

NEW ZEALAND DATA SHEET

1. PRODUCT NAME

CAMPTOSAR® Injection: Irinotecan hydrochloride injection 20 mg/mL.

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

Each mL of CAMPTOSAR Injection contains 20 mg irinotecan hydrochloride.

Excipient(s) with known effects:

- Sorbitol

For the full list of excipients, see section 6.1.

3. PHARMACEUTICAL FORM

Solution for injection.

CAMPTOSAR injection is supplied as a sterile, light yellow or pale yellow, clear, aqueous solution with pH 3.5. It is intended for dilution with 5% Glucose Injection or 0.9% Sodium Chloride Injection prior to infusion.

4. CLINICAL PARTICULARS

4.1 Therapeutic indications

CAMPTOSAR is indicated for the first line treatment of patients with metastatic carcinoma of the colon or rectum, in combination with 5FU/leucovorin. CAMPTOSAR is also indicated for patients with metastatic carcinoma of the colon or rectum whose disease has recurred or progressed following initial therapy.

4.2 Dose and method of administration

It is recommended that patients receive premedication with antiemetic agents. Prophylactic or therapeutic administration of atropine should be considered in patients experiencing cholinergic symptoms (see section 4.4).

Combination Agent Therapy

Dosage Regimens

CAMPTOSAR injection in Combination with 5-Fluorouracil (5-FU) and Leucovorin (LV)
CAMPTOSAR should be administered as an intravenous infusion over 90 minutes (see Preparation of Infusion Solution). For all regimens, the dose of LV should be administered immediately after CAMPTOSAR, with the administration of 5-FU to follow immediately after the administration of LV. The recommended regimens are shown in Table 1.

Table 1: Combination Agent Dosage Regimens and Dose Modifications^a

Regimen 1 6 week cycle. Treatment resumes Day 43	CAMPTOSAR	125 mg/m ² IV over 90 min on Day 1, 8, 15, 22, then 2 wk rest		
	LV	20 mg/m ² IV bolus injection Day 1, 8, 15, 22, then 2 wk rest		
	5-FU	500mg/m ² IV bolus injection Day 1, 8, 15, 22 then 2 wk rest		
		Starting dose and modified dose levels^b (mg/m²)		
		Starting dose	Dose level 1	Dose level 2
	CAMPTOSAR	125	100	75
	LV	20	20	20
	5-FU	500	400	300
Regimen 2 6 week cycle. Treatment resumes Day 43	CAMPTOSAR	180 mg/m ² IV over 90 min on Day 1, 15, 29 then 1 wk rest		
	LV	200 mg/m ² IV over 2 hr on Day 1, 2, 15, 16, 29, 30 then 1 wk rest		
	5-FU Bolus	400 mg/m ² IV on Day 1, 2, 15, 16, 29, 30 then 1 wk rest		
	5-FU Infusion ^c	600 mg/m ² IV over 22 hr on Day 1, 2, 15, 16, 29, 30 then 1 wk rest		
		Starting dose and modified dose levels^b (mg/m²)		
		Starting dose	Dose level 1	Dose level 2
	CAMPTOSAR	180	150	120
	LV	200	200	200
	5-FU Bolus	400	320	240
	5-FU Infusion ^c	600	480	360

^a Dose reductions beyond dose level –2 by decrements of $\geq 20\%$ may be warranted for patients continuing to experience toxicity. Provided intolerable toxicity does not develop, treatment with additional courses may be continued indefinitely as long as patients continue to experience clinical benefit.

^b See Table 2.

^c Infusion follows bolus administration.

Dose Modifications

Patients should be carefully monitored for toxicity and assessed prior to each treatment, especially during the first cycle of therapy. Doses of CAMPTOSAR and 5-FU should be modified as necessary to accommodate individual patient tolerance to treatment. Based on the recommended dose levels described in Table 1, subsequent doses should be adjusted as suggested in Table 2, which shows the recommended dose modifications for combination schedules. All dose modifications should be based on the worst preceding toxicity. Patients should be diarrhoea free (return to pre-treatment bowel function) without requiring antidiarrhoeal medications for at least 24 hours before receiving the next chemotherapy administration.

A new course of therapy should not begin until the toxicity has recovered to NCI Grade 1 or less, the granulocyte count has recovered to $\geq 1.5 \times 10^9/L$, the platelet count has recovered to $\geq 100 \times 10^9/L$, and treatment-related diarrhoea is fully resolved. Treatment should be

delayed for 1 to 2 weeks to allow recovery from treatment-related toxicity. If the patient has not recovered after a 2 week delay, consideration should be given to discontinuing therapy. Provided intolerable toxicity does not develop, treatment with additional courses of CAMPTOSAR/5-FU/LV may be continued indefinitely as long as patients continue to experience clinical benefit.

Table 2: Recommended dose modifications during a course of therapy with the CAMPTOSAR/5-FU/LV combination and at the start of each subsequent course of therapy

Toxicity NCI CTC Grade ^a	During a Course of Therapy	At the Start of Subsequent Courses of Therapy ^b
No toxicity	Maintain dose level	Maintain dose level
Neutropenia		
1	Maintain dose level	Maintain dose level
2	Decrease by 1 dose level	Maintain dose level
3	Omit dose, until resolved to \leq Grade 2, then decrease by 1 dose level	Decrease by 1 dose level
4	Omit dose until resolved to \leq Grade 2, then decrease by 2 dose levels	Decrease by 2 dose levels
Neutropenic fever	Omit dose until resolved, then decrease by 2 dose levels.	
Other haematological toxicities	Dose modifications for leucopenia or thrombocytopenia during a course of therapy and at the start of subsequent courses of therapy are also based on NCI toxicity criteria and are the same as recommended for neutropenia above.	
Diarrhoea		
1	Delay dose until resolved to baseline, then give same dose	Maintain dose level
2	Omit dose until resolved to baseline, then decrease by 1 dose level	Maintain dose level
3	Omit dose until resolved to baseline, then decrease by 1 dose level	Decrease by 1 dose level
4	Omit dose until resolved to baseline, then decrease by 2 dose levels	Decrease by 2 dose levels
Other non-haematological toxicities ^c		
1	Maintain dose level	Maintain dose level
2	Omit dose until resolved to \leq Grade 1, then decrease by 1 dose level	Maintain dose level
3	Omit dose until resolved to \leq Grade 2, then decrease by 1 dose level	Decrease by 1 dose level
4	Omit dose until resolved to \leq Grade 2, then decrease by 2 dose levels	Decrease by 2 dose levels

^a Severity of adverse events based on NCI CTC (version 2.0) see <http://ctep.info.nih.gov/CTC3/default.htm>.

^b Relative to the starting dose used in the previous course.

^c For mucositis/stomatitis decrease only 5-FU, not CAMPTOSAR.

Single Agent Therapy

Dosage Regimens

CAMPTOSAR should be administered as an intravenous infusion (see Preparation of Infusion solution) over 90 minutes in a recommended weekly or once every 3 week dosage schedule as shown below in Table 3.

Table 3: Single-Agent Regimens of CAMPTOSAR and Dose Modifications

Weekly regimen ^a 6 week cycle Treatment resumes Day 43	125 mg/m ² IV over 90 mins Day 1, 8, 15, 22 then 2 week rest		
	Starting dose and modified dose levels ^c (mg/m ²)		
	Starting Dose	Dose Level 1	Dose Level 2
	125	100	75
	350 mg/m ² IV over 90 mins once every 3 weeks		
	Starting dose and modified dose levels ^a (mg/m ²)		
	Starting Dose	Dose Level 1	Dose Level 2
	350	300	250

a Subsequent doses may be adjusted as high as 150 mg/m² or as low as 50 mg/m² in 25 to 50 mg/m² decrements depending on individual patient tolerance.

b Subsequent doses may be adjusted as low as 200 mg/m² in 50 mg/m² decrements depending on individual patient tolerance.

c See Table 5.

A reduction in the starting dose by one level of CAMPTOSAR may be considered for patients with any of the following circumstances: over 65 years, prior pelvic/abdominal radiotherapy, performance status of 2 or moderately increased bilirubin levels (17-34 µmol/L).

