

# **Trabectedin Teva 0.25 mg and 1 mg**

## **Powder for Concentrate for Solution for IV Infusion**

### **Summary of Product Characteristics**

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

Trabectedin Teva 0.25 mg

Trabectedin Teva 1 mg

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

##### **Trabectedin Teva 0.25 mg**

Each vial of powder contains 0.25 mg of trabectedin.

1 ml of reconstituted solution contains 0.05 mg of trabectedin (see Section 6.6)

##### Excipients with known effect:

Each vial of powder contains 4.65 mg of potassium.

For the full list of excipients, see section 6.1.

##### **Trabectedin Teva 1 mg**

Each vial of powder contains 1 mg of trabectedin.

1 ml of reconstituted solution contains 0.05 mg of trabectedin (see Section 6.6)

##### Excipients with known effect:

Each vial of powder contains 18.59 mg of potassium.

For the full list of excipients, see section 6.1.

#### **3. PHARMACEUTICAL FORM**

Powder for concentrate for solution for infusion.

White to off-white powder.

#### **4. CLINICAL PARTICULARS**

##### **4.1 Therapeutic indications**

Trabectedin Teva 0.25 mg and 1mg is indicated for the treatment of patients with advanced soft tissue sarcoma, after failure of anthracyclines and ifosfamide, or who are unsuited to receive these agents. Efficacy data are based mainly on liposarcoma and leiomyosarcoma patients.

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

Trabectedin Teva 0.25 mg and 1mg must be administered under the supervision of a physician experienced in the use of chemotherapy. Its use should be confined to personnel specialized in the administration of cytotoxic agents.

##### Posology

For the treatment of soft tissue sarcoma, the recommended starting dose is 1.5 mg/m<sup>2</sup> body surface area, administered as an intravenous infusion over 24 hours with a three-week interval between cycles.

All patients must be premedicated with corticosteroids such as dexamethasone 20 mg intravenously 30 minutes before each Trabectedin Teva 0.25 mg and 1 mg infusion; not only as antiemetic prophylaxis, but also because it appears to provide hepatoprotective effects. Additional antiemetics may be administered as needed (see Interactions).

The following criteria are required to allow treatment with Trabectedin Teva 0.25 mg and 1mg:

- Absolute neutrophil count (ANC)  $\geq 1,500/\text{mm}^3$
- Platelet count  $\geq 100,000/\text{mm}^3$
- Haemoglobin  $\geq 9 \text{ g/dl}$
- Bilirubin  $\leq$  upper limit of normal (ULN)
- Alkaline phosphatase of non-osseous origin  $\leq 2.5 \times \text{ULN}$  (consider hepatic isoenzymes 5-nucleotidase or GGT, to distinguish if the elevation could be osseous in origin)
- Albumin  $\geq 25 \text{ g/l}$
- Alanine aminotransferase (ALT) and Aspartate aminotransferase (AST)  $\leq 2.5 \times \text{ULN}$
- Creatinine clearance  $\geq 30 \text{ ml/min}$
- Creatine phosphokinase (CPK)  $\leq 2.5 \times \text{ULN}$

The same criteria as above must be met prior to initiation of next cycles. Otherwise, treatment must be delayed for up to 3 weeks until the criteria are met. If these toxicities persist beyond 3 weeks, treatment discontinuation should be considered.

Additional monitoring of haematological and biochemical parameters [bilirubin, alkaline phosphatase, aminotransferases (AST and ALT) and CPK] should occur weekly during the first two cycles of therapy, and at least once between treatments in subsequent cycles.

The same dose should be given for all cycles provided that no grade 3-4 toxicities are seen and that the patient fulfils the re-treatment criteria.

### **Dose adjustments during treatment**

#### **Dose adjustments during treatment**

Prior to re-treatment, patients must fulfil the baseline criteria defined above. If any of the following events occur at any time between cycles, the trabectedin dose must be reduced to 1.2mg/m<sup>2</sup> in subsequent cycles:

- Neutropenia  $< 500/\text{mm}^3$  lasting for more than 5 days or associated with fever or infection
- Thrombocytopenia  $< 25,000/\text{mm}^3$
- Increase of bilirubin  $> \text{ULN}$
- Alkaline phosphatase of non-osseous origin  $> 2.5 \times \text{ULN}$
- Increase of aminotransferases (AST or ALT)  $> 2.5 \times \text{ULN}$  which has not recovered by day 21
- Any other grade 3 or 4 adverse reactions (such as nausea, vomiting, fatigue)

Once a dose has been reduced because of toxicity, dose escalation in the subsequent cycles is not recommended. If any of these toxicities reappear in subsequent cycles in a patient exhibiting clinical benefit, the trabectedin dose may be further reduced to 1 mg/m<sup>2</sup>.

In the event that further dose reductions are necessary, treatment discontinuation should be considered. Colony-stimulating factors can be administered for hematologic toxicity in subsequent cycles according to local standard practice.

#### **Duration of treatment**

In clinical trials, there were no pre-defined limits to the number of cycles administered.

Treatment continued whilst clinical benefit was noted. Trabectedin has been administered for 6 or more cycles in 29.5% of patients. The monotherapy regimen has been used for up to 38 cycles. No cumulative toxicities have been observed in patients treated with multiple cycles.

