

## FULL PRESCRIBING INFORMATION

### RETEVMO 40 MG

Selpercatinib 40 mg, Capsules

### RETEVMO 80 MG

Selpercatinib 80 mg, Capsules

## 1 INDICATIONS AND USAGE

### 1.1 Metastatic *RET* Fusion-Positive Non-Small Cell Lung Cancer

RETEVMO is indicated for the treatment of adult patients with metastatic *RET* fusion-positive non-small cell lung cancer (NSCLC).

### 1.2 *RET*-Mutant Medullary Thyroid Cancer

RETEVMO is indicated for the treatment of adult and pediatric patients 12 years of age and older with advanced or metastatic *RET*-mutant medullary thyroid cancer (MTC) who require systemic therapy.

### 1.3 *RET* Fusion-Positive Thyroid Cancer

RETEVMO is indicated for the treatment of adult and pediatric patients 12 years of age and older with advanced or metastatic *RET* fusion-positive thyroid cancer who require systemic therapy and who are radioactive iodine-refractory (if radioactive iodine is appropriate).

## 2 DOSAGE AND ADMINISTRATION

### 2.1 Patient Selection

Select patients for treatment with RETEVMO based on the presence of a *RET* gene fusion (NSCLC or thyroid cancer) or specific *RET* gene mutation (MTC) in tumor specimens or plasma [see *Clinical Studies* (14)].

### 2.2 Important Administration Instructions

RETEVMO may be taken with or without food unless coadministered with a proton pump inhibitor (PPI) [see *Dosage and Administration* (2.4), *Clinical Pharmacology* (12.3)].

### 2.3 Recommended Dosage

The recommended dosage of RETEVMO based on body weight is:

- Less than 50 kg: 120 mg
- 50 kg or greater: 160 mg

Take RETEVMO orally twice daily (approximately every 12 hours) until disease progression or unacceptable toxicity.

Swallow the capsules whole. Do not crush or chew the capsules.

Do not take a missed dose unless it is more than 6 hours until next scheduled dose.

If vomiting occurs after RETEVMO administration, do not take an additional dose and continue to the next scheduled time for the next dose.

## 2.4 Dosage Modifications for Concomitant Use of Acid-Reducing Agents

Avoid concomitant use of a PPI, a histamine-2 (H2) receptor antagonist, or a locally-acting antacid with RETEVMO [see *Drug Interactions (7.1)*]. If concomitant use cannot be avoided:

- Take RETEVMO with food when coadministered with a PPI.
- Take RETEVMO 2 hours before or 10 hours after administration of an H2 receptor antagonist.
- Take RETEVMO 2 hours before or 2 hours after administration of a locally-acting antacid.

## 2.5 Dosage Modifications for Adverse Reactions

The recommended dose reductions for adverse reactions are provided in Table 1.

**Table 1: Recommended RETEVMO Dose Reductions for Adverse Reactions**

Dose Reduction	Patients Weighing Less Than 50 kg	Patients Weighing 50 kg or Greater
First	80 mg orally twice daily	120 mg orally twice daily
Second	40 mg orally twice daily	80 mg orally twice daily
Third	40 mg orally once daily	40 mg orally twice daily

Permanently discontinue RETEVMO in patients unable to tolerate three dose reductions.

The recommended dosage modifications for adverse reactions are provided in Table 2.

**Table 2: Recommended RETEVMO Dosage Modifications for Adverse Reactions**

Adverse Reaction	Severity	Dosage Modification
Hepatotoxicity [see <i>Warnings and Precautions (5.1)</i> ]	Grade 3 or Grade 4	<ul style="list-style-type: none"> <li>• Withhold RETEVMO and monitor AST/ALT once weekly until resolution to Grade 1 or baseline.</li> <li>• Resume at reduced dose by 2 dose levels and monitor AST and ALT once weekly until 4 weeks after reaching dose taken prior to the onset of Grade 3 or 4 increased AST or ALT.</li> <li>• Increase dose by 1 dose level after a minimum of 2 weeks without recurrence and then increase to dose taken prior to the onset of Grade 3 or 4 increased AST or ALT after a minimum of 4 weeks without recurrence.</li> </ul>
Interstitial Lung Disease/ Pneumonitis [see <i>Warnings and Precautions (5.2)</i> ]	Grade 2	<ul style="list-style-type: none"> <li>• Withhold RETEVMO until resolution.</li> <li>• Resume at a reduced dose.</li> <li>• Discontinue RETEVMO for recurrent ILD/pneumonitis.</li> </ul>
	Grade 3 or Grade 4	<ul style="list-style-type: none"> <li>• Discontinue RETEVMO for confirmed ILD/pneumonitis.</li> </ul>
Hypertension [see <i>Warnings and Precautions (5.3)</i> ]	Grade 3	<ul style="list-style-type: none"> <li>• Withhold RETEVMO for Grade 3 hypertension that persists despite optimal antihypertensive therapy. Resume at a reduced dose when hypertension is controlled.</li> </ul>
	Grade 4	<ul style="list-style-type: none"> <li>• Discontinue RETEVMO.</li> </ul>

QT Interval Prolongation [see Warnings and Precautions (5.4)]	Grade 3	<ul style="list-style-type: none"> <li>Withhold RETEVMO until recovery to baseline or Grade 0 or 1.</li> <li>Resume at a reduced dose.</li> </ul>
	Grade 4	<ul style="list-style-type: none"> <li>Discontinue RETEVMO.</li> </ul>
Hemorrhagic Events [see Warnings and Precautions (5.5)]	Grade 3 or Grade 4	<ul style="list-style-type: none"> <li>Withhold RETEVMO until recovery to baseline or Grade 0 or 1.</li> <li>Discontinue RETEVMO for severe or life-threatening hemorrhagic events.</li> </ul>
Hypersensitivity Reactions [see Warnings and Precautions (5.6)]	All Grades	<ul style="list-style-type: none"> <li>Withhold RETEVMO until resolution of the event. Initiate corticosteroids.</li> <li>Resume at a reduced dose by 3 dose levels while continuing corticosteroids.</li> <li>Increase dose by 1 dose level each week until the dose taken prior to the onset of hypersensitivity is reached, then taper corticosteroids.</li> </ul>
Hypothyroidism [see Warnings and Precautions (5.9)]	Grade 3 or Grade 4	<ul style="list-style-type: none"> <li>Withhold RETEVMO until resolution to Grade 1 or baseline.</li> <li>Discontinue RETEVMO based on severity.</li> </ul>
Other Adverse Reactions [see Adverse Reactions (6.1)]	Grade 3 or Grade 4	<ul style="list-style-type: none"> <li>Withhold RETEVMO until recovery to baseline or Grade 0 or 1.</li> <li>Resume at a reduced dose.</li> </ul>

## 2.6 Dosage Modifications for Concomitant Use of Strong and Moderate CYP3A Inhibitors

Avoid concomitant use of strong and moderate CYP3A inhibitors with RETEVMO. If concomitant use of a strong or moderate CYP3A inhibitor cannot be avoided, reduce the RETEVMO dose as recommended in Table 3. After the inhibitor has been discontinued for 3 to 5 elimination half-lives, resume RETEVMO at the dose taken prior to initiating the CYP3A inhibitor [see Drug Interactions (7.1)].

**Table 3: Recommended RETEVMO Dosage for Concomitant Use of Strong and Moderate CYP3A Inhibitors**

Current RETEVMO Dosage	Recommended RETEVMO Dosage	
	Moderate CYP3A Inhibitor	Strong CYP3A Inhibitor
120 mg orally twice daily	80 mg orally twice daily	40 mg orally twice daily
160 mg orally twice daily	120 mg orally twice daily	80 mg orally twice daily

## 2.7 Dosage Modification for Severe Hepatic Impairment

Reduce the recommended dosage of RETEVMO for patients with severe hepatic impairment as recommended in Table 4 [see Use in Specific Populations (8.7)].