Patients with Impaired Hepatic Function (Single Agent)

In patients with hepatic dysfunction, the following starting doses are recommended:

Table 4: Starting Doses in Patients with Hepatic Dysfunction – Single Agent Regimens

Regimen	Serum Total Bilirubin Concentration	Serum ALT/AST Concentration	Starting Dose, mg/m ²
Single – Agent Weekly	1.5–3.0 x IULN	≤5.0 x IULN	60
	3.1–5.0 x IULN	≤5.0 x IULN	50
	<1.5 x IULN	5.1–20.0 x IULN	60
	1.5–5.0 x IULN	5.1–20.0 x IULN	40
Single Agent Once Every 3 Weeks	1.5–3.0 x IULN	-	200
	>3.0 x IULN	-	Not recommended ^a

a The safety and pharmacokinetics of CAMPTOSAR given once every 3 weeks have not been defined in patients with bilirubin >3.0 x IULN and this schedule cannot be recommended in these patients.

Dose Modifications

Patients should be carefully monitored for toxicity and doses of CAMPTOSAR should be modified as necessary to accommodate individual patient tolerance to treatment. Based on recommended dose-levels described in Tables 3 and 4, subsequent doses of CAMPTOSAR should be adjusted as suggested in Table 5. All dose modifications should be based on the worst preceding toxicity.

A new cycle of therapy should not begin until the toxicity has recovered to NCI Grade 1 or less, the granulocyte count has recovered to $\geq 1.5 \times 10^9/L$, the platelet count has recovered to $\geq 100 \times 10^9/L$, and treatment-related diarrhoea is fully resolved. Treatment may be delayed for 1 to 2 weeks to allow recovery from treatment-related toxicity. If the patient has not recovered, consideration should be given to discontinuing CAMPTOSAR therapy. Provided intolerable toxicity does not develop, treatment with additional cycles of CAMPTOSAR may be continued indefinitely as long as patients continue to experience clinical benefit.

Table 5: Recommended dose modifications for single agent regimens

Toxicity NCI ^a Grade	During a cycle of therapy	At The Start Of Subsequent Cycle Of Therapy	
	Weekly	Weekly	Once Every 3 Weeks
No Toxicity	Maintain dose level	Increase by 1 dose level up to a maximum dose of 150 mg/m ²	Maintain dose level
Neutropenia			
1	Maintain dose level	Maintain dose level	Maintain dose level
2	Decrease by 1 dose level	Maintain dose level	Maintain dose level
3	Omit dose until resolved to ≤Grade 2, then decrease by 1 dose level	Decrease by 1 dose level	Decrease by 1 dose level
4	Omit dose until resolved to ≤Grade 2, then decrease by 2 dose levels	Decrease by 2 dose levels	Decrease by 1 dose level
Neutropenic Fever	Omit dose until resolved, then decrease by 2 dose levels	Decrease by 2 dose levels	Decrease by 1 dose level
Other Haematological Toxicities	Dose modifications for leucopenia, thrombocytopenia and anaemia during a cycle of therapy and at the start of subsequent cycles of therapy are also based on NCI toxicity criteria and are the same as recommended for neutropenia above.		
Diarrhoea			
1	Maintain dose level	Maintain dose level	Maintain dose level
2	Decrease by 1 dose level	Maintain dose level	Maintain dose level
3	Omit dose until resolved to ≤Grade 2, then decrease by 1 dose level	Decrease by 1 dose level	Decrease by 1 dose level
4	Omit dose until resolved to ≤Grade 2, then decrease by 2 dose levels	Decrease by 2 dose levels	Decrease by 1 dose level
Other non-haematological toxicities			
1	Maintain dose level	Maintain dose level	Maintain dose level
2	Decrease by 1 dose level	Decrease by 1 dose level	Decrease by 1 dose level
3	Omit dose until resolved to ≤Grade 2, then decrease by 1 dose level	Decrease by 1 dose level	Decrease by 1 dose level
4	Omit dose until resolved to ≤Grade 2, then decrease by 2 dose levels	Decrease by 2 dose levels	Decrease by 1 dose level

^a Severity of adverse events based on NCI CTC (version 2.0) see <http://ctep.info.nih.gov/CTC3/default.htm>.

Preparation and Administration Precautions

As with other potentially toxic anticancer agents, care should be exercised in the handling and preparation of infusion solutions prepared from CAMPTOSAR Injection. The use of gloves is recommended. If a solution of CAMPTOSAR contacts the skin, wash the skin immediately and thoroughly with soap and water. If CAMPTOSAR contacts the mucous membranes, flush thoroughly with water.

Preparation of Infusion Solution

CAMPTOSAR Injection is intended for single use only and any unused portion should be discarded.

CAMPTOSAR Injection must be diluted prior to infusion in 5% Glucose Injection or 0.9% Sodium Chloride Injection to a final concentration range of 0.12 to 2.8 mg/mL. Other drugs should not be added to the infusion solution. Parenteral drug products should be inspected visually for particulate matter and discoloration prior to administration whenever solution and container permit.

CAMPTOSAR Injection has been shown to be chemically and physically stable when diluted with infusion solutions (0.9% sodium chloride solution and 5% glucose solution) for up to 28 days when stored in low-density polyethylene (LDPE) or polyvinyl chloride (PVC) containers at 5°C or at 30°C/ambient humidity and protected from light. When exposed to light, chemical and physical stability is indicated for up to 3 days.

It is recommended, however, that in order to reduce microbiological hazard, the infusion solutions should be prepared immediately prior to use and infusion commenced as soon as practicable after preparation. If not used immediately, in-use storage times and conditions prior to use should not be longer than 24 hours at 2°C to 8°C or 6 hours at room temperature (25°C).

Do not freeze CAMPTOSAR or admixtures of CAMPTOSAR as this may result in precipitation of the drug.

4.3 Contraindications

CAMPTOSAR is contraindicated in patients with a known hypersensitivity to the drug or its excipients.

CAMPTOSAR is contraindicated in women who intend to become pregnant (see section 4.6 and section 5.3).

4.4 Special warnings and precautions for use

Administration: CAMPTOSAR should be administered only under the supervision of a physician who is experienced in the use of cancer chemotherapeutic agents. Appropriate management of complications is possible only when adequate diagnostic and treatment facilities are readily available.

Extravasation: CAMPTOSAR is administered by intravenous infusion. Care should be taken to avoid extravasation and the infusion site should be monitored for signs of inflammation. Should extravasation occur, flushing the site with sterile water and application of ice are recommended.

“Mayo Clinic” Regimen: Except in a well-designed clinical study, CAMPTOSAR should not be used in combination with the “Mayo Clinic” regimen of 5-FU/LV (administration for 4-5 consecutive days every 4 weeks; see Table 9) because of reports of increased toxicity, including toxic deaths. CAMPTOSAR should be used as recommended in section 4.2.

Monitoring: Careful monitoring of the white blood cell count with differential, haemoglobin, and platelet count is recommended before each dose of CAMPTOSAR. Liver function should be monitored before initiation of treatment and monthly or as clinically indicated.

Diarrhoea and its Management: CAMPTOSAR Injection can induce both an early and a late form of diarrhoea that appear to be mediated by different mechanisms. Both forms of diarrhoea may be severe.

Early diarrhoea (occurring during or shortly after infusion of CAMPTOSAR) is cholinergic in nature. It is usually transient and only infrequently is severe. It may be accompanied by symptoms of rhinitis, increased salivation, miosis, lacrimation, diaphoresis, flushing, bradycardia and intestinal hyperperistalsis that can cause abdominal cramping. Administration of 0.25 to 1 mg of intravenous or subcutaneous atropine should be considered (unless clinically contraindicated) in patients experiencing cholinergic symptoms occurring during or shortly after infusion of CAMPTOSAR. Patients ≥ 65 years of age should be closely monitored due to a greater risk of early diarrhoea observed in this population.