### **Special patient populations**

#### ***Paediatric patients (18 years of age and younger)***

The safety and efficacy of trabectedin in paediatric patients have not been established. Therefore, this medicinal product must not be used in children and adolescents.

#### ***Elderly patients (65 years of age and older)***

No specific studies in older people have been performed. Overall, 20% of the 1,164 patients in the integrated safety analysis of monotherapy clinical trials were over 65 years. No relevant differences in the safety profile were seen in this patient population. It seems that plasma clearance and distribution volume of trabectedin are not influenced by age. Therefore, dose adjustments based uniquely on age criteria are not routinely recommended.

#### ***Hepatic impairment***

Patients with hepatic impairment may be at increased risk for toxicity. Recommendations for a starting dose in these patients cannot be made because the use of trabectedin in patients with impaired hepatic function has not been adequately studied. However, special caution is advised and dose adjustments may be necessary in these patients since systemic exposure may be increased and the risk of hepatotoxicity might be increased. Patients with elevated bilirubin at the time of initiation of cycle must not be treated with Trabectedin Teva 0.25 mg and 1 mg (see section 4.4).

#### ***Renal impairment***

Studies including patients with renal insufficiency (creatinine clearance < 30 ml/min) have not been conducted and therefore, Trabectedin Teva 0.25 mg and 1 mg must not be used in this patient population (see section 4.4). The pharmacokinetics of trabectedin is not expected to be impacted by mild or moderate renal impairment (see section 5.2).

### **Method of administration**

Intravenous infusion.

Administration through a central venous line is strongly recommended (see sections 4.4 and 6.6).

For instructions on reconstitution and dilution of the medicinal product before administration see section 6.6.

Intravenous infusion over 24 hours with a three-week interval between cycles.

### **4.3 Contraindications**

- Hypersensitivity to trabectedin or to any of the excipients listed in section 6.1
- Concurrent serious or uncontrolled infection
- Breast-feeding (see section 4.6)
- Combination with yellow fever vaccine (see section 4.4)

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

#### **Hepatic impairment**

Patients must meet specific criteria on hepatic function parameters to start treatment with

Trabectedin Teva 0.25 mg and 1 mg. Since the systemic exposure to trabectedin may be increased due to hepatic impairment and therefore, the risk of hepatotoxicity might be increased, patients with clinically relevant liver diseases, such as active chronic hepatitis, should be closely monitored and the dose adjusted if needed. Patients with elevated bilirubin at the time of initiation of a new treatment cycle must not be treated with trabectedin (see section 4.2).

#### Renal impairment

Creatinine clearance must be monitored prior to and during treatment. Trabectedin as a single agent must not be used in patients with creatinine clearance < 30 ml/min (see section 4.2).

#### Neutropenia and thrombocytopenia

Grades 3 or 4 neutropenia and thrombocytopenia associated with trabectedin therapy have been very commonly reported. A full blood cell count including differential and platelet counts must be performed at baseline, weekly for the first two cycles and then once between cycles (see section 4.2). Patients who develop fever should promptly seek medical attention. If this occurs, active supportive therapy should be started immediately.

Trabectedin Teva 0.25 mg and 1 mg should not be administered to patients with baseline neutrophil counts of less than 1,500 cells/mm<sup>3</sup> and platelet counts of less than 100,000 cells/mm<sup>3</sup>. If severe neutropenia (ANC < 500 cells/mm<sup>3</sup>) lasting more than 5 days or associated with fever or infection occurs, dose reduction is recommended (see section 4.2).

#### Nausea and vomiting

Antiemetic prophylaxis with corticosteroids such as dexamethasone must be administered to all patients (see section 4.2).

#### Rhabdomyolysis and severe CPK elevations (> 5 x ULN)

Trabectedin must not be used in patients with CPK > 2.5 x ULN (see section 4.2).

Rhabdomyolysis has been uncommonly reported usually in association with myelotoxicity, severe liver function test abnormalities and/or renal or multiorgan failure.

Therefore, CPK should be closely monitored whenever a patient may be experiencing any of these toxicities or muscle weakness or muscle pain. If rhabdomyolysis occurs, supportive measures such as parenteral hydration, urine alkalinisation and dialysis should be promptly established, as indicated. Treatment with trabectedin should be discontinued until the patient fully recovers.

Caution should be taken if medicinal products associated with rhabdomyolysis (e.g., statins) are administered concomitantly with trabectedin, since the risk of rhabdomyolysis may be increased.

#### Liver function test (LFT) abnormalities

Reversible acute increases in aspartate aminotransferase (AST) and alanine aminotransferase (ALT) have been reported in most patients treated with trabectedin. Grade 3 or 4 transaminase elevations occurred very commonly; grade 4 transaminase elevations occurred commonly. The median time to the occurrence of ALT or AST increase to grade 3 or 4 levels was 8 days. Elevated levels decreased to below grade 3 or 4 in about 8 days. Transaminase elevations were non-cumulative and decreased in magnitude and incidence with each subsequent cycle. Trabectedin must not be used in patients with elevated bilirubin at the time of initiation of cycle. Patients with increases in AST, ALT and alkaline phosphatase between cycles may necessitate dose reduction (see section 4.2).

#### Injection site reactions

The use of central venous access is strongly recommended (see section 4.2). Patients may develop a potentially severe injection site reaction when trabectedin is administered through a peripheral venous line.