**Table 4: Recommended RETEVMO Dosage for Severe Hepatic Impairment**

Current RETEVMO Dosage	Recommended RETEVMO Dosage
120 mg orally twice daily	80 mg orally twice daily
160 mg orally twice daily	80 mg orally twice daily

### **3 DOSAGE FORMS AND STRENGTHS**

Capsules:

- 40 mg: gray opaque capsule imprinted with “Lilly”, “3977” and “40 mg” in black ink.
- 80 mg: blue opaque capsule imprinted with “Lilly”, “2980” and “80 mg” in black ink.

### **4 CONTRAINDICATIONS**

Hypersensitivity to the active substance or to any of the excipients listed in section 11.

### **5 WARNINGS AND PRECAUTIONS**

#### **5.1 Hepatotoxicity**

Serious hepatic adverse reactions occurred in 3% of patients treated with RETEVMO. Increased AST occurred in 59% of patients, including Grade 3 or 4 events in 11% and increased ALT occurred in 55% of patients, including Grade 3 or 4 events in 12% [see *Adverse Reactions (6.1)*]. The median time to first onset for increased AST was 6 weeks (range: 1 day to 3.4 years) and increased ALT was 5.8 weeks (range: 1 day to 2.5 years).

Monitor ALT and AST prior to initiating RETEVMO, every 2 weeks during the first 3 months, then monthly thereafter and as clinically indicated. Withhold, reduce dose or permanently discontinue RETEVMO based on the severity [see *Dosage and Administration (2.5)*].

#### **5.2 Interstitial Lung Disease/ Pneumonitis**

Severe, life-threatening, and fatal interstitial lung disease (ILD)/pneumonitis can occur in patients treated with RETEVMO. ILD/pneumonitis occurred in 1.8% of patients who received RETEVMO, including 0.3% with Grade 3 or 4 events, and 0.3% with fatal reactions.

Monitor for pulmonary symptoms indicative of ILD/pneumonitis. Withhold RETEVMO and promptly investigate for ILD in any patient who presents with acute or worsening of respiratory symptoms which may be indicative of ILD (e.g., dyspnea, cough, and fever). Withhold, reduce dose or permanently discontinue RETEVMO based on severity of confirmed ILD [see *Dosage and Administration (2.5)*].

#### **5.3 Hypertension**

Hypertension occurred in 41% of patients, including Grade 3 hypertension in 20% and Grade 4 in one (0.1%) patient [see *Adverse Reactions (6.1)*]. Overall, 6.3% had their dose interrupted and 1.3% had their dose reduced for hypertension. Treatment-emergent hypertension was most commonly managed with anti-hypertension medications.

Do not initiate RETEVMO in patients with uncontrolled hypertension. Optimize blood pressure prior to initiating RETEVMO. Monitor blood pressure after 1 week, at least monthly thereafter and as clinically indicated. Initiate or adjust anti-hypertensive therapy as appropriate. Withhold, reduce dose, or permanently discontinue RETEVMO based on the severity [see *Dosage and Administration (2.5)*].

#### **5.4 QT Interval Prolongation**

RETEVMO can cause concentration-dependent QT interval prolongation [see *Clinical Pharmacology (12.2)*]. An increase in QTcF interval to >500 ms was measured in 7% of patients and an increase in the QTcF interval of at least 60 ms over baseline was measured in 20% of patients [see *Adverse Reactions (6.1)*]. RETEVMO has not been studied in patients with clinically significant active cardiovascular disease or recent myocardial infarction.

Monitor patients who are at significant risk of developing QTc prolongation, including patients with known long QT syndromes, clinically significant bradyarrhythmias, and severe or uncontrolled heart failure. Assess QT interval, electrolytes and TSH at baseline and periodically during treatment, adjusting frequency based upon risk factors including diarrhea. Correct hypokalemia, hypomagnesemia and hypocalcemia prior to initiating RETEVMO and during treatment.

Monitor the QT interval more frequently when RETEVMO is concomitantly administered with strong and moderate CYP3A inhibitors or drugs known to prolong QTc interval. Withhold and dose reduce or permanently discontinue RETEVMO based on the severity [see *Dosage and Administration (2.5)*].

## **5.5 Hemorrhagic Events**

Serious including fatal hemorrhagic events can occur with RETEVMO. Grade  $\geq 3$  hemorrhagic events occurred in 3.1% of patients treated with RETEVMO, including 4 (0.5%) patients with fatal hemorrhagic events, including cerebral hemorrhage (n = 2), tracheostomy site hemorrhage (n = 1), and hemoptysis (n=1).

Permanently discontinue RETEVMO in patients with severe or life-threatening hemorrhage [see *Dosage and Administration (2.5)*].

## **5.6 Hypersensitivity**

Hypersensitivity occurred in 6% of patients receiving RETEVMO, including Grade 3 hypersensitivity in 1.9%. The median time to onset was 1.9 weeks (range: 5 days to 2 years). Signs and symptoms of hypersensitivity included fever, rash and arthralgias or myalgias with concurrent decreased platelets or transaminitis.

If hypersensitivity occurs, withhold RETEVMO and begin corticosteroids at a dose of 1 mg/kg prednisone (or equivalent). Upon resolution of the event, resume RETEVMO at a reduced dose and increase the dose of RETEVMO by 1 dose level each week as tolerated until reaching the dose taken prior to onset of hypersensitivity [see *Dosage and Administration (2.5)*]. Continue steroids until patient reaches target dose and then taper. Permanently discontinue RETEVMO for recurrent hypersensitivity.

## **5.7 Tumor Lysis Syndrome**

Tumor lysis syndrome (TLS) occurred in 0.6% of patients with medullary thyroid carcinoma receiving RETEVMO [see *Adverse Reactions (6.1)*]. Patients may be at risk of TLS if they have rapidly growing tumors, a high tumor burden, renal dysfunction, or dehydration. Closely monitor patients at risk, consider appropriate prophylaxis including hydration, and treat as clinically indicated.

## **5.8 Risk of Impaired Wound Healing**

Impaired wound healing can occur in patients who receive drugs that inhibit the vascular endothelial growth factor (VEGF) signaling pathway. Therefore, RETEVMO has the potential to adversely affect wound healing.

Withhold RETEVMO for at least 7 days prior to elective surgery. Do not administer for at least 2 weeks following major surgery and until adequate wound healing. The safety of resumption of RETEVMO after resolution of wound healing complications has not been established.

## 5.9 Hypothyroidism

RETEVMO can cause hypothyroidism. Hypothyroidism occurred in 13% of patients treated with RETEVMO; all reactions were Grade 1 or 2. Hypothyroidism occurred in 13% of patients (50/373) with thyroid cancer and 13% of patients (53/423) with other solid tumors including NSCLC [see *Adverse Reactions* (6.1)].

Monitor thyroid function before treatment with RETEVMO and periodically during treatment. Treat with thyroid hormone replacement as clinically indicated. Withhold RETEVMO until clinically stable or permanently discontinue RETEVMO based on severity [see *Dosage and Administration* (2.5)].

## 5.10 Embryo-Fetal Toxicity

Based on data from animal reproduction studies and its mechanism of action, RETEVMO can cause fetal harm when administered to a pregnant woman. Administration of selpercatinib to pregnant rats during organogenesis at maternal exposures that were approximately equal to those observed at the recommended human dose of 160 mg twice daily resulted in embryolethality and malformations.