Late diarrhoea (generally occurring more than 24 hours after administration of CAMPTOSAR) can be prolonged, may lead to dehydration, electrolyte imbalance or infection and can be life-threatening. Late diarrhoea should be treated promptly with loperamide. Patients should be instructed to have loperamide readily available and begin treatment at the first episode of poorly formed or loose stools or the earliest onset of bowel movements more frequent than normally expected for the patient. One dosage regimen for loperamide used in clinical trials consisted of 4 mg at the first onset of late diarrhoea and then 2 mg every 2 hours until the patient was diarrhoea-free for at least 12 hours. During the night, the patient may take 4 mg of loperamide every 4 hours. Loperamide is not recommended to be used for more than 48 consecutive hours at these doses, because of the risk of paralytic ileus, nor for less than 12 hours. Premedication with loperamide is not recommended.

Patients with diarrhoea should be carefully monitored and given fluid and electrolyte replacement if they become dehydrated and should be given antibiotics if they develop ileus, fever or severe neutropenia. After the first treatment, subsequent chemotherapy should be delayed until patients are diarrhoea-free (return to pre-treatment bowel function) for at least 24 hours without the need for antidiarrhoea medication. If NCI Grade 2, 3 or 4 diarrhoea occurs, subsequent doses of CAMPTOSAR should be reduced within the current cycle (see section 4.2).

In addition to antibiotic treatment, hospitalisation is recommended for management of the diarrhoea, in the following cases: diarrhoea associated with fever, severe diarrhoea

(requiring intravenous hydration), patients with vomiting associated with delayed (i.e. late) diarrhoea and diarrhoea persisting beyond 48 hours following the initiation of high-dose loperamide therapy and in the few rare instances where patients are deemed unlikely to observe recommendations regarding management of adverse events (need for immediate and prolonged antidiarrhoeal treatment combined with high fluid intake at onset of delayed diarrhoea).

Nausea and Vomiting: Irinotecan is emetogenic. It is recommended that patients receive premedication with antiemetic agents. In clinical studies with the weekly dosage schedule, the majority of patients received 10 mg of dexamethasone given in conjunction with another type of antiemetic agent, such as a 5-HT₃ blocker (e.g., ondansetron or granisetron). Antiemetic agents should be given on the day of treatment, starting at least 30 minutes before administration of CAMPTOSAR. Physicians should also consider providing patients with an antiemetic regimen (e.g., prochlorperazine) for subsequent use as needed. Patients with vomiting associated with delayed (i.e., late) diarrhoea should be hospitalised as soon as possible for treatment.

Haematology: Irinotecan commonly causes neutropenia, leucopenia, and anaemia, any of which may be severe and therefore should not be used in patients with severe bone marrow failure (see section 4.8, Haematological). Serious thrombocytopenia is uncommon.

Neutropenia: Deaths due to sepsis following severe myelosuppression have been reported in patients treated with CAMPTOSAR. Neutropenic complications should be managed promptly with antibiotic support. Therapy with CAMPTOSAR should be temporarily omitted if neutropenic fever occurs or if the absolute neutrophil count drops below $1.5 \times 10^9/L$. A new cycle of therapy should not begin until the granulocyte count has recovered to $\geq 1.5 \times 10^9/L$. After the patient recovers, subsequent doses of CAMPTOSAR should be reduced depending upon the level of neutropenia observed (see section 4.2). Routine administration of a colony-stimulating factor (CSF) is not necessary, but physicians may wish to consider CSF use in individual patients experiencing significant neutropenia.

Hypersensitivity: Hypersensitivity reactions including severe anaphylactic and anaphylactoid reactions have been observed.

Immunosuppressant Effects/Increased Susceptibility to Infections: Administration of live or live-attenuated vaccines in patients immunocompromised by chemotherapeutic agents, including irinotecan, may result in serious or fatal infections. Vaccination with a live vaccine should be avoided in patients receiving irinotecan. Killed or inactivated vaccines may be administered; however, the response to such vaccines may be diminished.

Cardiovascular: Thromboembolic events have been observed rarely in patients receiving CAMPTOSAR. The specific cause of these events has not been determined (see section 4.8, *Cardiovascular*).

Colitis/Ileus: Cases of colitis have been reported. In some cases, colitis was complicated by ulceration, bleeding, ileus and infection. Cases of ileus without preceding colitis have also been observed rarely. Patients experiencing ileus should receive prompt antibiotic support.

Chronic Inflammatory Bowel Disease and/or Bowel Obstruction: Patients must not be treated with irinotecan until resolution of the bowel obstruction.

Patients with Reduced UGT1A1 Activity: Uridine diphosphate-glucuronosyl transferase 1A1 (UGT1A1), which mediates the conjugation of the active metabolite SN-38, is encoded by the UGT1A1 gene (see section 5.2, *Biotransformation and Elimination*). This gene is highly polymorphic resulting in variable metabolic capacities among individuals. One specific variation of the UGT1A1 gene includes a polymorphism in the promoter region known as the UGT1A1*28 variant allele. This variant and other congenital deficiencies in UGT1A1 expression (such as Crigler-Najjar and Gilbert's syndrome) are associated with reduced enzyme activity and increased systemic exposure to SN-38. Higher plasma concentrations of SN-38 are observed in individuals who are homozygous for the UGT1A1*28 allele (also referred to as UGT1A1 7/7 genotype) compared to patients who have one or two wild-type alleles.

Individuals with Crigler-Najjar syndrome (types 1 and 2) or those who are homozygous for the UGT1A1*28 allele (Gilbert's syndrome) are at increased risk of haematological toxicity (Grades 3 and 4) following administration of irinotecan at moderate or high doses (>150 mg/m²). A relationship between UGT1A1 genotype and the occurrence of irinotecan induced diarrhoea has not been established.

Patients known to be homozygous for UGT1A1*28 should be administered the normally-indicated irinotecan starting dose and monitored for haematologic toxicities. A reduced irinotecan starting dose should be considered for patients who have experienced haematologic toxicity with previous treatment. The exact reduction in starting dose in this patient population has not been established and any subsequent dose modifications should be based on individual patient tolerance to treatment.

Patients with Poor Performance Status: Physicians should exercise particular caution in monitoring the effects of CAMPTOSAR in patients with poor performance status, in elderly patients and in patients who have previously received pelvic/abdominal irradiation (see section 4.8). Patients with poor performance status are at increased risk of irinotecan-related adverse events. In patients receiving either CAMPTOSAR/5-FU/LV or 5-FU/LV in clinical trials comparing these agents, higher rates of hospitalisation, neutropenic fever, thromboembolism, first-cycle treatment discontinuation and early deaths were observed in patients with a baseline performance status of 2 than in patients with a baseline performance of 0 or 1. Patients with performance status of 3 or 4 should not receive CAMPTOSAR.

Irradiation Therapy: Patients who have previously received pelvic/abdominal irradiation are at increased risk of severe myelosuppression following the administration of CAMPTOSAR. The concurrent administration with irradiation has not been adequately studied and is not recommended.

Impaired Renal Function: Studies in patients with impaired renal function have not been conducted (see section 5.2, *Special Populations*). Therefore, caution should be undertaken in patients with impaired renal function. Irinotecan is not recommended for use in patients on dialysis.

Hepatic Insufficiency: In patients with hyperbilirubinaemia, the clearance of irinotecan is decreased and therefore the risk of haematotoxicity is increased (see section 5.2, *Special Populations*).

The use of CAMPTOSAR in patients with a serum total bilirubin concentration of > 3.0 x institutional upper limit of normal (IULN) given as a single agent on the once every 3 weeks schedule has not been established. In clinical trials of the single agent weekly dosage schedule, patients with even modest elevations in total baseline serum total bilirubin levels (17-34 $\mu\text{mol/L}$) had a significantly greater likelihood of experiencing first-course Grade 3 or 4 neutropenia than those with bilirubin levels that were less than 17 $\mu\text{mol/L}$ (50% versus 18%; $p < 0.001$) (see section 5.2, *Special Populations* and section 4.2). Patients with deficient glucuronidation of bilirubin, such as those with Gilbert's syndrome, may be at greater risk of myelosuppression when receiving therapy with CAMPTOSAR.