Trabectedin extravasation may cause tissue necrosis requiring debridement. There is no specific antidote for extravasation of trabectedin. Extravasation should be managed by local standard practice.

#### Allergic reactions

During postmarketing experience, hypersensitivity reactions with very rare occurrence of fatal outcome, have been reported in association with trabectedin administration (see sections 4.3 and 4.8).

#### Cardiac dysfunction

Patients should be monitored for cardiac-related adverse events or myocardial dysfunction.

A thorough cardiac assessment including determination of left ventricular ejection fraction (LVEF) by echocardiogram or multigated acquisition scan (MUGA) should be conducted before initiation of trabectedin and at 2- to 3-month intervals thereafter until trabectedin is discontinued.

Patients with LVEF less than the lower limit of normal (LVEF < LLN), prior cumulative anthracycline dose of > 300mg/m<sup>2</sup>, aged > 65 years, or a history of cardiovascular disease (especially in those with cardiac medication) may be at increased risk of cardiac dysfunction at treatment with trabectedin as monotherapy or in combination with doxorubicin.

For patients with grade 3 or 4 cardiac adverse events indicative of cardiomyopathy or for patients with a LVEF that decreases below the LLN (assessed as either an absolute decrease of LVEF of  $\geq 15\%$  or < LLN with an absolute decrease of  $\geq 5\%$ ), trabectedin should be discontinued.

#### Capillary leak syndrome (CLS)

Cases of Capillary Leak Syndrome (CLS) have been reported with trabectedin (including cases with fatal outcomes). If symptoms of possible CLS develop, such as unexplained oedema with or without hypotension, the treating physician should reassess serum albumin level. A rapid decline in serum albumin level may be indicative of CLS. If a diagnosis of CLS is confirmed after exclusion of other causes, the treating physician should discontinue trabectedin and initiate CLS treatment according to institutional guidelines (see sections 4.2 and 4.8).

#### Others

Co-administration of trabectedin with potent inhibitors of the enzyme CYP3A4 should be avoided (see section 4.5). If this is not possible, close monitoring of toxicities is required and dose reductions of trabectedin should be considered.

Caution should be taken if medicinal products associated with hepatotoxicity are administered concomitantly with trabectedin, since the risk of hepatotoxicity may be increased.

Concomitant use of trabectedin with phenytoin may reduce phenytoin absorption leading to an exacerbation of convulsions. Combination of trabectedin with phenytoin or live attenuated vaccines is not recommended and with yellow fever vaccine is specifically contraindicated (see section 4.3).

Women of childbearing potential must use effective contraception during treatment and 3 months thereafter, and immediately inform the treating physician if a pregnancy occurs (see section 5.3). Men in fertile age must use effective contraception during treatment and 5 months after treatment (see section 4.6).

Immediately inform the treating physician if a pregnancy occurs.

This medicine contains 1.28 mmol (or 50.22 mg) potassium per 2.7 mg of trabectedin. To be taken into consideration by patients with reduced kidney function or patients on a controlled potassium diet.

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

##### Effects of other substances on trabectedin

Interaction studies have only been performed in adults.

Since trabectedin is metabolised mainly by CYP3A4, the concentrations of trabectedin in plasma are likely to be increased in patients who are co-administered drugs that potently inhibit the activity of this isoenzyme. Similarly, the co-administration of trabectedin with potent inducers of CYP3A4 may increase the metabolic clearance of trabectedin. Two in vivo drug-drug interaction phase 1 studies have confirmed trends toward increased and decreased trabectedin exposures when administered with ketoconazole and rifampicin, respectively.

When ketoconazole was co-administered with trabectedin, the plasma exposure of trabectedin was increased by approximately 21% for C<sub>max</sub> and 66% for AUC, but no new safety concerns were identified. Close monitoring of toxicities is required in patients receiving trabectedin in combination with potent CYP3A4 inhibitors (e.g. oral ketoconazole, fluconazole, ritonavir, clarithromycin or aprepitant) and such combinations should be avoided if possible. If such combinations are needed, appropriate dose adjustments should be applied in the event of toxicities (see sections 4.2 and 4.4).

When rifampicin was co-administered with trabectedin, it resulted in reduced plasma exposure of trabectedin by approximately 22% for C<sub>max</sub> and 31% for AUC. Therefore, the concomitant use of trabectedin with strong CYP3A4 inducers (e.g., rifampicin, phenobarbital, Saint John's Wort) should be avoided if possible (see section 4.4).

Alcohol consumption must be avoided during treatment with trabectedin due to the hepatotoxicity of the medicinal product (see section 4.4).

Preclinical data have demonstrated that trabectedin is a substrate to P-gp. Concomitant administration of inhibitors of P-gp, e.g. cyclosporine and verapamil, may alter trabectedin distribution and/or elimination. The relevance of this interaction, e.g., central nervous system (CNS) toxicity has not been established. Caution should be taken in such situations.

#### **4.6 Pregnancy and lactation**

##### Pregnancy

No sufficient clinical data on exposed pregnancies are available. However, based on its known mechanism of action, trabectedin may cause serious birth defects when administered during pregnancy. Trabectedin crossed the placenta when administered to pregnant rats. Trabectedin should not be used during pregnancy. If pregnancy occurs during treatment, the patient must be informed of the potential risk to the fetus (see section 5.3) and be monitored carefully. If trabectedin is used at the end of pregnancy, potential adverse reactions should be monitored carefully in the newborns.