Advise pregnant women and females of reproductive potential of the potential risk to a fetus. Advise females of reproductive potential to use effective contraception during treatment with RETEVMO and for 1 week after the last dose. Advise males with female partners of reproductive potential to use effective contraception during treatment with RETEVMO and for 1 week after the last dose [see *Use in Specific Populations* (8.1, 8.3)].

## 5.11 Effects on ability to drive and use machines

RETEVMO may have minor influence on the ability to drive and use machines. Patients should be advised to be cautious when driving or using machines in case they experience fatigue or dizziness during treatment with RETEVMO.

## 6 ADVERSE REACTIONS

The following clinically significant adverse reactions are described elsewhere in the labeling:

- Hepatotoxicity [see *Warnings and Precautions* (5.1)]
- Interstitial Lung Disease / Pneumonitis [see *Warnings and Precautions* (5.2)]
- Hypertension [see *Warnings and Precautions* (5.3)]
- QT Interval Prolongation [see *Warnings and Precautions* (5.4)]
- Hemorrhagic Events [see *Warnings and Precautions* (5.5)]
- Hypersensitivity [see *Warnings and Precautions* (5.6)]
- Tumor Lysis Syndrome [see *Warnings and Precautions* (5.7)]
- Risk of Impaired Wound Healing [see *Warnings and Precautions* (5.8)]
- Hypothyroidism [see *Warnings and Precautions* (5.9)]

### 6.1 Clinical Trials Experience

Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in practice.

#### RET Gene Fusion or Gene Mutation Positive Solid Tumors

The pooled safety population described in the WARNINGS and PRECAUTIONS and below reflects exposure to RETEVMO as a single agent at 160 mg orally twice daily evaluated in 796 patients with advanced solid tumors in LIBRETTO-001 [see *Clinical Studies* (14)]. Among the 796 patients who received RETEVMO, 84% were exposed for 6 months or longer and 73% were exposed for greater than one year. Among these patients, 96% received at least one dose of RETEVMO at the recommended dosage of 160 mg orally twice daily.

The median age was 59 years (range: 15 to 92 years); 0.3% were pediatric patients 12 to 16 years of age; 51% were male; and 69% were White, 23% were Asian, 5% were Hispanic/Latino, and 3% were Black. The most common tumors were NSCLC (45%), MTC (40%), and non-medullary thyroid carcinoma (7%).

Serious adverse reactions occurred in 44% of patients who received RETEVMO. The most frequent serious adverse reactions ( $\geq 2\%$  of patients) were pneumonia, pleural effusion, abdominal pain, hemorrhage, hypersensitivity, dyspnea, and hyponatremia. Fatal adverse reactions occurred in 3% of patients; fatal adverse reactions included sepsis (n = 6), respiratory failure (n = 5), hemorrhage (n = 4), pneumonia (n = 3), pneumonitis (n = 2), cardiac arrest (n=2), sudden death (n = 1), and cardiac failure (n = 1).

Permanent discontinuation due to an adverse reaction occurred in 8% of patients who received RETEVMO. Adverse reactions resulting in permanent discontinuation in  $\geq 0.5\%$  of patients included increased ALT (0.6%), fatigue (0.6%), sepsis (0.5%), and increased AST (0.5%).

Dosage interruptions due to an adverse reaction occurred in 64% of patients who received RETEVMO. Adverse reactions requiring dosage interruption in  $\geq 5\%$  of patients included increased ALT, increased AST, diarrhea, and hypertension.

Dose reductions due to an adverse reaction occurred in 41% of patients who received RETEVMO. Adverse reactions requiring dosage reductions in  $\geq 2\%$  of patients included increased ALT, increased AST, QT prolongation, fatigue, diarrhea, drug hypersensitivity, and edema.

The most common adverse reactions ( $\geq 25\%$ ) were edema, diarrhea, fatigue, dry mouth, hypertension, abdominal pain, constipation, rash, nausea, and headache.

The most common Grade 3 or 4 laboratory abnormalities ( $\geq 5\%$ ) were decreased lymphocytes, increased alanine aminotransferase (ALT), increased aspartate aminotransferase (AST), decreased sodium, and decreased calcium.

Table 5 summarizes the adverse reactions in LIBRETTO-001.

**Table 5: Adverse Reactions ( $\geq 20\%$ ) in Patients Who Received RETEVMO in LIBRETTO-001**

Adverse Reaction	RETEVMO (n = 796)	
	Grades 1-4# (%)	Grades 3-4 (%)
<b>Gastrointestinal</b>		
Diarrhea <sup>1</sup>	47	5*
Dry Mouth	43	0
Abdominal pain <sup>2</sup>	34	2.5*
Constipation	33	0.8*
Nausea	31	1.1*
Vomiting	22	1.8*
<b>Vascular</b>		
Hypertension	41	20
<b>General</b>		
Edema <sup>3</sup>	49	0.8*
Fatigue <sup>4</sup>	46	3.1*
Arthralgia	21	0.3*
<b>Skin</b>		

Rash <sup>5</sup>	33	0.6*
<b>Nervous System</b>		
Headache <sup>6</sup>	28	1.4*
<b>Respiratory</b>		
Cough <sup>7</sup>	24	0
Dyspnea <sup>8</sup>	22	3.1
<b>Investigations</b>		
Prolonged QT interval	21	4.8*
<b>Blood and Lymphatic System</b>		
Hemorrhage <sup>9</sup>	22	2.6

<sup>1</sup> Diarrhea includes diarrhea, defecation urgency, frequent bowel movements, gastrointestinal hypermotility, anal incontinence.

<sup>2</sup> Abdominal pain includes abdominal pain, abdominal pain upper, abdominal pain lower, abdominal discomfort, abdominal tenderness, epigastric discomfort, gastrointestinal pain.

<sup>3</sup> Edema includes edema, edema peripheral, face edema, periorbital edema, eye edema, eyelid edema, orbital edema, localized edema, lymphedema, scrotal edema, peripheral swelling, scrotal swelling, swelling, swelling face, eye swelling, generalized edema, genital edema.

<sup>4</sup> Fatigue includes fatigue, asthenia, malaise.

<sup>5</sup> Rash includes rash, rash erythematous, rash macular, rash maculopapular, rash morbilliform, rash papular, rash pruritic, butterfly rash, exfoliative rash, rash follicular, rash generalized, rash vesicular.

<sup>6</sup> Headache includes headache, sinus headache, tension headache.

<sup>7</sup> Includes cough, productive cough, upper airway cough syndrome.

<sup>8</sup> Includes dyspnea, dyspnea exertional, dyspnea at rest.

<sup>9</sup> Hemorrhage includes hemorrhage, epistaxis, hematuria, hemoptysis, contusion, rectal hemorrhage, vaginal hemorrhage, ecchymosis, hematochezia, petechiae, traumatic hematoma, anal hemorrhage, blood blister, blood urine present, cerebral hemorrhage, gastric hemorrhage, hemorrhage intracranial, hemorrhage subcutaneous, spontaneous hematoma, abdominal wall hematoma, angina bullosa hemorrhagica, conjunctival hemorrhage, disseminated intravascular coagulation, diverticulum intestinal hemorrhagic, eye hemorrhage, gastrointestinal hemorrhage, gingival bleeding, hematemesis, hemorrhagic stroke, hemorrhoidal hemorrhage, hepatic hemorrhage, hepatic hematoma, intraabdominal hemorrhage, laryngeal hemorrhage, lower gastrointestinal hemorrhage, melena, mouth hemorrhage, occult blood positive, post procedural hemorrhage, postmenopausal hemorrhage, pelvic hematoma, periorbital hematoma, periorbital hemorrhage, pharyngeal hemorrhage, pulmonary contusion, purpura, retinal hemorrhage, retroperitoneal hematoma, scleral hemorrhage, skin hemorrhage, subarachnoid hemorrhage, subdural hemorrhage, upper gastrointestinal hemorrhage, uterine hemorrhage, vessel puncture site hematoma.