Cholinergic Effects: CAMPTOSAR has cholinergic effects and should be used with caution in patients with asthma or cardiovascular diseases and in patients with mechanical intestinal or urinary obstruction.

Respiratory: Interstitial pulmonary disease presenting as pulmonary infiltrates is uncommon during irinotecan therapy. Interstitial pulmonary disease can be fatal. Risk factors possibly associated with the development of interstitial pulmonary disease include pre-existing lung disease, use of pneumotoxic drugs, radiation therapy, and colony stimulating factors. Patients with risk factors should be closely monitored for respiratory symptoms before and during irinotecan therapy.

Others: Since this product contains sorbitol, it is unsuitable in hereditary fructose intolerance.

Advice for Patients: Patients should be advised of the expected toxic effects of CAMPTOSAR, particularly of gastrointestinal complications such as nausea, vomiting, abdominal cramping, diarrhoea and infection.

Patients should be advised to consult their physician if any of the following occur after treatment with CAMPTOSAR: diarrhoea for the first time; inability to control diarrhoea within 24 hours; vomiting; fever or evidence of infection; symptoms of dehydration, such as faintness, light-headedness or dizziness; bloody or black stools; inability to take fluids by mouth due to nausea or vomiting. Patients should also be alerted to the possibility of

alopecia. Laxatives should be avoided (see section 4.5) and patients should contact their physician to discuss any laxative use.

Paediatric Population: The safety and effectiveness of CAMPTOSAR in children have not been established.

Effects on Laboratory Tests: There are no known interactions between CAMPTOSAR and laboratory tests.

4.5 Interaction with other medicines and other forms of interaction

CYP3A4 and/or UGT1A1 Inhibitors

Irinotecan and its active metabolite SN-38 are metabolised via the human cytochrome P450 3A4 isoenzyme (CYP3A4) and uridine diphosphate-glucuronosyl transferase 1A1 (UGT1A1) (see section 5.2). Coadministration of irinotecan with inhibitors of CYP3A4 and/or UGT1A1 may result in increased systemic exposure to irinotecan and the active metabolite SN-38. Physicians should take this into consideration when administering irinotecan with these drugs.

Ketoconazole: Irinotecan clearance is greatly reduced in patients receiving concomitant ketoconazole, leading to increased exposure to the active metabolite SN-38. Ketoconazole should be discontinued at least 1 week prior to starting irinotecan therapy and should not be administered during irinotecan therapy.

Atazanavir Sulfate: Coadministration of atazanavir sulfate, a CYP3A4 and UGT1A1 inhibitor, has the potential to increase systemic exposure to SN-38, the active metabolite of irinotecan. Physicians should take this into consideration when co-administering these drugs.

CYP3A4 Inducers

Anticonvulsants: Concomitant administration of CYP3A-inducing anticonvulsant drugs (*e.g.*, carbamazepine, phenobarbital or phenytoin) leads to reduced exposure to SN-38. Consideration should be given to starting or substituting non-enzyme-inducing anticonvulsants at least one week prior to initiation of irinotecan therapy in patients requiring anticonvulsant treatment.

St. John's Wort (*Hypericum perforatum*): Exposure to the active metabolite SN-38 is reduced in patients taking concomitant St. John's Wort. St. John's Wort should be discontinued at least 1 week prior to the first cycle of irinotecan, and should not be administered during irinotecan therapy.

Other Interactions

Neuromuscular Blocking Agents: Interaction between irinotecan and neuromuscular blocking agents cannot be ruled out. Since irinotecan has anticholinesterase activity, drugs with anticholinesterase activity may prolong the neuromuscular blocking effects of suxamethonium and the neuromuscular blockade of non-depolarising drugs may be antagonised.

Antineoplastic Agents: The adverse effects of CAMPTOSAR, such as myelosuppression and diarrhoea, would be expected to be exacerbated by other antineoplastic agents having similar adverse effects.

Dexamethasone: Lymphocytopenia has been reported in patients receiving CAMPTOSAR and it is possible that the administration of dexamethasone as antiemetic prophylaxis may have enhanced the likelihood of this effect. However, serious opportunistic infections have not been observed and no complications have specifically been attributed to lymphocytopenia.

Hyperglycaemia has also been reported in patients receiving CAMPTOSAR. Usually this has been observed in patients with a history of diabetes mellitus or evidence of glucose intolerance prior to administration of CAMPTOSAR. It is probable that dexamethasone, given as antiemetic prophylaxis, contributed to hyperglycaemia in some patients.

Prochlorperazine: The incidence of akathisia in clinical trials of the single agent weekly dosage schedule was greater (8.5%, 4/47 patients) when prochlorperazine was administered on the same day as CAMPTOSAR than when these drugs were given on separate days (1.3%, 1/80 patients). However, the 8.5% incidence of akathisia is within the range reported for use of prochlorperazine when given as a premedication for other chemotherapies.

Laxatives: It would be expected that the incidence or severity of diarrhoea would be worsened by laxative use during therapy with CAMPTOSAR, but this has not been studied.

Diuretics: In view of the potential risk of dehydration secondary to vomiting and/or diarrhoea induced by CAMPTOSAR, the physician may wish to withhold diuretics during dosing with CAMPTOSAR and, certainly, during periods of active vomiting or diarrhoea.

4.6 Fertility, pregnancy and lactation

Fertility

No significant adverse effects on fertility and general reproductive performance were observed after intravenous administration of irinotecan in doses of up to 6 mg/kg/day to rats. Atrophy of male reproductive organs was observed after multiple daily irinotecan doses both in rodents at 20 mg/kg (AUC approximately the same value as in patients administered 125 mg/m² weekly) and dogs at 0.4 mg/kg (AUC about 1/15th the value in patients administered 125 mg/m² weekly).

Pregnancy- Category D.

CAMPTOSAR may cause fetal harm when administered to a pregnant woman. Administration of 6 mg/kg/day intravenous irinotecan hydrochloride to rats (AUC about 0.2 times the corresponding values in patients administered 125 mg/m²) and rabbits (about one-half the recommended human weekly starting dose on a mg/m² basis) during the period of organogenesis, is embryotoxic as characterised by increased post-implantation loss and decreased numbers of live fetuses. Irinotecan hydrochloride was teratogenic in rats at doses greater than 1.2 mg/kg/day (AUC about 1/40th the corresponding values in patients administered 125 mg/m²) and in rabbits at 6.0 mg/kg/day. Teratogenic effects included a variety of external, visceral, and skeletal abnormalities.

There are no adequate and well-controlled studies of irinotecan hydrochloride in pregnant women. If the drug is used during pregnancy, or if the patient becomes pregnant while receiving this drug, the patient should be apprised of the potential hazard to the fetus. Women of childbearing potential should be advised to avoid becoming pregnant while receiving treatment with CAMPTOSAR.

Lactation

Radioactivity appeared in rat milk within 5 minutes of intravenous administration of radiolabelled irinotecan hydrochloride and was concentrated up to 65-fold at 4 hours after administration relative to plasma concentrations. As many drugs are excreted in human milk and because of the potential for serious adverse reactions in nursing infants, it is recommended that nursing be discontinued when receiving therapy with CAMPTOSAR.

4.7 Effects on ability to drive and use machinery

The effect of irinotecan on the ability to drive or use machinery has not been evaluated.

However, patients should be warned about the potential for dizziness or visual disturbances which may occur within 24 hours following the administration of irinotecan, and advised not to drive or operate machinery if these symptoms occur.

4.8 Undesirable effects

Combination Therapy

In the two Phase III studies, a total of 955 patients with metastatic colorectal cancer received irinotecan hydrochloride in combination with 5-FU/LV, 5-FU/LV alone, or irinotecan hydrochloride alone (see section 5.1, Clinical Efficacy and Safety, Table 9). In these studies, 370 patients received irinotecan in combination with 5-FU/LV, 362 patients received 5-FU/LV alone, and 223 patients received irinotecan hydrochloride alone.

