 hours by paclitaxel (220 mg/m² by 3-hour infusion) (AT), was compared versus standard FAC regimen (5-FU 500 mg/m², doxorubicin 50 mg/m², cyclophosphamide 500 mg/m²), both administered every three weeks for eight courses. In this randomised study, 267 patients with metastatic breast cancer, who had either received no prior chemotherapy or only non-anthracycline chemotherapy in the adjuvant setting, were enrolled. Results showed a significant difference in time to progression for patients receiving AT compared to those receiving FAC (8.2 vs. 6.2 months; p= 0.029). The median survival was in favour of Paclitaxel/doxorubicin vs. FAC (23.0 vs. 18.3 months; p= 0.004). In the AT and FAC treatment arm 44% and 48% respectively received follow-up chemotherapy which included taxanes in 7% and 50% respectively. The overall response rate was also significantly higher in the AT arm compared to the FAC arm (68% vs. 55%). Complete responses were seen in 19% of the Paclitaxel/doxorubicin arm patients vs. 8% of the FAC arm patients. All efficacy results have been subsequently confirmed by a blinded independent review.

In the second pivotal study, the efficacy and safety of the paclitaxel and trastuzumab combination was evaluated in a planned subgroup analysis (metastatic breast cancer patients who formerly received adjuvant anthracyclines) of the study HO648g. The efficacy of trastuzumab in combination with paclitaxel in patients who did not receive prior adjuvant anthracyclines has not been proven. The combination of trastuzumab (4 mg/kg loading dose then 2 mg/kg weekly) and paclitaxel (175 mg/m²) 3-hour infusion, every three weeks was compared to single-agent paclitaxel (175 mg/m²) three-hour infusion, every three weeks in 188 patients with metastatic breast cancer overexpressing HER2 (2+ or 3+ as measured by immunohistochemistry), who had previously been treated with anthracyclines. paclitaxel was administered every three weeks for at least six courses while trastuzumab was given weekly until disease progression. The study showed a significant benefit for the paclitaxel /trastuzumab combination in terms of time to progression (6.9 vs. 3.0 months), response rate (41% vs. 17%), and duration of response (10.5 vs. 4.5 months) when compared to paclitaxel alone. The most significant toxicity observed with the paclitaxel /trastuzumab combination was cardiac dysfunction (see 4.8).

Advanced non-small-cell lung cancer

In the treatment of advanced NSCLC, paclitaxel 175 mg/m² followed by cisplatin 80 mg/m² has been evaluated in two phase III trials (367 patients on paclitaxel containing regimens). Both were randomised trials, one compared to treatment with cisplatin 100 mg/m², the other used teniposide 100 mg/m² followed by cisplatin 80 mg/m² as comparator (367 patients on comparator). Results in each trial were similar. For the primary outcome of mortality, there was no significant difference between the paclitaxel containing regimen and the comparator (median survival times 8.1 and 9.5 months on paclitaxel containing regimens, 8.6 and 9.9 months on comparators).

Similarly, for progression-free survival there was no significant difference between treatments. There was a significant benefit in terms of clinical response rate. Quality of life results are suggestive of a benefit on paclitaxel containing regimens in terms of appetite loss and provide clear evidence of the inferiority of paclitaxel containing regimens in terms of peripheral neuropathy ($p < 0.008$).

AIDS-related Kaposi's sarcoma

In the treatment of AIDS-related KS, the efficacy and safety of paclitaxel were investigated in a non-comparative study in patients with advanced KS, previously treated with systemic chemotherapy. The primary end-point was best tumour response. Of the 107 patients, 63 were considered resistant to liposomal anthracyclines. This subgroup is considered to constitute the core efficacy population. The overall success rate (complete/partial response) after 15 cycles of treatment was 57% (CI 44 - 70%) in liposomal anthracycline-resistant patients. Over 50% of the responses were apparent after the first three cycles. In liposomal anthracycline-resistant patients, the response rates were comparable for patients who had never received a protease inhibitor (55.6%) and those who received one at least two months prior to treatment with paclitaxel (60.9%). The median time to progression in the core population was 468 days (95% CI 257-NE). Median survival could not be computed, but the lower 95% bound was 617 days in core patients.