\* Only includes a grade 3 adverse reaction.

# Graded according to National Cancer Institute Common Terminology Criteria for Adverse Events (NCI CTCAE) version 4.03

Clinically relevant adverse reactions in ≤15% of patients who received RETEVMO include hypothyroidism (13%); hypersensitivity (6%); interstitial lung disease/pneumonitis, chylothorax, chylous ascites or tumor lysis syndrome (all < 2%).

Table 6 summarizes the laboratory abnormalities in LIBRETTO-001.



**Table 6: Select Laboratory Abnormalities (≥20%) Worsening from Baseline in Patients Who Received RETEVMO in LIBRETTO-001**

Laboratory Abnormality	RETEVMO <sup>1</sup>	
	Grades 1-4 <sup>#</sup> (%)	Grades 3-4 (%)
<b>Chemistry</b>		
Increased AST	59	11
Decreased calcium	59	5.7
Increased ALT	56	12
Decreased albumin	56	2.3
Increased glucose	53	2.8
Increased creatinine	47	2.4
Decreased sodium	42	11
Increased alkaline phosphatase	40	3.4
Increased total cholesterol	35	1.7
Increased potassium	34	2.7
Decreased glucose	34	1.0
Decreased magnesium	33	0.6
Increased bilirubin	30	2.8
<b>Hematology</b>		
Decreased lymphocytes	52	20
Decreased platelets	37	3.2
Decreased hemoglobin	28	3.5
Decreased neutrophils	25	3.2

<sup>1</sup> Denominator for each laboratory parameter is based on the number of patients with a baseline and post-treatment laboratory value available, which ranged from 765 to 791 patients.

<sup>#</sup> Graded according to National Cancer Institute Common Terminology Criteria for Adverse Events (NCI CTCAE) version 4.03

### Increased Creatinine

In healthy subjects administered RETEVMO 160 mg orally twice daily, serum creatinine increased 18% after 10 days. Consider alternative markers of renal function if persistent elevations in serum creatinine are observed [see *Clinical Pharmacology* (12.3)].

### Reporting of suspected adverse reactions

Reporting suspected adverse reactions after authorization 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>

## 7 DRUG INTERACTIONS

### 7.1 Effects of Other Drugs on RETEVMO

#### Acid-Reducing Agents

Concomitant use of RETEVMO with acid-reducing agents decreases selpercatinib plasma concentrations [see *Clinical Pharmacology (12.3)*], which may reduce RETEVMO anti-tumor activity.

Avoid concomitant use of PPIs, H2 receptor antagonists, and locally-acting antacids with RETEVMO. If coadministration cannot be avoided, take RETEVMO with food (with a PPI) or modify its administration time (with a H2 receptor antagonist or a locally-acting antacid) [see *Dosage and Administration (2.4)*].

#### Strong and Moderate CYP3A Inhibitors

Concomitant use of RETEVMO with a strong or moderate CYP3A inhibitor increases selpercatinib plasma concentrations [see *Clinical Pharmacology (12.3)*], which may increase the risk of RETEVMO adverse reactions, including QTc interval prolongation.

Avoid concomitant use of strong and moderate CYP3A inhibitors with RETEVMO. If concomitant use of strong and moderate CYP3A inhibitors cannot be avoided, reduce the RETEVMO dosage and monitor the QT interval with ECGs more frequently [see *Dosage and Administration (2.6)*, *Warning and Precautions (5.4)*].

#### Strong and Moderate CYP3A Inducers

Concomitant use of RETEVMO with a strong or moderate CYP3A inducer decreases selpercatinib plasma concentrations [see *Clinical Pharmacology (12.3)*], which may reduce RETEVMO anti-tumor activity.

Avoid coadministration of strong or moderate CYP3A inducers with RETEVMO.

### 7.2 Effects of RETEVMO on Other Drugs

#### CYP2C8 and CYP3A Substrates

RETEVMO is a moderate CYP2C8 inhibitor and a weak CYP3A inhibitor. Concomitant use of RETEVMO with CYP2C8 and CYP3A substrates increases their plasma concentrations [see *Clinical Pharmacology (12.3)*], which may increase the risk of adverse reactions related to these substrates. Avoid coadministration of RETEVMO with CYP2C8 and CYP3A substrates where minimal concentration changes may lead to increased adverse reactions. If coadministration cannot be avoided, follow recommendations for CYP2C8 and CYP3A substrates provided in their approved product labeling.

#### Certain P-gp Substrates

RETEVMO is a P-gp inhibitor. Concomitant use of RETEVMO with P-gp substrates increases their plasma concentrations [see *Clinical Pharmacology (12.3)*], which may increase the risk of adverse reactions related to these substrates. Avoid coadministration of RETEVMO with P-gp substrates where minimal concentration changes may lead to increased adverse reactions. If coadministration cannot be avoided, follow recommendations for P-gp substrates provided in their approved product labeling.

### 7.3 Drugs that Prolong QT Interval

RETEVMO is associated with QTc interval prolongation [see *Warnings and Precautions (5.4)*, *Clinical Pharmacology (12.2)*]. Monitor the QT interval with ECGs more frequently in patients who require treatment with concomitant medications known to prolong the QT interval.

## 8 USE IN SPECIFIC POPULATIONS

### 8.1 Pregnancy

#### Risk Summary

Based on findings from animal studies, and its mechanism of action [see *Clinical Pharmacology (12.1)*], RETEVMO can cause fetal harm when administered to a pregnant woman. There are no available data on RETEVMO use in pregnant women to inform drug-associated risk. Administration of selpercatinib to pregnant rats during the period of organogenesis resulted in embryoletality and malformations at maternal exposures that were approximately equal to the human exposure at the clinical dose of 160 mg twice daily. Advise pregnant women of the potential risk to a fetus.

In the U.S. general population, the estimated background risk of major birth defects and miscarriage in clinically recognized pregnancies is 2% to 4% and 15% to 20%, respectively.

## Data

### *Animal Data*

Selpercatinib administration to pregnant rats during the period of organogenesis at oral doses  $\geq 100$  mg/kg [approximately 3.6 times the human exposure based on the area under the curve (AUC) at the clinical dose of 160 mg twice daily] resulted in 100% post-implantation loss. At the dose of 50 mg/kg [approximately equal to the human exposure (AUC) at the clinical dose of 160 mg twice daily], 6 of 8 females had 100% early resorptions; the remaining 2 females had high levels of early resorptions with only 3 viable fetuses across the 2 litters. All viable fetuses had decreased fetal body weight and malformations (2 with short tail and one with small snout and localized edema of the neck and thorax).

## **8.2 Lactation**

### Risk Summary

There are no data on the presence of selpercatinib or its metabolites in human milk or on their effects on the breastfed child or on milk production. Because of the potential for serious adverse reactions in breastfed children, advise women not to breastfeed during treatment with RETEVMO and for 1 week after the last dose.

## **8.3 Females and Males of Reproductive Potential**

Based on animal data, RETEVMO can cause embryoletality and malformations at doses resulting in exposures less than or equal to the human exposure at the clinical dose of 160 mg twice daily [see *Use in Specific Populations (8.1)*].

### Pregnancy Testing

Verify pregnancy status in females of reproductive potential prior to initiating RETEVMO [see *Use in Specific Populations (8.1)*].

### Contraception

#### *Females*

Advise female patients of reproductive potential to use effective contraception during treatment with RETEVMO and for 1 week after the last dose.