##### Women of childbearing potential

Women of childbearing potential must use effective contraception during treatment and 3 months thereafter, and immediately inform the treating physician if a pregnancy occurs (see section 5.3).

If pregnancy occurs during treatment the possibility of genetic counselling should be considered.

Fertility

Men in fertile age must use effective contraception during treatment and 5 months after treatment (see section 4.4).

Trabectedin can have genotoxic effects. Advice on conservation of ovules or sperm should be sought prior to treatment because of the possibility of irreversible infertility due to therapy with trabectedin.

Genetic counseling is also recommended for patients wishing to have children after therapy.

Lactation

It is not known whether trabectedin is excreted in human milk. The excretion of trabectedin in milk has not been studied in animals. Breast-feeding is contraindicated during treatment and 3 months thereafter (see section 4.3).

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

No studies on the effects on the ability to drive and to use machines have been performed.

However, fatigue and/or asthenia have been reported in patients receiving trabectedin.

Patients who experience any of these adverse reactions during therapy must not drive or operate machines.

**4.8 Undesirable effects**Summary of the safety profile

Most patients treated with trabectedin can be expected to have adverse reactions of any grade (91%) and less than one third serious adverse reactions of grade 3 or 4 severity (10%). The most common adverse reactions of any severity grade were neutropenia, nausea, vomiting, increases in AST/ALT, anemia, fatigue, thrombocytopenia, anorexia and diarrhea.

Fatal adverse reactions have occurred in 1.9% of patients. They were often the result of a combination of events including pancytopenia, febrile neutropenia, some of them with sepsis, hepatic involvement, renal or multiorgan failure and rhabdomyolysis.

Tabulated summary of adverse reactions

The following safety profile of trabectedin is based on adverse reactions reported in clinical trials, post- authorisation safety studies and spontaneous reporting.

The table below displays the adverse reactions reported in patients with soft tissue sarcoma and who were treated with trabectedin recommended regimen. Both adverse reactions and laboratory values have been used to provide frequencies.

The frequencies of the adverse reactions reported below are classified as very common ( $\geq 1/10$ ), common ( $\geq 1/100$  to  $< 1/10$ ) and uncommon ( $\geq 1/1,000$  to  $< 1/100$ ).

<b>System Organ Class</b>	<b>Adverse reactions reported in <math>\geq 1\%</math> of patients with soft tissue sarcoma in clinical trials</b>
Infections and Infestations	<b>Very Common</b> Neutropenic infection <b>Common</b> Sepsis <b>Uncommon</b> Septic shock

Blood and Lymphatic System Disorders	<b>Very Common</b> Neutropenia, Thrombocytopenia, Anaemia, Leukopenia <b>Common</b> Febrile neutropenia
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Immune System Disorders	<b>Common</b> Hypersensitivity
Metabolism and Nutrition Disorders	<b>Very Common</b> Decreased appetite <b>Common</b> Dehydration, Hypokalaemia
Psychiatric Disorders	<b>Very Common</b> Insomnia
Nervous System Disorders	<b>Very Common</b> Headache <b>Common</b> Peripheral sensory neuropathy, Dysgeusia, Dizziness
Vascular Disorders	<b>Common</b> Hypotension, Flushing <b>Uncommon</b> Capillary leak syndrome
Respiratory, Thoracic and Mediastinal Disorders	<b>Very Common</b> Dyspnoea, Cough <b>Uncommon</b> Pulmonary oedema
Gastrointestinal Disorders	<b>Very Common</b> Vomiting, Nausea, Constipation, Abdominal pain, Diarrhoea, Stomatitis <b>Common</b> Dyspepsia
Hepatobiliary Disorders	<b>Very Common</b> Alanine aminotransferase increased, Aspartate aminotransferase increased, Blood alkaline phosphatase increased, Blood bilirubin increased <b>Common</b> Gamma-glutamyltransferase increased <b>Rare</b> Hepatic failure
Skin and Subcutaneous Tissue Disorders	<b>Very Common</b> Palmar-plantar, Erythrodysesthesia <b>Common</b> Rash, Alopecia
Musculoskeletal and Connective Tissue Disorders	<b>Very Common</b> Arthralgia, Back pain, Blood creatine, Phosphokinase increased <b>Common</b> Myalgia <b>Uncommon</b> Rhabdomyolysis
General Disorders and Administration Site Conditions	<b>Very Common</b> Fatigue, Pyrexia, Oedema <b>Common</b> Injection site reaction <b>Uncommon</b> Extravasation Soft tissue necrosis

Investigations	<b>Very Common</b> Blood creatinine increased, Blood albumin decreased <b>Common</b> Weight decreased
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#### Description of selected adverse reactions

##### *Most frequent adverse reactions*

##### Blood and lymphatic system disorders

###### Neutropenia:

Neutropenia is the most common haematological toxicity. It followed a predictable pattern of rapid onset and reversibility, and was rarely associated with fever or infection. Neutrophil nadirs occurred at a median of 15 days and recovered within a week. The analysis per cycle performed in patients treated with the monotherapy regimen showed neutropenia of grade 3 and 4 in approximately 19% and 8% of cycles, respectively. In this population febrile neutropenia occurred in 2% of patients and in < 1% of cycles.