5.2 Pharmacokinetic properties

Following intravenous administration, paclitaxel exhibits a biphasic decline in plasma concentrations.

The pharmacokinetics of paclitaxel were determined following three and 24 hour infusions at doses of 135 and 175 mg/m². Mean terminal half-life estimates ranged from 3.0 to 52.7 hours, and mean, non-compartmentally derived, values for total body clearance ranged from 11.6 to 24.0 l/hr/m²; total body clearance appeared to decrease with higher plasma concentrations of paclitaxel. Mean steady-state volume of distribution ranged from 198 to 688 l/m², indicating extensive extravascular distribution and/or tissue binding. With the 3-hour infusion, increasing doses result in non-linear pharmacokinetics. For the 30% increase in dose from 135 mg/m² to 175 mg/m², the C_{max} and AUC₀ values increased 75% and 81%, respectively.

Following an intravenous dose of 100 mg/m² given as a three-hour infusion to 19 KS patients, the mean C_{max} was 1,530 ng/ml (range 761 - 2,860 ng/ml) and the mean AUC 5,619 ng.hr/ml (range 2,609 - 9,428 ng.hr/ml). Clearance was 20.6 l/h/m² (range 11-38) and the volume of distribution was 291 l/m² (range 121-638). The terminal elimination half-life averaged 23.7 hours (range 12 - 33).

Inpatient variability in systemic paclitaxel exposure was minimal. There was no evidence for accumulation of paclitaxel with multiple treatment courses.

In vitro studies of binding to human serum proteins indicate that 89-98% of drug is bound. The presence of cimetidine, ranitidine, dexamethasone or diphenhydramine did not affect protein binding of paclitaxel.

The disposition of paclitaxel has not been fully elucidated in humans. Mean values for cumulative urinary recovery of unchanged drug have ranged from 1.3 to 12.6% of the dose, indicating extensive non-renal clearance. Hepatic metabolism and biliary clearance may be the principal mechanism for disposition of paclitaxel. Paclitaxel appears to be metabolised primarily by cytochrome P450 enzymes. Following administration of a radiolabelled paclitaxel, an average of 26, 2 and 6% of the radioactivity was excreted in the faeces as 6 α -hydroxypaclitaxel, 3'-p-hydroxypaclitaxel, and 6 α -3'-p-dihydroxy-paclitaxel, respectively. The formation of these hydroxylated metabolites is catalysed by CYP2C8, -3A4, and both -2C8 and -3A4 respectively. The effect of renal or hepatic dysfunction on the disposition of paclitaxel following a 3-hour infusion has not been investigated formally. Pharmacokinetic parameters obtained from one patient undergoing haemodialysis who received a three-hour infusion of paclitaxel 135 mg/m² were within the range of those defined in non-dialysis patients.

In clinical trials where paclitaxel and doxorubicin were administered concomitantly, the distribution and elimination of doxorubicin and its metabolites were prolonged. Total plasma exposure to doxorubicin was 30% higher when paclitaxel immediately followed doxorubicin than when there was a 24-hour interval between drugs.

For use of paclitaxel in combination with other therapies, please consult the Summary of Product Characteristics of cisplatin, doxorubicin or trastuzumab for information on the use of these medicinal products.

5.3 Preclinical safety data

The carcinogenic potential of paclitaxel has not been studied. However, paclitaxel is a potential carcinogenic and genotoxic agent, based upon its pharmacodynamic mechanism of action. Paclitaxel has been shown to be mutagenic in both *in vitro* and *in vivo* mammalian test systems.

6 PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Polyoxyl Castor Oil

(Macrogol glycerol ricinolate)

Ethanol anhydrous

Nitrogen

6.2 Incompatibilities

Polyoxyl castor oil (macrogol glycerol ricinolate) can result in DEHP [di-(2-ethylhexyl)phthalate] leaching from plasticised polyvinyl chloride (PVC) containers, at levels which increase with time and concentration. Consequently, the preparation, storage and administration of diluted paclitaxel concentrate should be carried out using non-PVC-containing equipment.

6.3 Shelf life

The expiry date of the product is indicated on the packaging materials.