#### *Males*

Advise males with female partners of reproductive potential to use effective contraception during treatment with RETEVMO and for 1 week after the last dose.

### Infertility

RETEVMO may impair fertility in females and males of reproductive potential [see *Use in Specific Populations (8.4)*, *Nonclinical Toxicology (13.1)*].

## **8.4 Pediatric Use**

The safety and effectiveness of RETEVMO have been established in pediatric patients aged 12 years and older for medullary thyroid cancer (MTC) who require systemic therapy and for advanced *RET* fusion-positive thyroid cancer who require systemic therapy and are radioactive iodine-refractory (if radioactive iodine is

appropriate). Use of RETEVMO for these indications is supported by evidence from adequate and well-controlled studies in adults with additional pharmacokinetic and safety data in pediatric patients aged 12 years and older [see *Adverse Reactions (6.1)*, *Clinical Pharmacology (12.3)*, *Clinical Studies (14.2, 14.3)*]. The safety and effectiveness of RETEVMO have not been established in these indications in patients less than 12 years of age.

The safety and effectiveness of RETEVMO have not been established in pediatric patients for other indications [see *Indications and Usage (1)*].

#### Juvenile Animal Toxicity Data

In a juvenile rat toxicity study, animals were dosed daily with selpercatinib from post-natal day 21 to day 70 (approximately equivalent to a human child to late adolescent). Selpercatinib increased physeal thickness of multiple bones, extending into the metaphysis and associated with decreased trabecular bone, which was not reversible at doses approximately equivalent to or greater than the adult human exposure at the clinical dose of 160 mg twice daily. Growth plate changes were associated with impairment of bone modeling, resulting in decreased femur length and with reduction in bone mineral density. Selpercatinib also induced reversible hypocellularity of bone marrow in males at  $\geq 30$  mg/kg (approximately equivalent to or greater than the adult human exposure at the clinical dose of 160 mg twice daily), and reversible alterations of dentin composition at  $\geq 50$  mg/kg (approximately 3 times the adult human exposure at the clinical dose of 160 mg twice daily). Irreversible, dose-dependent degeneration of testicular germinal epithelium, with vacuolation of Sertoli cells and corresponding depletion of spermatozoa in the epididymides, was also observed at  $\geq 30$  mg/kg (approximately equivalent to or greater than the adult human exposure at the clinical dose of 160 mg twice daily) and affected male reproductive performance at 50 mg/kg (approximately 3 times the adult human exposure at the clinical dose of 160 mg twice daily). Females exhibited delay in attainment of vaginal patency, a marker of sexual maturity, at 125 mg/kg (approximately 4 times the adult human exposure at the clinical dose of 160 mg twice daily); this affect was associated with lower mean body weight. Similar effects in irregular thickening of growth plates in adult rats and minipigs, and tooth dysplasia and malocclusion, resulting in tooth loss in adult rats were observed in repeat dose studies of up to 13-week duration with selpercatinib.

Monitor growth plates in adolescent patients with open growth plates. Consider interrupting or discontinuing therapy based on the severity of any growth plate abnormalities and based on an individual risk-benefit assessment.

### **8.5 Geriatric Use**

Of 796 patients who received RETEVMO, 34% (268 patients) were  $\geq 65$  years of age and 9% (74 patients) were  $\geq 75$  years of age. No overall differences were observed in the safety or effectiveness of RETEVMO between patients who were  $\geq 65$  years of age and younger patients.

### **8.6 Renal Impairment**

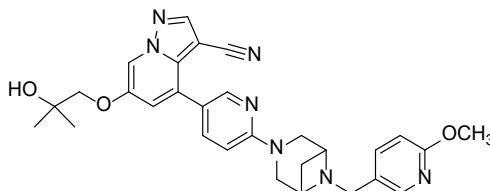
No dosage modification is recommended for patients with mild to severe renal impairment [estimated Glomerular Filtration Rate (eGFR)  $\geq 15$  to 89 mL/min, estimated by Modification of Diet in Renal Disease (MDRD) equation]. The recommended dosage has not been established for patients with end-stage renal disease (ESRD) [see *Clinical Pharmacology (12.3)*].

### **8.7 Hepatic Impairment**

Reduce the dose when administering RETEVMO to patients with severe [total bilirubin greater than 3 to 10 times upper limit of normal (ULN) and any AST] hepatic impairment [see *Dosage and Administration (2.7)*]. No dosage modification is recommended for patients with mild (total bilirubin less than or equal to ULN with AST greater than ULN or total bilirubin greater than 1 to 1.5 times ULN with any AST) or moderate (total bilirubin greater than 1.5 to 3 times ULN and any AST) hepatic impairment. Monitor for RETEVMO-related adverse reactions in patients with hepatic impairment [see *Clinical Pharmacology (12.3)*].

## **11 DESCRIPTION**

Selpercatinib is a kinase inhibitor. The molecular formula for selpercatinib is  $C_{29}H_{31}N_7O_3$  and the molecular weight is 525.61 g/mol. The chemical name is 6-(2-hydroxy-2-methylpropoxy)-4-(6-(6-((6-methoxypyridin-3-yl)methyl)-3,6-diazabicyclo[3.1.1]heptan-3-yl)pyridin-3-yl)pyrazolo[1,5-a]pyridine-3-carbonitrile. Selpercatinib has the following chemical structure:



Selpercatinib is a white to light yellow powder that is slightly hygroscopic. The aqueous solubility of selpercatinib is pH dependent, from sparingly soluble at low pH to practically insoluble at neutral pH.

RETEVMO (selpercatinib) is supplied as 40 mg or 80 mg hard gelatin capsules for oral use. Each capsule contains inactive ingredients of microcrystalline cellulose and colloidal silicon dioxide. The 40 mg capsule shell is composed of gelatin, titanium dioxide, and ferric oxide. The 80 mg capsule shell is composed of gelatin, titanium dioxide, and FD&C blue #1. The black ink is composed of shellac, alcohol (ethanol 96%), Fferric oxide, purified water, propylene glycol, isopropyl alcohol, butyl alcohol, strong ammonia solution, and potassium hydroxide.

## 12 CLINICAL PHARMACOLOGY

### 12.1 Mechanism of Action

Selpercatinib is a kinase inhibitor. Selpercatinib inhibited wild-type RET and multiple mutated RET isoforms as well as VEGFR1 and VEGFR3 with  $IC_{50}$  values ranging from 0.92 nM to 67.8 nM. In other enzyme assays, selpercatinib also inhibited FGFR 1, 2, and 3 at higher concentrations that were still clinically achievable. In cellular assays, selpercatinib inhibited RET at approximately 60-fold lower concentrations than FGFR1 and 2 and approximately 8-fold lower concentration than VEGFR3.

Certain point mutations in *RET* or chromosomal rearrangements involving in-frame fusions of *RET* with various partners can result in constitutively activated chimeric RET fusion proteins that can act as oncogenic drivers by promoting cell proliferation of tumor cell lines. In in vitro and in vivo tumor models, selpercatinib demonstrated anti-tumor activity in cells harboring constitutive activation of RET proteins resulting from gene fusions and mutations, including CCDC6-RET, KIF5B-RET, RET V804M, and RET M918T. In addition, selpercatinib showed anti-tumor activity in mice intracranially implanted with a patient-derived *RET* fusion positive tumor.

### 12.2 Pharmacodynamics

#### Exposure-Response Relationship

Selpercatinib exposure-response relationships and the time course of pharmacodynamic response have not been fully characterized.