###### Thrombocytopenia:

Bleeding events associated to thrombocytopenia occurred in < 1%. The analysis per cycle performed in these patients showed thrombocytopenia of grade 3 and 4 in approximately 3% and < 1% of cycles, respectively.

###### Anaemia:

Anaemia occurred in 93% and 94% of patients. The percentages of patients anaemic at baseline were 46% and 35%, respectively. The analysis per cycle showed anaemia of grade 3 and 4 in approximately 3% and 1% of cycles, respectively.

##### Hepatobiliary disorders

###### AST/ALT increases:

The median time to reach the peak values was 5 days for both AST and ALT. Most of the values had decreased to grade 1 or resolved by day 14-15 (see section 4.4). The analysis per cycle performed in patients treated with the monotherapy regimen showed grade 3 elevations of AST and ALT in 12% and 20% of cycles, respectively. Grade 4 elevations of AST and ALT occurred in 1% and 2% of cycles, respectively. Most transaminase elevations improved to grade 1 or to pre-treatment levels within 15 days, and less than 2% of cycles had recovering times longer than 25 days. ALT and AST increases did not follow a cumulative pattern but showed a tendency towards less severe elevations over time.

###### Hyperbilirubinemia:

Bilirubin peaks approximately a week after onset and resolves approximately two weeks after onset.

Liver function tests predicting severe toxicity (meeting Hy's law) and clinical manifestations of severe hepatic injury were uncommon with a lower than 1% incidence of individual signs and symptoms including jaundice, hepatomegaly or liver pain. Mortality in the presence of hepatic injury occurred in less than 1% of patients.

##### *Other adverse reactions*

Hepatic failure: Rare cases of hepatic failure (including cases with fatal outcomes) have been reported in patients with serious underlying medical conditions treated with trabectedin, both in clinical trials and in post marketing setting. Some potential risk factors that may have contributed to increased trabectedin toxicity observed in these cases were dose management

inconsistent with recommended guidelines, potential CYP3A4 interaction due to multiple competing CYP3A4 substrates or CYP3A4 inhibitors, or lack of dexamethasone prophylaxis.

Capillary Leak Syndrome (CLS): Cases of Capillary Leak Syndrome (CLS) have been reported with trabectedin (including cases with fatal outcomes) (see section 4.4).

#### 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 limited data on the effects of trabectedin overdose. The major anticipated toxicities are gastrointestinal, bone marrow suppression and hepatic toxicity.

#### **Treatment**

There is no specific antidote for trabectedin currently available. In the event of an overdose, patients should be closely monitored and symptomatic supportive care measures instituted as required.

### **5. PHARMACOLOGICAL PROPERTIES**

#### **5.1 Pharmacodynamic properties**

Pharmacotherapeutic group: Antineoplastic agent, ATC code: L01CX01.

#### Mechanism of action

Trabectedin binds to the minor groove of DNA, bending the helix to the major groove. This binding to DNA triggers a cascade of events affecting several transcription factors, DNA binding proteins, and DNA repair pathways, resulting in perturbation of the cell cycle.

#### Pharmacodynamic effects

Trabectedin has been shown to exert antiproliferative *in vitro* and *in vivo* activity against a range of human tumour cell lines and experimental tumours, including malignancies such as sarcoma, breast, non-small cell lung, ovarian and melanoma.

#### Electrocardiogram (ECG) investigations

In a placebo-controlled QT/QTc study, trabectedin did not prolong the QTc interval in patients with advanced solid malignancies.

#### Clinical efficacy and safety

The efficacy and safety of trabectedin in soft tissue sarcoma is based in a randomised trial in patients with locally advanced or metastatic liposarcoma or leiomyosarcoma, whose disease had progressed or relapsed after treatment with at least anthracyclines and ifosfamide. In this trial trabectedin was administered either at 1.5 mg/m<sup>2</sup> as a 24-hour intravenous infusion every 3 weeks or at 0.58 mg/m<sup>2</sup> weekly as a 3-hour intravenous infusion for 3-weeks of a 4-week cycle. The protocol specified final time to progression (TTP) analysis showed a 26.6% reduction in the relative risk of progression for patients treated in the 24-h q3wk group [Hazard Ratio (HR)=0.734, CI: 0.554-0.974]. Median TTP values were 3.7 months (CI: 2.1-5.4 m) in the 24-h q3wk group and 2.3 months (CI: 2.0-3.5 m) in the 3-h qwk group (p=0.0302). No significant differences were detected in overall survival (OS). Median OS with the 24-h q3wk regimen was 13.9 months (CI: 12.5-18.6 ) and 60.2 % of patients were alive at 1 year (CI: 52.0-68.5%).

Additional efficacy data are available from 3 single-arm Phase II trials with similar populations treated with the same regimen. These trials evaluated a total of 100 patients with lipo- and leiomyosarcoma and 83 patients with other types of sarcoma.

Results from an expanded access program for patients with STS (study ET743-SAR-3002) show that among the 903 patients assessed for OS, the median survival time was 11.9 months (95% CI: 11.2, 13.8). The median survival by histology tumor type was 16.2 months [95% CI: 14.1, 19.5] for subjects with leiomyosarcomas and liposarcomas, and 8.4 months [95% CI: 7.1, 10.7] for subjects with other types of sarcomas. The median survival for subjects with liposarcoma was 18.1 months [95% CI: 15.0, 26.4] and for subjects with leiomyosarcoma 16.2 months [95% CI: 11.7, 24.3].