After first opening

Use within 28 days of first opening

After dilution with infusion solutions

The maximum storage times for infusion solutions with Ebetaxel in glucose 5% respectively sodium chloride 0.9% are 14 days when stored in a refrigerator at $5\pm 3^{\circ}\text{C}$.

The maximum storage times for Ebetaxel infusion solutions prepared in glucose 5% are 1 week when stored at room temperature without light protection. The maximum storage times for Ebetaxel infusion solutions prepared in sodium chloride 0.9% are 5 days when stored at room temperature without light protection.

Infusion solution after dilution:

From a microbiological point of view, the ready to use preparation should be used immediately. If not used immediately, in-use storage times and conditions prior to use are the responsibility of the user and would normally not be longer than 24 hours at 2 to 8°C, unless dilution has taken place in controlled and validated aseptic conditions.

Diluted solution should be for single use only.

6.4 Special precautions for storage

Store below 25°C. Store

vials in the original

packaging in order to

protect the content from

light

6.5 Nature and contents of container

Colourless Type I glass vial with grey fluoropolymer-coated halobutyl rubber stoppers and aluminium overseal.

Packs of 1 vial containing 5ml, 16.7ml, 25ml, 50ml, and 100ml of Paclitaxel 6mg/ml Concentrate for Solution for Infusion.

6.6 Special precautions for disposal

Handling: as with all antineoplastic agents, caution should be exercised when handling Paclitaxel 6mg/ml Concentrate for Solution for Infusion. Dilution should be carried out under aseptic conditions by trained personnel in a designated area. Adequate protective gloves should be worn. Precautions should be taken to avoid contact with the skin and mucous membranes. In the event of contact with the skin, the area should be washed with soap and water. Following topical exposure, tingling, burning and redness have been observed. In the event of contact with the mucous membranes, these should be flushed thoroughly with water. Upon inhalation, dyspnoea, chest pain, burning throat and nausea have been reported.

If unopened vials are refrigerated, a precipitate may form that redissolves with little or no agitation upon reaching room temperature. Product quality is not affected. If the solution remains cloudy or if an insoluble precipitate is noted, the vial should be discarded.

Preparation for IV administration: Prior to infusion, Paclitaxel 6mg/ml Concentrate for Solution for Infusion must be diluted, using aseptic techniques, in 0.9% sodium chloride injection, or 5% glucose injection, or 5% glucose and 0.9% sodium chloride injection, to a final concentration of 0.3 to 1.2 mg/mL.

Upon preparation, solutions may show haziness, which is attributed to the formulation vehicle, and is not removed by filtration. Paclitaxel infusion should be administered through an in-line filter with a microporous membrane $\leq 0.22\mu\text{m}$. No significant losses in potency have been noted following simulated delivery of the solution through IV tubing containing an in-line filter.

There have been rare reports of precipitation during paclitaxel infusions, usually towards the end of a 24 hour infusion period. Although the cause of this precipitation has not been elucidated, it is probably linked to the supersaturation of the diluted solution. To reduce the precipitation risk, paclitaxel should be used as soon as possible after dilution and excessive agitation, vibration or shaking should be avoided. The infusion sets should be flushed thoroughly before use. During infusion the appearance of the solution should be inspected regularly and the infusion should be stopped if precipitation is present.

To minimise patient exposure to DEHP, which may be leached from plasticised PVC infusion bags, sets, or other medical instruments, diluted paclitaxel solutions should

be stored in non-PVC bottles (glass, polypropylene) or plastic bags (polypropylene, polyolefin) and administered through polyethylene-lined administration sets. Use of filter devices (eg. IVEX-2®) which incorporate short inlet and/or outlet plasticised PVC tubing has not resulted in significant leaching of DEHP.

Disposal: All items used for preparation, administration or otherwise coming into contact with paclitaxel injection should undergo disposal according to local guidelines for the handling of cytotoxic compounds.

7 MARKETING AUTHORISATION HOLDER AND IMPORTER

Novartis Israel Ltd., P.O.Box 7126, Tel-Aviv

8 MARKETING AUTHORISATION NUMBER

130-95-30965-00

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