Fifty-nine (6.1%) patients died within 30 days of study treatment: 27 (7.3%) received irinotecan hydrochloride in combination with 5-FU/LV, 19 (5.3%) received 5-FU/LV alone, and 13 (5.8%) received irinotecan hydrochloride alone. Deaths potentially related to treatment occurred in 3 (0.7%) patients who received irinotecan hydrochloride in combination with 5-FU/LV (2 neutropenic fever/sepsis, 1 treatment toxicity), 3 (0.7%) patients who received 5-FU/LV alone (1 neutropenic fever/sepsis, 1 CNS bleeding during thrombocytopenia, 1 unknown) and 2 (0.9%) patients who received irinotecan hydrochloride alone (2 neutropenic fever). Deaths within 60 days of study treatment were reported for 18 (4.9%) patients who received irinotecan hydrochloride in combination with 5-FU/LV, 18 (5.0%) patients who received 5-FU/LV alone and 15 (6.7%) patients who received irinotecan hydrochloride alone. Discontinuations due to adverse events were reported for 26 (7.0%) patients who received irinotecan hydrochloride in combination with 5-FU/LV, 15 (4.1%) patients who received 5-FU/LV alone, and 26 (11.7%) patients who received irinotecan hydrochloride alone.

Table 6 lists the Grade 3 and 4 clinically relevant adverse events reported in the combination treatment arms of the two Phase III studies.

Table 6: Percent (%) of Patients Experiencing Clinically Relevant Grade 3 and 4 Adverse Events in Phase III Studies of Combination Therapies^a

Adverse Event	Study 1			Study 2	
	Irinotecan HCl 5-FU/LV n=225 ^b	5-FU/LV n=219 ^b	Irinotecan HCl n=223 ^b	Irinotecan HCl 5-FU/LV n=145 ^c	5-FU/LV N=143 ^c
Total Grade 3/4 Adverse Events	53.3	45.7	45.7	72.4	39.2
GASTROINTESTINAL					
Diarrhoea - late	22.7	13.2	31.0	14.5	6.3
- Grade 3	15.1	5.9	18.4	10.3	4.2
- Grade 4	7.6	7.3	12.6	4.1	2.1
Diarrhoea - early	4.9	1.4	6.7	-	-
Nausea	15.6	8.2	16.1	2.1	3.5
Abdominal pain	14.6	11.5	13.0	2.1	0.7
Vomiting	9.7	4.1	12.1	3.5	2.8
Anorexia	5.8	3.7	7.2	2.1	0.7
Constipation	3.1	1.8	0.4	0.7	1.4
Mucositis	2.2	16.9	2.2	4.1	2.8
HAEMATOLOGICAL					
Neutropenia	53.8	66.7	31.0	46.2	13.4
- Grade 3	29.8	23.7	19.3	36.4	12.7
- Grade 4	24.0	42.5	12.1	9.8	0.7
Leucopenia	37.8	23.3	21.5	17.4	3.5
Anaemia	8.4	5.5	4.5	2.1	2.1
Neutropenic fever	7.1	14.6	5.8	3.4	0.7
Thrombocytopenia	2.6	2.7	1.7	0	0
Neutropenic infection	1.8	0	2.2	2.1	0
BODY AS A WHOLE					
Asthenia	19.5	11.9	13.9	9.0	4.2
Pain	3.1	3.6	2.2	9.7	8.4
Fever	1.7	3.6	0.4	0.7	0.7
Infection	0	1.4	0.4	7.6	3.5
METABOLIC & NUTRITIONAL					
Increased bilirubin	7.1	8.2	7.2	3.5	10.6
DERMATOLOGICAL					
Exfoliative dermatitis	0	0.5	0	-	-
Rash	0	0.9	0.4	-	-
Hand and foot syndrome	-	-	-	0.7	0.7
Cutaneous signs	-	-	-	0.7	0
RESPIRATORY					
Dyspnoea	6.3	0.5	2.2	1.4	0
Cough	1.3	0	0.4	-	-
Pneumonia	2.7	1.0	1.3	-	-
NEUROLOGICAL					
Dizziness	1.3	0	1.8	-	-
Somnolence	1.8	1.8	1.3	-	-
Confusion	1.8	0	0	-	-
CARDIOVASCULAR					
Vasodilation	0.9	0	0	-	-
Hypotension	1.3	0.5	1.7	1.4	0
Thrombophlebitis	2.7	3.2	1.8	-	-
Pulmonary embolus	2.7	1.4	0.4	-	-
Myocardial infarction	1.3	0	0.4	-	-

^a Severity of adverse events based on NCI CTC (version 1.0), see <http://ctep.info.nih.gov/CTC3/default.htm>.

^b Number of patients in the as-treated population for each group.

^c Number of patients treated in the de Gramont regimen (B2/C2 treatment arms of Table 9).

The most clinically significant adverse events for patients receiving irinotecan hydrochloride-based therapy were diarrhoea, nausea, vomiting, neutropenia and alopecia. The most clinically significant adverse events for patients receiving 5-FU/LV therapy were diarrhoea, neutropenia, neutropenic fever and mucositis. In Study 1, Grade 4 neutropenia, neutropenic fever (defined as \geq Grade 2 fever and Grade 4 neutropenia), and mucositis were observed less often with irinotecan hydrochloride/5-FU/LV than with administration of 5-FU/LV.

Single Agent Therapy

Information on adverse reactions for CAMPTOSAR as single agent therapy is available from 304 patients with metastatic carcinoma of the colon or rectum treated in Phase II trials with the once weekly dosage schedule, 316 patients treated with the once-every-3-week dosage schedule and over 1100 patients with a variety of tumour types treated in Japan. In general the types of toxicities observed were similar. 4.3% of patients treated with the weekly dosage schedule and 8% of patients treated with the once-every-3-week dosage schedule discontinued treatment with CAMPTOSAR because of medical events.

Seventeen of the 304 patients treated with the weekly dosage schedule died within 30 days of the administration of CAMPTOSAR and in five cases (1.6%), the deaths were potentially drug-related. Eleven patients treated with irinotecan hydrochloride in the once-every-3-week dosage schedule died within 30 days of treatment and in three cases (1%), the deaths were potentially related to treatment with irinotecan hydrochloride. The main causes of the deaths potentially related to treatment were neutropenic infection, Grade 4 diarrhoea and asthenia.

The frequency of the most common adverse events reported from the single agent second line studies is presented in Table 7 below. Additional information on adverse events follows the table, organised by body system category.

Table 7: Adverse events reported from the second line single agent therapy in 304 patients^a

Event	Weekly dosage schedule		3 weekly dosage schedule (NCI Grade 3 & 4 only)	
	% of Patients	% NCI Grade 3 & 4	Study 1 (%)	Study 2 (%)
GASTROINTESTINAL				
Diarrhoea (late)	87.8	30.6	21.7	22.0
Nausea	86.2	16.8	13.8	11.0
Vomiting	66.8	12.5	13.8	14.2
Abdominal cramping/pain	56.9	16.4	13.8	8.7
Anorexia	54.9	5.9	5.3	5.5
Diarrhoea (early)	50.7	7.9	12.2	1.6
Constipation	29.9	2.0	9.5	7.9
Flatulence	12.2	–	--	--
Stomatitis	11.8	0.7	--	--
Dyspepsia	10.5	--	--	--
HAEMATOLOGICAL				
Leucopenia ^b	63.2	28.0	22.2	14.2
Anaemia	60.5	6.9	7.4	6.3
Neutropenia ^b	53.9	26.3	22.2	14.2
Thrombocytopenia	--	--	1.1	3.9
BODY AS A WHOLE				
Asthenia	75.7	12.2	14.8	13.4
Fever	45.4	0.7	--	--
Pain	23.7	2.3	18.5 ^c	16.5 ^d
Headache	16.8	0.7	--	--
Back pain	14.5	1.6	--	--
Chills	13.8	0.3	--	--
Minor infection	14.5	0	--	--
Oedema	10.2	1.3	--	--
Abdominal enlargement	10.2	0.3	--	--
METABOLIC AND NUTRITIONAL				
Weight reduction	30.3	0.7		
Dehydration	14.8	4.3		
Increased alkaline phosphatase	13.2	3.9		
Increased SGOT	10.5	1.3		
DERMATOLOGICAL				
Alopecia	60.5	N/A ^e	N/A ^e	N/A ^e
Sweating	16.4	0	--	--
Rash	12.8	0.7	1.6	0.8
RESPIRATORY				
Dyspnoea	22.0	3.6		
Increased coughing	17.4	0.3		
Rhinitis	15.5	0		

^a Severity of adverse events based on NCI CTC (version 1.0), see <http://ctep.info.nih.gov/CTC3/default.htm>.