#### Cardiac Electrophysiology

The effect of RETEVMO on the QTc interval was evaluated in a thorough QT study in healthy subjects. The largest mean increase in QTc is predicted to be 10.6 msec (upper 90% confidence interval: 12.1 msec) at the mean steady-state maximum concentration ( $C_{max}$ ) observed in patients after administration of 160 mg twice daily. The increase in QTc was concentration-dependent.

### 12.3 Pharmacokinetics

The pharmacokinetics of selpercatinib were evaluated in patients with locally advanced or metastatic solid tumors administered 160 mg twice daily unless otherwise specified. Steady state selpercatinib AUC and  $C_{max}$

increased in a slightly greater than dose proportional manner over the dose range of 20 mg once daily to 240 mg twice daily [0.06 to 1.5 times the maximum recommended total daily dosage].

Steady-state was reached by approximately 7 days and the median accumulation ratio after administration of 160 mg twice daily was 3.4-fold. Mean steady-state selpercatinib [coefficient of variation (CV%)]  $C_{max}$  was 2,980 (53%) ng/mL and  $AUC_{0-24h}$  was 51,600 (58%) ng\*h/mL.

### Absorption

The median  $t_{max}$  of selpercatinib is 2 hours. The mean absolute bioavailability of RETEVMO capsules is 73% (60% to 82%) in healthy subjects.

### *Effect of Food*

No clinically significant differences in selpercatinib AUC or  $C_{max}$  were observed following administration of a high-fat meal (approximately 900 calories, 58 grams carbohydrate, 56 grams fat and 43 grams protein) in healthy subjects.

### Distribution

The apparent volume of distribution ( $V_{ss}/F$ ) of selpercatinib is 191 L.

Protein binding of selpercatinib is 96% in vitro and is independent of concentration. The blood-to-plasma concentration ratio is 0.7.

### Elimination

The apparent clearance (CL/F) of selpercatinib is 6 L/h in patients and the half-life is 32 hours following oral administration of RETEVMO in healthy subjects.

### *Metabolism*

Selpercatinib is metabolized predominantly by CYP3A4. Following oral administration of a single radiolabeled 160 mg dose of selpercatinib to healthy subjects, unchanged selpercatinib constituted 86% of the radioactive drug components in plasma.

### *Excretion*

Following oral administration of a single radiolabeled 160 mg dose of selpercatinib to healthy subjects, 69% of the administered dose was recovered in feces (14% unchanged) and 24% in urine (12% unchanged).

### Specific Populations

The apparent volume of distribution and clearance of selpercatinib increase with increasing body weight (27 kg to 179 kg).

No clinically significant differences in the pharmacokinetics of selpercatinib were observed based on age (15 years to 92 years), sex, or mild, moderate, or severe renal impairment (eGFR  $\geq$ 15 to 89 mL/min). The effect of ESRD on selpercatinib pharmacokinetics has not been studied.

### *Patients with Hepatic Impairment*

The selpercatinib  $AUC_{0-INF}$  increased by 7%, 32%, and 77% in subjects with mild (total bilirubin less than or equal to ULN with AST greater than ULN or total bilirubin greater than 1 to 1.5 times ULN with any AST), moderate (total bilirubin greater than 1.5 to 3 times ULN and any AST), and severe (total bilirubin greater than 3 to 10 times ULN and any AST) hepatic impairment, respectively, compared to subjects with normal hepatic function.

### Drug Interaction Studies

#### *Clinical Studies and Model-Informed Approaches*

*Proton-Pump Inhibitors (PPI)*: Coadministration with multiple daily doses of omeprazole (PPI) decreased selpercatinib  $AUC_{0-INF}$  and  $C_{max}$  when RETEVMO was administered fasting. Coadministration with multiple daily doses of omeprazole did not significantly change the selpercatinib  $AUC_{0-INF}$  and  $C_{max}$  when RETEVMO was administered with food (Table 7).

**Table 7: Change in Selpercatinib Exposure After Coadministration with PPI**

	<b>Selpercatinib AUC<sub>0-INF</sub></b>	<b>Selpercatinib C<sub>max</sub></b>
RETEVMO fasting	Reference	Reference
RETEVMO fasting + PPI	↓ 69%	↓ 88%
RETEVMO with a high-fat meal <sup>1</sup> + PPI	↑ 2%	↓ 49%
RETEVMO with a low-fat meal <sup>2</sup> + PPI	No change	↓ 22%

<sup>1</sup> High-fat meal: approximately 150, 250, and 500-600 calories from protein, carbohydrate, and fat, respectively; approximately 800 to 1,000 calories total.

<sup>2</sup> Low-fat meal: approximately 390 calories and 10 g of fat.

**H2 Receptor Antagonists:** No clinically significant differences in selpercatinib pharmacokinetics were observed when coadministered with multiple daily doses of ranitidine (H2 receptor antagonist) given 10 hours prior to and 2 hours after the RETEVMO dose (administered fasting).

**Strong CYP3A Inhibitors:** Coadministration of multiple doses of itraconazole (strong CYP3A inhibitor) increased the selpercatinib AUC<sub>0-INF</sub> by 133% and C<sub>max</sub> by 30%.

**Moderate CYP3A Inhibitors:** Coadministration of multiple doses of diltiazem, fluconazole, or verapamil (moderate CYP3A inhibitors) is predicted to increase the selpercatinib AUC by 60-99% and C<sub>max</sub> by 46-76%.

**Strong CYP3A Inducers:** Coadministration of multiple doses of rifampin (strong CYP3A inducer) decreased the selpercatinib AUC<sub>0-INF</sub> by 87% and C<sub>max</sub> by 70%.

**Moderate CYP3A Inducers:** Coadministration of multiple doses of bosentan or efavirenz (moderate CYP3A inducers) is predicted to decrease the selpercatinib AUC by 40-70% and C<sub>max</sub> by 34-57%.

**Weak CYP3A Inducers:** Coadministration of multiple doses of modafinil (weak CYP3A inducer) is predicted to decrease the selpercatinib AUC by 33% and C<sub>max</sub> by 26%.

**CYP2C8 Substrates:** Coadministration of RETEVMO with repaglinide (sensitive CYP2C8 substrate) increased the repaglinide AUC<sub>0-INF</sub> by 188% and C<sub>max</sub> by 91%.

**CYP3A Substrates:** Coadministration of RETEVMO with midazolam (sensitive CYP3A substrate) increased the midazolam AUC<sub>0-INF</sub> by 54% and C<sub>max</sub> by 39%.

**P-glycoprotein (P-gp) Substrates:** Coadministration of RETEVMO with dabigatran (P-gp substrate) increased the dabigatran AUC<sub>0-INF</sub> by 38% and C<sub>max</sub> by 43%.

**P-gp Inhibitors:** No clinically significant differences in selpercatinib pharmacokinetics were observed when coadministered with a single dose of rifampin (P-gp inhibitor).

**MATE1 Substrates:** No clinically significant differences in glucose levels were observed when metformin (MATE1 substrate) was coadministered with selpercatinib.

#### *In Vitro Studies*

**CYP Enzymes:** Selpercatinib does not inhibit or induce CYP1A2, CYP2B6, CYP2C9, CYP2C19, or CYP2D6 at clinically relevant concentrations.

**Transporter Systems:** Selpercatinib inhibits MATE1 and BCRP, but does not inhibit OAT1, OAT3, OCT1, OCT2, OATP1B1, OATP1B3, BSEP, and MATE2-K at clinically relevant concentrations. Selpercatinib may increase serum creatinine by decreasing renal tubular secretion of creatinine via inhibition of MATE1 [see *Adverse Effects (6.1)*]. Selpercatinib is a substrate for P-gp and BCRP, but not for OAT1, OAT3, OCT1, OCT2, OATP1B1, OATP1B3, MATE1, or MATE2-K.