Additional efficacy data are available from a randomized, active-controlled phase III study of trabectedin vs. dacarbazine (Study ET743-SAR-3007), in patients treated for unresectable or metastatic lipo- or leiomyosarcoma who have been previously treated with at least an anthracycline and ifosfamide containing regimen, or an anthracycline containing regimen and one additional cytotoxic chemotherapy regimen. Patients in the trabectedin arm were required to receive dexamethasone 20 mg intravenous injection prior to each trabectedin infusion. Overall, 384 patients were randomized to the trabectedin group [1.5 mg/m<sup>2</sup> once every 3 weeks (q3wk 24-h)] and 193 patients to the dacarbazine group (1 g/m<sup>2</sup> once every 3 weeks). The median patient age was 56 years (range 17 to 81), 30% were male, 77% Caucasian, 12% African American and 4% Asian. Patients in the trabectedin and dacarbazine arms received a median of 4 and 2 cycles, respectively. The primary efficacy endpoint of the study was OS, which included 381 death events (66% of all randomized patients): 258 (67.2%) deaths in the trabectedin group and 123 (63.7%) deaths in the dacarbazine group (HR 0.927 [95% CI: 0.748, 1.150; *p*=0.4920]). The final analysis showed no significant difference with a median survival follow-up of 21.2 months resulted in a median of 13.7 months (95% CI: 12.2, 16.0) for the trabectedin arm and 13.1 months [95% CI: 9.1, 16.2] for the dacarbazine arm. The main secondary endpoints are summarized in the table below:

#### **Efficacy results from Study ET743-SAR-3007**

<b>Endpoints / Study population</b>	<b>Trabectedin</b>	<b>Dacarbazine</b>	<b>Hazard Ratio / Odds Ratio</b>	<b><i>p</i> value</b>
<b>Primary endpoint</b>	<b>n=384</b>	<b>n=193</b>		
<b>Overall survival, n (%)</b>	258 (67.2%)	123 (63.7%)	0.927 (0.748-1.150)	0.4920
<b>Secondary endpoints</b>	<b>n=345</b>	<b>n=173</b>		
<b>PFS (months; 95% CI)</b>	4.2	1.5	0.55 (0.44, 0.70)	<0.0001
<b>ORR, n (%); Odds ratio (95% CI)</b>	34 (9.9%)	12 (6.9%)	1.47 (0.72, 3.2)	0.33
<b>DOR (months; 95% CI)</b>	6.5	4.2	0.47 (0.17, 1.32)	0.14
<b>CBR, n (%); Odds ratio (95% CI)</b>	34.2%	18.5%	2.3 (1.45, 3.7)	<0.0002

Additional efficacy data are available from a randomized, open-label, multicenter phase II study [JapicCTI-121850] conducted in Japanese patients with translocation-related sarcoma (TRS), most common being myxoid round-cell liposarcoma (n=24), synovial sarcoma (n=18), mesenchymal chondrosarcoma (n=6), and extraskeletal Ewing sarcoma/PNET, alveolar soft part sarcoma, alveolar rhabdomyosarcoma and clear cell sarcoma (n=5 each). The study assessed the efficacy and safety of trabectedin vs. best supportive care (BSC) as second-line or later therapy for patients with advanced TRS unresponsive or intolerant to standard chemotherapy regimen. The patients received the trabectedin dose of 1.2 mg/m<sup>2</sup> recommended for Japanese patients [1.2 mg/m<sup>2</sup> once every 3 weeks (q3wk 24-h)]. A total of 76 Japanese patients were enrolled in the study, among which 73 patients were included in the final analysis set. The study primary endpoint was PFS, that showed a statistically significant improvement in favour of trabectedin over BSC [HR=0.07; 95% CI: 0.03-0.16; *p*<0.0001], with a median PFS in the trabectedin group of 5.6 months [95% CI: 4.1-7.5] and in the BSC group of 0.9 months [95% CI: 0.7-1.0]. The secondary endpoints included objective response analysed using the

RECIST and Choi criteria. Using the RECIST criteria the ORR among patients treated with trabectedin was 3 (8.1%; 95% CI: 1.7-21.9%) and 0 (0%, 95% CI: 0.0-9.7%) among patients treated with best supportive care, while the CBR was 24 (64.9%, 95% CI: 47.5-79.9%) versus 0 (0%, 95% CI: 0.0-9.7%), respectively. Using the Choi criteria the ORR among patients treated with trabectedin was 4 (10.8%; 95% CI: 3.0-25.4%) and 0 (0%, 95% CI: 0.0-9.7%) among patients treated

with best supportive care, while the CBR was 7 (18.9%, 95% CI: 8.0-35.2%) versus 0 (0%, 95% CI: 0.0-9.7%), respectively.

#### *Paediatric population*

In SAR-2005 phase I-II study, a total of 50 paediatric patients with rhabdomyosarcoma, Ewing sarcoma or non-rhabdomyosarcoma soft tissue sarcoma were enrolled. Eight patients were treated with a dose of 1.3 mg/m<sup>2</sup> and 42 with 1.5 mg/m<sup>2</sup>. Trabectedin was administered as a 24-hour intravenous infusion every 21 days. Forty patients were fully evaluable for response. One partial response (PR) centrally confirmed was observed: overall RR: 2.5% CI 95% (0.1%-13.2%). The PR corresponded to a patient with an alveolar rhabdomyosarcoma. Duration of the response was 6.5 months. No responses were observed for Ewing sarcoma and NRSTS [RR: 0% CI 95% (0%-30.9%)]. Three patients achieved stable disease (one with rhabdomyosarcoma after 15 cycles, one with spindle cell sarcoma after 2 cycles, and one with Ewing sarcoma after 4 cycles).