^b Combined results for leucopenia/neutropenia are presented for the once-every-3-week dosage schedule.

^c In this study, 22.2% of patients treated with best supportive care experienced NCI Grade 3/4 pain.

^d In this study, 13.2% of patients treated with infusional 5-FU experienced NCI Grade 3/4 pain.

^e Complete hair loss = NCI Grade 2.

Overview of Adverse Events

Gastrointestinal: Nausea, vomiting, and diarrhoea are common adverse events following treatment with CAMPTOSAR and can be severe. Among those patients treated at the 125 mg/m² single agent weekly dose, the median duration of any grade of late diarrhoea was 3 days and for Grade 3 or 4 late diarrhoea was 7 days. The frequency of Grade 3 or 4 late diarrhoea was significantly greater in patients 65 years or older (39.8% versus 23.4%, p=0.0025).

Abdominal pain and cramping are associated with early-onset diarrhoea (diarrhoea which occurs within 24 hours of drug administration). In studies it has been found that atropine is useful in ameliorating these events. Colonic ulceration, sometimes with gastrointestinal bleeding, ileus and infection, has been observed in association with administration of CAMPTOSAR.

Haematological: CAMPTOSAR commonly causes neutropenia, leucopenia (including lymphocytopenia), and anaemia. Serious thrombocytopenia is uncommon. In clinical studies with the single agent weekly dosage schedule, one death due to neutropenic sepsis without fever was judged to be potentially drug-related (0.3%, 1/304). Blood transfusions were given to 9.9% of patients. When evaluated in the trials of single agent weekly administration, the frequency of Grade 3 and 4 neutropenia was significantly higher in patients who received previous pelvic/abdominal irradiation than in those who had not received such irradiation (48.1% versus 24.1%, p=0.0356). In these same studies, patients with total baseline serum bilirubin levels of 17 µmol/L or more also had a significantly greater likelihood of experiencing first-course Grade 3 or 4 neutropenia than those with bilirubin levels that were less than 17 µmol/L (50% versus 17.7%, p<0.001).

Cholinergic Symptoms: Patients may have cholinergic symptoms of rhinitis, increased salivation, miosis, lacrimation, diaphoresis, flushing and intestinal hyperperistalsis that can cause abdominal cramping and early diarrhoea. If these symptoms occur, they manifest during or shortly after drug infusion. They are thought to be related to the anticholinesterase activity of the irinotecan parent compound and are more likely to occur at higher doses. The timing of the symptoms is most consistent with the occurrence of peak irinotecan hydrochloride serum levels during parenteral administration.

Metabolic and Nutritional: The dehydration observed in 14.8% of patients in clinical studies was as a consequence of diarrhoea, nausea and vomiting.

Hepatic: In the clinical studies evaluating the single agent weekly dosage schedule, NCI Grade 3 or 4 liver enzyme abnormalities were observed in fewer than 10% of patients. These events typically occur in patients with known hepatic metastases. For the once-every-3-week dosage schedule, hepatic events, such as ascites and jaundice of NCI Grade 3/4 severity, occurred in 8.5% of patients in one study and 8.7% of patients in another study.

Renal: Increases in serum creatinine or blood urea nitrogen, generally attributable to complications of infection or to dehydration related to nausea, vomiting or diarrhoea have been observed. There have been cases of acute renal failure. Rare instances of renal dysfunction due to tumour lysis syndrome have also been reported.

Dermatological: Alopecia has been reported during treatment with CAMPTOSAR. Rashes have also been reported but did not result in discontinuation of treatment.

Respiratory: Severe pulmonary events are infrequent. Over half the patients with dyspnoea in the clinical studies evaluating the single agent weekly dosage schedule had lung metastases; the extent to which malignant pulmonary involvement or other pre-existing lung disease may have contributed to dyspnoea in these patients is unknown. For the once-every-3-week dosage schedule, respiratory events, such as dyspnoea and cough of NCI Grade 3/4 severity occurred in 10.1% of patients in one study and 4.7% of patients in another study.

A potentially life-threatening pulmonary syndrome, consisting of dyspnoea, fever and a reticulonodular pattern on chest x-ray was observed in a small percentage of patients in early Japanese studies. The contribution of irinotecan hydrochloride to these preliminary events was difficult to assess because these patients also had lung tumours and some had pre-existing nonmalignant pulmonary disease. As a result of these observations, however, clinical studies in the USA enrolled few patients with compromised pulmonary function, significant ascites, or pleural effusions.

Neurological: Insomnia and dizziness were observed in 19.4% and 14.8% respectively of patients studied in clinical trials of the single agent weekly dosage schedule, but were not usually considered to be directly related to the administration of CAMPTOSAR. Dizziness may sometimes represent symptomatic evidence of orthostatic hypotension in patients with dehydration.

Cardiovascular: Vasodilation (flushing) may occur during administration of CAMPTOSAR. Irinotecan hydrochloride has anti-cholinesterase activity. As such, there are possible cardiovascular effects due to its administration. These include sudden death, blackout and bradycardia. Patients should be monitored for cholinergic effects during administration of CAMPTOSAR and atropine should be readily available for treatment of these effects. There were no cases of sudden death reported in the Phase II clinical studies of the single agent weekly dosage schedule involving 304 patients. In these studies, two patients (0.7%) suffered syncope and one patient (0.3%) suffered bradycardia.

Thromboembolic events including angina pectoris, arterial thrombosis, cerebral infarct, cerebrovascular accident, deep thrombophlebitis, embolus lower extremity, heart arrest, myocardial infarct, myocardial ischaemia, peripheral vascular disorder, pulmonary embolus, sudden death, thrombophlebitis, thrombosis and vascular disorder have been observed rarely in patients receiving CAMPTOSAR. The specific cause of these events has not been determined.

Other: Other NCI Grade 3 or 4 drug-related adverse events observed in 1-10% of patients in clinical trials included mucositis, bilirubinaemia and hypovolaemia. In fewer than 1% of patients, NCI Grade 3 or 4 rectal disorder, gastrointestinal monilia, hypokalaemia, hypomagnesaemia, increased GGTP, malaise, sepsis and abnormal gait were observed.

Post-marketing Surveillance

Cardiac Disorders: Myocardial ischaemic events have been observed following irinotecan therapy predominantly in patients with underlying cardiac disease, other known risk factors for cardiac disease or previous cytotoxic chemotherapy.

Gastrointestinal Disorders: Infrequent cases of intestinal obstruction, ileus, megacolon or gastrointestinal haemorrhage, and rare cases of colitis, including typhlitis (ileocaecal syndrome), ischaemic and ulcerative colitis have been reported. In some cases, colitis was complicated by ulceration, bleeding, ileus or infection. Cases of ileus without preceding colitis have also been reported. Rare cases of intestinal perforation have been reported.

Rare cases of symptomatic pancreatitis or asymptomatic elevated pancreatic enzymes have been observed.

Hypovolaemia: There have been rare cases of renal impairment and acute renal failure, generally in patients who became infected and/or volume depleted from severe gastrointestinal toxicities. Infrequent cases of renal insufficiency, hypotension or circulatory failure have been observed in patients who experienced episodes of dehydration associated with diarrhoea and/or vomiting, or sepsis.

Infections and Infestations: Bacterial, fungal and viral infections have been reported.

Immune System Disorders: Hypersensitivity reactions including severe anaphylactic or anaphylactoid reactions have been reported.