## 13 NONCLINICAL TOXICOLOGY

### 13.1 Carcinogenesis, Mutagenesis, Impairment of Fertility

Carcinogenicity studies have not been conducted with selpercatinib. Selpercatinib was not mutagenic in the in vitro bacterial reverse mutation (Ames) assays, with or without metabolic activation, or clastogenic in the in vitro micronucleus assay in human peripheral lymphocytes, with or without metabolic activation. Selpercatinib was positive in the in vivo micronucleus assay in rats at concentrations >7 times the  $C_{max}$  at the human dose of 160 mg twice daily.

In general toxicology studies, male rats and minipigs exhibited testicular degeneration which was associated with luminal cell debris and/or reduced luminal sperm in the epididymis at selpercatinib exposures approximately 0.4 (rat) and 0.1 (minipig) times the clinical exposure by AUC at the recommended human dose. In a dedicated fertility study in male rats, administration of selpercatinib at doses up to 30 mg/kg/day (approximately twice the clinical exposure by AUC at the 160 mg twice daily dose) for 28 days prior to cohabitation with untreated females did not affect mating or have clear effects on fertility. Males did, however, display a dose-dependent increase in testicular germ cell depletion and spermatid retention at doses  $\geq 3$  mg/kg (~0.2 times the clinical exposure by AUC at the 160 mg twice daily dose) accompanied by altered sperm morphology at 30 mg/kg.

In a dedicated fertility study in female rats treated with selpercatinib for 15 days before mating to Gestational Day 7, there were decreases in the number of estrous cycles at a dose of 75 mg/kg (approximately equal to the human exposure by AUC at the 160 mg twice daily clinical dose). While selpercatinib did not have clear effects on mating performance or ability to become pregnant at any dose level, half of females at the 75 mg/kg dose level had 100% nonviable embryos. At the same dose level in females with some viable embryos there were increases in post-implantation loss. In a 3-month general toxicology study in minipigs, there were findings of decreased or absent corpora lutea at a selpercatinib dose of 15 mg/kg (approximately 0.3 times to the human exposure by AUC at the 160 mg twice daily clinical dose). Corpora luteal cysts were present in the minipig at selpercatinib doses  $\geq 2$  mg/kg (approximately 0.07 times the human exposure by AUC at the 160 mg twice daily clinical dose).

## 14 CLINICAL STUDIES

### 14.1 Metastatic *RET* Fusion-Positive Non-Small Cell Lung Cancer

The efficacy of RETEVMO was evaluated in patients with advanced *RET* fusion-positive NSCLC enrolled in a multicenter, open-label, multi-cohort clinical trial (LIBRETTO-001, NCT03157128). The study enrolled patients with advanced or metastatic *RET* fusion-positive NSCLC who had progressed on platinum-based chemotherapy and patients with locally advanced (stage III who were not candidates for surgical resection or definitive chemoradiation) or metastatic NSCLC without prior systemic therapy in separate cohorts. Identification of a *RET* gene alteration was prospectively determined in local laboratories using next generation sequencing (NGS), polymerase chain reaction (PCR), fluorescence in situ hybridization (FISH) or other local testing methods. Adult patients received RETEVMO 160 mg orally twice daily until unacceptable toxicity or disease progression; patients enrolled in the dose escalation phase were permitted to adjust their dose to 160 mg twice daily. The major efficacy outcome measures were confirmed overall response rate (ORR) and duration of response (DOR), as determined by a blinded independent review committee (BIRC) according to RECIST v1.1.

#### Metastatic *RET* Fusion-Positive NSCLC Previously Treated with Platinum Chemotherapy

Efficacy was evaluated in 247 patients with *RET* fusion-positive NSCLC previously treated with platinum chemotherapy enrolled into a cohort of LIBRETTO-001.

The median age was 61 years (range: 23 to 81); 57% were female; 44% were White, 48% were Asian, 4.9% were Black, and 2.8% were Hispanic/Latino. ECOG performance status was 0-1 (97%) or 2 (3%) and 97% of patients had metastatic disease. Patients received a median of 2 prior systemic therapies (range 1–15); 58% had prior anti-PD-1/PD-L1 therapy. *RET* fusions were detected in 94% of patients using NGS (84.6% tumor



samples; 9.3% blood or plasma samples), 4.0% using FISH, 1.6% using PCR and 0.4% by other local testing methods.

Efficacy results for previously treated *RET* fusion-positive NSCLC are summarized in Table 8.

**Table 8: Efficacy Results in LIBRETTO-001 (Metastatic *RET* Fusion-Positive NSCLC Previously Treated with Platinum Chemotherapy)**

	<b>RETEVMO (n = 247)</b>
<b>Overall Response Rate<sup>1</sup> (95% CI)</b>	61% (55%, 67%)
Complete response	7.3%
Partial response	54%
<b>Duration of Response</b>	
Median in months (95% CI)	28.6 (20, NE)
% with ≥ 12 months <sup>2</sup>	63%

<sup>1</sup> Confirmed overall response rate assessed by BIRC.

<sup>2</sup> Based on observed duration of response.

NE = not estimable

For the 144 patients who received an anti-PD-1 or anti-PD-L1 therapy, either sequentially or concurrently with platinum-based chemotherapy, an exploratory subgroup analysis of ORR was 63% (95% CI: 54%, 70%) and the median DOR was 28.6 months (95% CI: 14.8, NE).

Among the 247 patients with previously treated *RET* fusion-positive NSCLC, 16 had measurable CNS metastases at baseline as assessed by BIRC. One patient received radiation therapy (RT) to the brain within 2 months prior to study entry. Responses in intracranial lesions were observed in 14 of these 16 patients; 39% of responders had an intracranial DOR of ≥ 12 months.

#### Treatment-naïve *RET* Fusion-Positive NSCLC

Efficacy was evaluated in 69 patients with treatment-naïve *RET* fusion-positive NSCLC enrolled into a cohort of LIBRETTO-001.

The median age was 63 years (range 23 to 92); 62% were female; 70% were White, 19% were Asian, and 6% were Black. ECOG performance status was 0-1 (94%) or 2 (6%) and 99% of patients had metastatic disease. *RET* fusions were detected in 91% of patients using NGS (60.9% tumor samples; 30.4% in blood), 7.2% using FISH and 1.4% using PCR.

Efficacy results for treatment naïve *RET* fusion-positive NSCLC are summarized in Table 9.

**Table 9: Efficacy Results in LIBRETTO-001 (Treatment-Naïve Metastatic *RET* Fusion-Positive NSCLC)**

	<b>RETEVMO (n = 69)</b>
<b>Overall Response Rate<sup>1</sup> (95% CI)</b>	84% (73%, 92%)
Complete response	5.8%
Partial response	78%
<b>Duration of Response</b>	
Median in months (95% CI)	20.2 (13, NE)
% with ≥ 12 months <sup>2</sup>	50%

<sup>1</sup> Confirmed overall response rate assessed by BIRC.

<sup>2</sup> Based on observed duration of response.

NE = not estimable

Among the 69 patients with treatment-naïve *RET* fusion-positive NSCLC, 5 had measurable CNS metastases at baseline as assessed by BIRC. Two patients received RT to the brain within 2 months prior to study entry. Responses in intracranial lesions were observed in 4 of these 5 patients; 38% of responders had an intracranial DOR of  $\geq 12$  months.

## 14.2 *RET*-Mutant Medullary Thyroid Cancer

The efficacy of RETEVMO was evaluated in patients with *RET*-mutant MTC enrolled in a multicenter, open-label, multi-cohort clinical trial (LIBRETTO-001, NCT03157128). The study enrolled patients with advanced or metastatic *RET*-mutant MTC who had been previously treated with cabozantinib or vandetanib (or both) and patients with advanced or metastatic *RET*-mutant MTC who were naïve to cabozantinib and vandetanib in separate cohorts.