Adverse reactions included reversible elevation of liver enzymes and haematological events; in addition, fever, infection, dehydration and thrombosis/embolism were also reported.

## **5.2 Pharmacokinetic properties**

### Distribution

Systemic exposure after intravenous administration as a constant rate intravenous infusion is dose proportional at doses up to and including 1.8 mg/m<sup>2</sup>. The pharmacokinetic profile of trabectedin is consistent with a multiple-compartment disposition model.

Following intravenous administration, trabectedin demonstrates a high apparent volume of distribution, consistent with extensive tissue and plasma protein binding (94 to 98% of trabectedin in plasma is protein bound). The distribution volume at steady state of trabectedin in human subjects exceeds 5,000 L.

### Biotransformation

Cytochrome P450 3A4 is the major cytochrome P450 isozyme responsible for the oxidative metabolism of trabectedin at clinically relevant concentrations. Other P450 enzymes may contribute to metabolism. Trabectedin does not induce or inhibit major cytochrome P450 enzymes.

### Elimination

Renal elimination of unchanged trabectedin in humans is low (less than 1%). The terminal half-life is long (population value of the terminal elimination phase: 180-hr). After a dose of radiolabelled trabectedin administered to cancer patients, faecal mean (SD) recovery of total radioactivity is 58% (17%), and urinary mean (SD) recovery is 5.8% (1.73%). Based on the population estimate for plasma clearance of trabectedin (30.9 l/h) and blood/plasma ratio (0.89), the clearance of trabectedin in whole blood is approximately 35 l/h. This value is approximately one-half the rate of human hepatic blood flow. Thus the trabectedin extraction ratio can be considered moderate. The inter-patient variability of the population estimate for plasma clearance of trabectedin was 49% and intra-patient variability was 28%.

### Special populations

A population pharmacokinetic analysis indicated that the plasma clearance of trabectedin is not influenced by age (range 19-83 years), gender, total body weight (range: 36 to 148 kg), or body surface area (range: 0.9 to 2.8 m<sup>2</sup>). An analysis made on a limited number of patients shows that race and

ethnicity are not expected to have clinically significant effects on trabectedin pharmacokinetics.

#### *Renal impairment*

There is no relevant influence of renal function measured by creatinine clearance on trabectedin pharmacokinetics within the range of values ( $\geq 30.3$  ml/min) present in the patients included in the clinical studies. No data are available in patients with a creatinine clearance of less than 30.3 ml/min. The low recovery ( $< 9\%$  in all studied patients) of total radioactivity in the urine after a single dose of  $^{14}\text{C}$ -labelled trabectedin indicates that renal impairment has little influence on the elimination of trabectedin or its metabolites.

#### *Hepatic impairment*

Although the population analysis showed no relationship between the serum liver enzymes concentrations and the plasma clearance of trabectedin, systemic exposure to trabectedin may be increased in patients with hepatic impairment; therefore close monitoring of toxicity is warranted.

### **5.3 Preclinical safety data**

Preclinical data indicate that trabectedin has limited effect on the cardiovascular, respiratory and central nervous system at exposures below the therapeutic clinical range, in terms of AUC.

The effects of trabectedin on cardiovascular and respiratory function have been investigated *in vivo* (anaesthetised Cynomolgus monkeys). A 1 hour infusion schedule was selected to attain maximum plasma levels ( $C_{\text{max}}$  values) in the range of those observed in the clinic. The plasma trabectedin levels attained were  $10.6 \pm 5.4$  ng/ml ( $C_{\text{max}}$ ) higher than those reached in patients after infusion of  $1,500 \mu\text{g}/\text{m}^2$  for 24 ( $C_{\text{max}}$  of  $1.8 \pm 1.1$  ng/ml) and similar to those reached after administration of the same dose by 3 hour infusion ( $C_{\text{max}}$  of  $10.8 \pm 3.7$  ng/ml).

Myelosuppression and hepatotoxicity were identified as the primary toxicity for trabectedin. Findings observed included haematopoietic toxicity (severe leukopenia, anaemia, and lymphoid and bone marrow depletion) as well as increases in liver function tests, hepatocellular degeneration, intestinal epithelial necrosis, and severe local reactions at the injection site.

Renal toxicological findings were detected in multi-cycle toxicity studies conducted in monkeys. These findings were secondary to severe local reaction at the administration site, and therefore uncertainly attributable to trabectedin; however, caution must be guaranteed in the interpretation of these renal findings, and treatment-related toxicity cannot be excluded.

Trabectedin is genotoxic both *in vitro* and *in vivo*. Long-term carcinogenicity studies have not been performed.

Fertility studies with trabectedin were not performed but limited histopathological changes were observed in the gonads in the repeat dose toxicity studies. Considering the nature of the compound (cytotoxic and mutagenic), it is likely to affect the reproductive capacity.