Investigations: Rare cases of hyponatraemia mostly related with diarrhoea and vomiting have been reported. Increases in serum levels of transaminases (*i.e.*, AST and ALT) in the absence of progressive liver metastasis, transient increase of amylase and occasionally transient increase of lipase have been very rarely reported.

Musculoskeletal and Connective Tissue Disorders: Early effects such as muscular contraction or cramps and paresthaesia have been reported.

Nervous System Disorders: Speech disorders, generally transient in nature, have been reported in patients treated with irinotecan; in some cases, the event was attributed to the cholinergic syndrome observed during or shortly after infusion of irinotecan.

Respiratory, Thoracic and Mediastinal Disorders: Interstitial pulmonary disease presenting as pulmonary infiltrates is uncommon during irinotecan therapy. Early effects such as dyspnoea have been reported (see section 4.4). Hiccups have also been reported.

Reporting of Suspected Adverse Reactions

Reporting suspected adverse reactions after authorisation of the medicine is important. It allows continued monitoring of the benefit/risk balance of the medicine. Healthcare professionals are asked to report any suspected adverse reactions. <https://nzphvc.otago.ac.nz/reporting/>.

4.9 Overdose

In humans, at single doses up to 750 mg/m², adverse events were similar to those reported with the recommended dosage regimens. There have been reports of overdosage at doses up to approximately twice the recommended therapeutic dose, which may be fatal. The most significant adverse reactions reported were severe neutropenia and severe diarrhoea.

There is no known antidote for overdosage of CAMPTOSAR. Support respiratory and cardiovascular function. Maximum supportive care should be instituted to prevent dehydration due to diarrhoea and to treat any infectious complications.

For advice on the management of overdose please contact the National Poisons Centre on 0800 POISON (0800 764766).

5. PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Mechanism of Action

CAMPTOSAR Injection (irinotecan hydrochloride injection) is an antineoplastic agent of the topoisomerase I inhibitor class.

Irinotecan hydrochloride is a semisynthetic derivative of camptothecin, an alkaloid extract from plants such as *Camptotheca acuminata*. Irinotecan hydrochloride is a pale yellow to yellow crystalline powder that is slightly soluble in water and organic solvents.

Pharmacodynamic Effects

Irinotecan hydrochloride is a derivative of camptothecin. Camptothecins interact specifically with the enzyme topoisomerase I, which relieves torsional strain in DNA by inducing reversible single-strand breaks. Irinotecan hydrochloride and its active metabolite SN-38 bind to the topoisomerase I-DNA complex and prevent religation of these single-strand breaks. Current research suggests that the cytotoxicity of irinotecan hydrochloride is due to double-strand DNA damage produced during DNA synthesis when replication enzymes interact with the ternary complex formed by topoisomerase I, DNA, and either irinotecan hydrochloride or SN-38. Mammalian cells cannot efficiently repair these double-strand breaks.

Irinotecan hydrochloride serves as a water-soluble precursor of the lipophilic metabolite SN-38, which is approximately 1000 times as potent as irinotecan hydrochloride as an inhibitor of topoisomerase I purified from human and rodent tumour cell lines. However, the precise contribution of SN-38 to the activity of CAMPTOSAR is unknown. Both irinotecan hydrochloride and SN-38 exist in an active lactone form and an inactive hydroxy acid anion form. An acidic pH promotes the formation of the lactone whereas a basic pH favours the hydroxy acid anion form.

Administration of irinotecan hydrochloride has resulted in antitumour activity in mice bearing cancers of rodent origin and in human carcinoma xenografts of various histological types.

Irinotecan hydrochloride is a non-competitive inhibitor of acetylcholinesterase and a cholinergic syndrome is associated with its administration (see section 4.8).

Clinical Efficacy and Safety

CAMPTOSAR has been studied in clinical trials in combination with 5-FU and LV as a first-line agent in metastatic colorectal cancer and as a single agent used after failure of initial therapy. Weekly and once every 3 weeks dosage schedules were studied using CAMPTOSAR as the single agent. Weekly and once every 2 week schedules were studied with CAMPTOSAR used in combination treatment. Patients with a WHO performance status of 3 or 4 have not been studied in clinical trials (see Table 8).

Table 8: WHO scale for performance status

0	Fully active; able to carry on all pre-disease performance without restriction
1	Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature
2	Ambulatory and capable of self-care but unable to carry out any work activities; up and about more than 50% of waking hours
3	Capable of only limited self-care; confined to bed or chair more than 50% of waking hours
4	Completely disabled; cannot carry out any self-care; totally confined to bed or chair

Combination therapy for first-line treatment of metastatic colorectal cancer

Two randomised, open-label, controlled, multinational, Phase III clinical trials support the use of CAMPTOSAR as first-line treatment of patients with metastatic carcinoma of the colon or rectum. The dosing regimens of these studies are given in Table 9.

Table 9: Dosage regimen of the studies evaluating the first line treatment of metastatic colorectal cancer

Arm	Agent	Study 1 Dosing Regimen	Study 2 Dosing Regimen
A	Irinotecan HCl	125 mg/m ² irinotecan HCl IV infusion over 90 mins. Treatment was administered once weekly for four weeks with treatment resuming on Day 43.	N/A
B1	Irinotecan HCl LV 5-FU	125 mg/m ² irinotecan HCl IV infusion over 90 mins followed immediately by 20 mg/m ² LV administered as an IV bolus injection and then 500 mg/m ² 5-FU as an IV bolus injection. Treatment was administered once weekly for four weeks with treatment resuming on Day 43 (Saltz regimen) ^a	80 mg/m ² IV infusion over 90 mins of irinotecan HCl plus a 500 mg/m ² LV IV infusion over 2 hours followed immediately by an 2300 mg/m ² 5-FU IV infusion over 24 hours. Treatment was administered once weekly for six weeks with treatment resuming on Day 50 (AIO regimen) ^a
B2	Irinotecan HCl LV 5-FU	N/A	180 mg/m ² IV infusion over 90 mins of irinotecan HCl on Day 1, plus one hour later a 200mg/m ² LV IV infusion over 2 hours followed immediately by a 400 mg/m ² 5-FU IV bolus injection and a 600 mg/m ² 5-FU IV infusion over 22 hours on Days 1 and 2. Treatment was administered every 2 weeks (de Gramont regimen) ^a
C1	LV 5-FU	20 mg/m ² LV administered as an IV bolus injection followed immediately by 425 mg/m ² 5-FU as an IV bolus injection. Treatment was given for 5 consecutive days with the treatment repeating on Day 29 (Mayo Clinic regimen) ^a .	500 mg/m ² LV IV infusion over 2 hours followed immediately by a 2600 mg/m ² 5-FU IV infusion over 24 hours. Administration was weekly for 6 weeks with treatment resuming on Day 50 (AIO regimen) ^a
C2	LV 5-FU	N/A	200 mg/m ² LV IV infusion over 2 hours followed immediately by a 400 mg/m ² 5-FU IV bolus injection and a 600 mg/m ² 5-FU IV infusion over 22 hours on Days 1 and 2. Treatment was administered every 2 weeks (de Gramont regimen) ^a

^a Based on the Saltz, Mayo Clinic, de Gramont and Association of Medical Oncology of the German Cancer Society (AIO) dosing regimens.

In both studies, concomitant medications such as antiemetics, atropine and loperamide were given to patients for prophylaxis and /or management of symptoms from treatment. In study 2, if late diarrhoea persisted for greater than 24 hours despite loperamide, a 7 day course of fluoroquinolone antibiotic prophylaxis was given. Treatment with oral fluoroquinolone was initiated in patients whose diarrhoea persisted for greater than 24 hours despite loperamide or if they developed a fever in addition to diarrhoea. Treatment with oral fluoroquinolone was also initiated in patients who developed an absolute neutrophil count (ANC) <0.5 x 10⁹/L, even in the absence of fever or diarrhoea. Patients also received treatment with intravenous antibiotics if they had persistent diarrhoea or fever or if ileus developed.