### *RET*-Mutant MTC Previously Treated with Cabozantinib or Vandetanib

Efficacy was evaluated in 55 patients with *RET*-mutant advanced MTC who had previously treated with cabozantinib or vandetanib enrolled into a cohort of LIBRETTO-001.

The median age was 57 years (range: 17 to 84); 66% were male; 89% were White, 7% were Hispanic/Latino, and 1.8% were Black. ECOG performance status was 0-1 (95%) or 2 (5%) and 98% of patients had metastatic disease. Patients received a median of 2 prior systemic therapies (range 1 – 8). *RET* mutation status was detected in 82% of patients using NGS (78% tumor samples; 4% blood or plasma), 16% using PCR, and 2% using an unknown test. The protocol excluded patients with synonymous, frameshift or nonsense *RET* mutations; the specific mutations used to identify and enroll patients are described in Table 10.

**Table 10: Mutations used to Identify and Enroll Patients with *RET*-Mutant MTC in LIBRETTO-001**

<b>RET Mutation Type<sup>1</sup></b>	<b>Previously Treated (n = 55)</b>	<b>Cabozantinib/ Vandetanib Naïve (n = 88)</b>	<b>Total (n = 143)</b>
M918T	33	49	82
Extracellular cysteine mutation <sup>2</sup>	7	20	27
V804M or V804L	5 <sup>4</sup>	6	11
Other <sup>3</sup>	10	13	23

<sup>1</sup> Somatic or germline mutations; protein change.

<sup>2</sup> Extracellular cysteine mutations involving cysteine residues 609, 611, 618, 620, 630, and 634.

<sup>3</sup> Other included: K666N (1), D631\_L633delinsV (2), D631\_L633delinsE (5), D378\_G385delinsE (1), D898\_E901del (2), A883F (4), E632\_L633del (4), L790F (2), T636\_V637insCRT(1), D898\_E901del + D903\_S904delinsEP (1).

<sup>4</sup> One patient also had a M918T mutation.

Efficacy results for *RET*-mutant MTC are summarized in Table 11.

**Table 11: Efficacy Results in LIBRETTO-001 (*RET*-Mutant MTC Previously Treated with Cabozantinib or Vandetanib)**

	<b>RETEVMO (n = 55)</b>
<b>Overall Response Rate<sup>1</sup> (95% CI)</b>	69% (55%, 81%)
Complete response	9%
Partial response	60%
<b>Duration of Response</b>	
Median in months (95% CI)	NE (19.1, NE)
% with ≥6 months <sup>2</sup>	76

<sup>1</sup> Confirmed overall response rate assessed by BIRC.

<sup>2</sup> Based on observed duration of response.

NE = not estimable

### Cabozantinib and Vandetanib-naïve *RET*-Mutant MTC

Efficacy was evaluated in 88 patients with *RET*-mutant MTC who were cabozantinib and vandetanib treatment-naïve enrolled into a cohort of LIBRETTO-001.

The median age was 58 years (range: 15 to 82) with two patients (2.3%) aged 12 to 16 years; 66% were male; and 86% were White, 4.5% were Asian, and 2.3% were Hispanic/Latino. ECOG performance status was 0-1 (97%) or 2 (3.4%). All patients (100%) had metastatic disease and 18% had received 1 or 2 prior systemic therapies (including 8% kinase inhibitors, 4.5% chemotherapy, 2.3% anti-PD1/PD-L1 therapy, and 1.1% radioactive iodine). *RET* mutation status was detected in 77.3% of patients using NGS (75.0% tumor samples; 2.3% blood samples), 18.2% using PCR, and 4.5% using an unknown test. The mutations used to identify and enroll patients are described in Table 10.

Efficacy results for cabozantinib and vandetanib-naïve *RET*-mutant MTC are summarized in Table 12.

**Table 12: Efficacy Results in LIBRETTO-001 (Cabozantinib and Vandetanib-naïve *RET*-Mutant MTC)**

	<b>RETEVMO (n = 88)</b>
<b>Overall Response Rate<sup>1</sup> (95% CI)</b>	73% (62%, 82%)
Complete response	11%
Partial response	61%
<b>Duration of Response</b>	
Median in months (95% CI)	22.0 (NE, NE)
% with ≥6 months <sup>2</sup>	61

<sup>1</sup> Confirmed overall response rate assessed by BIRC.

<sup>2</sup> Based on observed duration of response.

NE = not estimable

### **14.3 *RET* Fusion-Positive Thyroid Cancer**

The efficacy of RETEVMO was evaluated in patients with advanced *RET* fusion-positive thyroid cancer enrolled in a multicenter, open-label, multi-cohort clinical trial (LIBRETTO-001, NCT03157128). Efficacy was evaluated in 27 patients with *RET* fusion-positive thyroid cancer who were radioactive iodine (RAI)-refractory (if RAI was an appropriate treatment option) and were systemic therapy naïve and patients with *RET* fusion-

positive thyroid cancer who were RAI-refractory and had received sorafenib, lenvatinib, or both, in separate cohorts.

The median age was 54 years (range 20 to 88); 52% were male; 74% were White, 11% were Hispanic/Latino, 7.4% were Asian, and 3.7% were Black. ECOG performance status was 0-1 (89%) or 2 (11%). All (100%) patients had metastatic disease with primary tumor histologies including papillary thyroid cancer (78%), poorly differentiated thyroid cancer (11%), anaplastic thyroid cancer (7%) and Hurthle cell thyroid cancer (4%). Patients had received a median of 3 prior therapies (range 1–7). *RET* fusion-positive status was detected in 93% of patients using NGS tumor samples and in 7% using blood samples.

Efficacy results for *RET* fusion-positive thyroid cancer are summarized in Table 13.

**Table 13: Efficacy Results in LIBRETTO-001 (*RET* Fusion-Positive Thyroid Cancer)**

	<b>RETEVMO Previously Treated (n = 19)</b>	<b>RETEVMO Systemic Therapy Naïve (n = 8)</b>
<b>Overall Response Rate<sup>1</sup></b> (95% CI)	79% (54%, 94%)	100% (63%, 100%)
Complete response	5.3%	12.5%
Partial response	74%	88%
<b>Duration of Response</b>		
Median in months (95% CI)	18.4 (7.6, NE)	NE (NE, NE)
% with ≥6 months <sup>2</sup>	87	75

<sup>1</sup> Confirmed overall response rate assessed by BIRC.

<sup>2</sup> Based on observed duration of response.

NE = not estimable

## 16 HOW SUPPLIED/STORAGE AND HANDLING

RETEVMO (selpercatinib) capsules are supplied as follows:

40 mg: Gray opaque, imprinted with “Lilly”, “3977” and “40 mg” in black ink

60 count bottle

80 mg: Blue opaque, imprinted with “Lilly”, “2980” and “80 mg” in black ink

60 count bottle

120 count bottle

Store below 30°C.

### Shelf life

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

## 17 MANUFACTURER

Eli Lilly and Company, Lilly Corporate Center, Indianapolis, Indiana (IN) 46285, United States (USA).

## 18 LICENSE HOLDER

Eli Lilly Israel Limited

4 HaSheizaf St., POB 4246 Ra’anana 4366411, Israel

**19 LICENSE NUMBER**

RETEVMO 40 mg: 171-67-37212-99

RETEVMO 80 mg: 171-68-37213-99

Approved on February 2023 according to MOHs guidelines.

X RETECP I 01