Placental transfer of trabectedin and fetal exposure to trabectedin were observed in a study in pregnant rats that received a single I.V.  $^{14}\text{C}$ -trabectedin dose at  $0.061$  mg/kg. Maximum fetal tissue radioactivity concentration was similar to that in maternal plasma or blood.

## **6. PHARMACEUTICAL PARTICULARS**

### **6.1 List of excipients**

L-Arginine hydrochloride  
Phosphoric acid (for pH-adjustment)  
Potassium hydroxide (for pH-adjustment)

## 6.2 Incompatibilities

This medicinal product must not be mixed or diluted with other medicinal products except those mentioned in section 6.6.

## 6.3 Shelf life

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

### After reconstitution

Chemical and physical stability has been demonstrated for 30 hours up to 25°C.

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

### After dilution

Chemical and physical stability has been demonstrated for 30 hours up to 25°C.

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

## 6.4 Storage conditions

Store in a refrigerator (2°C - 8°C).

For storage conditions after reconstitution and dilution of the medicinal product, see section 6.3.

## 6.5 Nature and contents of container

### **Trabectedin Teva 0.25 mg**

Type I colourless glass vial with a bromobutyl rubber stopper sealed with an aluminium flip-off cap with a teal polypropylene disk containing 0.25 mg of trabectedin.

### **Trabectedin Teva 1 mg**

Type I colourless glass vial with a bromobutyl rubber stopper sealed with an aluminium flip-off cap with a pink polypropylene disk containing 1 mg of trabectedin.

Vials are sheathed in a protective sleeve (a clear, colourless, protective film covering around the vial (sleeving) to provide additional safety measures).

Each carton contains one vial.

## 6.6 Special precautions for disposal and other handling

### **Preparation for intravenous infusion**

Trabectedin 0.25 mg and 1mg must be reconstituted and further diluted prior to intravenous infusion.

The reconstitution and dilution of the reconstituted solution must be conducted under aseptic conditions in a manner consistent with recommended safe procedures for handling cytotoxic compounds.

### **Instructions for reconstitution**

#### **Trabectedin Teva 0.25mg**

Each vial containing 0.25 mg of trabectedin is reconstituted with 5 ml of water for injections. The solution obtained has a concentration of 0.05 mg/ml and is for single-use only.

A syringe is used to inject 5 ml of sterile water for injections into the vial. The vial must be shaken until complete dissolution. The reconstituted solution results in a clear, colorless solution, free of visible particles.

This reconstituted solution contains 0.05 mg/ml of trabectedin. It requires further dilution and is for single-use only.

### **Trabectedin Teva 1 mg**

Each vial containing 1 mg of trabectedin is reconstituted with 20 ml of water for injections. The solution obtained has a concentration of 0.05 mg/ml and is for single-use only.

A syringe is used to inject 20 ml of sterile water for injections into the vial. The vial must be shaken until complete dissolution. The reconstituted solution results in a clear, colorless solution, free of visible particles.

This reconstituted solution contains 0.05 mg/ml of trabectedin. It requires further dilution and is for single-use only.

### ***Instructions for dilution***

The reconstituted solution should be diluted with sodium chloride 9 mg/ml (0.9%) solution for infusion or glucose 50 mg/ml (5%) solution for infusion. The required volume should be calculated as follows:

$$\text{Volume (ml)} = \frac{\text{BSA (m}^2\text{)} \times \text{individual dose (mg/m}^2\text{)}}{0.05 \text{ mg/ml}}$$

BSA = Body Surface Area

The appropriate amount of solution should be withdrawn from the vial and added to an infusion bag containing 500 ml of sodium chloride 9 mg/ml (0.9%) solution for infusion or glucose 50 mg/ml (5%) solution for infusion if administration is to be made through a central venous line.

If central venous access is not feasible and a peripheral venous line has to be used, the reconstituted solution should be further diluted in an infusion bag containing  $\geq 1,000$  ml of sodium chloride 9 mg/ml (0.9%) solution for infusion or glucose 50 mg/ml (5%) solution for infusion.

Parenteral solutions should be inspected visually for particulate matter prior to administration. Once the infusion is prepared, it should be administered immediately.

### ***Instructions for handling and disposal***

Trabectedin is a cytotoxic anticancer medicinal product and, as with other potentially toxic compounds, caution should be exercised during handling. Procedures for proper handling and disposal of cytotoxic medicinal products must be followed. Trabectedin should be handled and disposed of in a manner consistent with other anticancer drugs. Personnel should be trained in the correct techniques to reconstitute and dilute the medicinal product and should wear protective clothing including mask, goggles and gloves during the reconstitution and dilution. Pregnant staff must be excluded from working with this medicinal product.

Accidental contact with the skin, eyes or mucous membranes must be treated immediately with copious amounts of water.

No incompatibilities have been observed between Trabectedin Teva 0.25 mg and 1 mg and type I glass bottles, polyvinylchloride (PVC) and polyethylene (PE) bags and tubing, polyisoprenereservoirs and titanium implantable vascular access systems.

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



**7. MANUFACTURER AND LICENSE HOLDER**

Teva Israel Ltd.,  
124 Dvora HaNevi'a St., Tel Aviv 6944020

**8. REGISTRATION NUMBER(S)**

Trabectedin Teva 0.25 mg: 177.56.37005

Trabectedin Teva 1 mg: 177.57.37006

**9. DATE OF REVISION OF THE TEXT**

August 2024