In both studies the combination of irinotecan hydrochloride/5-FU/LV therapy resulted in significant improvement in objective tumour response rate, time to tumour progression (TTP), and survival when compared with 5-FU/LV alone. These differences in survival were observed despite the use of post-study second-line therapy, including irinotecan-containing regimens in patients in the control arm. Patient characteristics and major efficacy results are shown in Table 10.

Table 10: Combination therapy in first line treatment of metastatic colorectal cancer: Study Results

	Study 1			Study 2	
	Irinotecan + bolus 5-FU/LV	Bolus 5-FU/LV	Irinotecan	Irinotecan + Infusional 5 FU/LV	Infusional 5-FU/LV
Number of patients	231	226	226	198	187
Demographics and Treatment Administration					
Female/Male (%)	34/65	45/54	35/64	33/67	47/53
Median Age in years (range)	62 (25-85)	61 (19-85)	61 (30-87)	62 (27-75)	59 (24-75)
Performance Status (%) ^a					
0	39	41	46	51	51
1	46	45	46	42	41
2	15	13	8	7	8
Median Primary Tumour (%)					
Colon	81	85	84	55	65
Rectum	17	14	15	45	35
Median Time from Diagnosis to Randomisation (months, range)	1.9 (0-161)	1.7 (0-203)	1.8 (0.1-185)	4.5 (0-88)	2.7 (0-104)
Prior Adjuvant 5-FU Therapy (%)					
No	89	92	90	74	76
Yes	11	8	10	26	24
Median Duration of Study Treatment (months)	5.5	4.1	3.9	5.6	4.5
Median Relative Dose Intensity (%)					
Irinotecan	72	--	75	87	--
5-FU	71	86	--	86	93
Efficacy Results					
Confirmed Objective Tumour Response Rate ^b (%) [95% CI]	39 [33-46]	21 [16-27]	18 [13-24]	35 [28-42]	22 [16-29]
Median Time to Tumour Progression (months) [95% CI]	7.0 [5.4-8.0]	4.3 [3.7-4.6]	4.2 [3.9-5.0]	6.7 [5.7-8.0]	4.4 [3.2-5.5]
Median Survival (months) [95% CI]	14.8 [12.3-17.1]	12.6 [11.1-14.6]	12.0 [11.3-13.5]	17.4 [15.2-20.2]	14.1 [12.6-17.4]

^a See Table 8.

^b Confirmed ≥ 4 to 6 weeks after first evidence of objective response.

Improvement was noted when response rates and time to tumour progression were examined across all demographic and disease-related sub-groups (as categorised by age, gender, ethnic origin, performance status, extent of organ involvement with cancer, time from diagnosis of cancer, prior adjuvant therapy and baseline laboratory abnormalities), with irinotecan hydrochloride-based combination therapy relative to 5-FU/LV.

The European Organisation of Research and Treatment of Cancer Quality of Life Questionnaire (EORTC QLQ-C30) was used in both studies. While there was no statistical evidence that there were significant differences between irinotecan hydrochloride/5-FU/LV combination and 5-FU/LV alone with regard to Quality of Life (QOL) improvement, descriptive evidence suggested a general trend favouring QOL improvement or less-worsening in favour of the irinotecan hydrochloride combination regimen.

Single Agent Treatment in Recurrent or Progressive Metastatic Colorectal Cancer After 5-FU Based Treatment

Weekly Dosage Schedule

Three multicentre, open-label, Phase II studies, all utilising repeated courses of once weekly treatment with CAMPTOSAR for 4 consecutive weeks, followed by a two week rest period were conducted in a total of 304 patients in the United States. These studies were designed to evaluate tumour response rate and toxicity with CAMPTOSAR in patients with metastatic colorectal cancer that recurred or progressed following a prior 5-FU based chemotherapeutic regimen. Starting doses of CAMPTOSAR in these trials were 100, 125 or 150 mg/m² with 150 mg/m² proving to be poorly tolerated due to unacceptably high rates of Grade 4 late diarrhoea and febrile neutropaenia. The results of the individual studies are shown in Table 11.

Table 11: Phase II clinical studies with the once weekly dosage schedule

	Study			
	A	B	C ^a	C ^a
Number of Patients	48	90	64	102
Dose (mg/m ² /wk x 4)	125 ^b	125	125	100
Prior 5-FU therapy (%)				
For metastatic disease	81.3	65.5	73.4	67.7
≤6 months after adjuvant	14.6	6.7	26.6	27.5
>6 months after adjuvant	2.1	15.6	0.0	2.0
Classification unknown	2.1	12.2	0.0	2.9
Duration of treatment (median, months)	5.4	3.5	3.9	3.3
Median relative dose intensity (%) ^c	74	67	73	81
Objective response rate (%) ^d [95% CI]	20.8 [9.3-32.3]	13.3 [6.3-20.4]	14.1 [5.5-22.6]	8.8 [3.3-14.3]
Time to response (median, months)	2.6	1.5	2.8	2.8
Response duration (median, months)	6.4	5.9	5.6	6.4
Survival (median, months)	10.4	8.1	10.7	9.3

^a The initial dose in Study C was 125 mg/m² but was reduced to 100 mg/m² because the toxicity at the starting dose was perceived to be greater than seen in previous studies. Results are analysed separately for the two starting doses.

^b Nine patients received 150 mg/m² as a starting dose; 2 (22.2%) responded to CAMPTOSAR.

^c Relative dose intensity for CAMPTOSAR based on planned dose intensity of 100, 83.3 and 66.7 mg/m²/wk corresponding with 150, 125 and 100 mg/m² starting doses respectively.

^d There were 2 complete responses and 38 partial responses.

Of the 304 patients treated in the Phase II studies, response rates to CAMPTOSAR were similar in males and females and among patients younger than 65 years. Rates were also similar in patients with cancer of the colon or cancer of the rectum and in patients with single and multiple metastatic sites. Response rate was 18.5% in patients with a WHO performance status of 0 and 8.2% in patients with a performance status of 1 or 2.

The response rates with CAMPTOSAR were unaffected by whether or not patients had responded to prior 5-FU based treatment given for metastatic disease. Patients who had received previous irradiation to the pelvis responded to CAMPTOSAR at approximately the same rate as those who had not previously received irradiation.

Overall, across the pivotal studies, stable disease was documented in 148 (48.7%) of the 304 patients in the intent to treat population and in 145 (55.6%) of the 261 patients in the evaluable population. Consistent with the results in Study C, a somewhat greater percentage of patients who were treated with the 125 mg/m² starting dose (53.4%; 103/193) than with the 100 mg/m² starting dose (39.2%; 40/102) had stable disease during therapy.

Once Every 3 Week Dosage Schedule

Two Phase III, multicentre, randomised studies were conducted with a three weekly dosage regimen in patients with metastatic colorectal cancer whose disease had recurred or progressed following 5-FU therapy (n=535). Second-line irinotecan hydrochloride was compared with best supportive care in one study and with infusional 5-FU-based therapy in the second study. The primary endpoint in both studies was survival. Parameters of clinical benefit and quality of life were also assessed. The starting dose was 350 mg/m² infused intravenously over 90 minutes to a maximum total dose of 700 mg. For patients 70 years or older and for patients with a WHO performance status of 2 the starting dose was reduced to 300 mg/m². Antiemetics, atropine and loperamide were provided as supportive care and late diarrhoea persisting for greater than 24 hours despite loperamide was treated with a 7-day course of a fluoroquinolone antibiotic.

A significant survival advantage for irinotecan hydrochloride over best supportive care or infusional 5-FU-based therapy was demonstrated. When adjusted for baseline patient characteristics (e.g., performance status), survival among patients treated with irinotecan hydrochloride remained significantly longer than in the control populations (p=0.001 for Study 1 and p=0.017 for Study 2). Clinical benefit in Study 1, as measured by pain-free survival and survival without weight loss, was significantly longer for patients treated with irinotecan hydrochloride than for patients in the best supportive care group (p=0.01 and p=0.05 respectively). The results are summarised in Table 12.

Table 12. Phase III clinical studies with a Once-Every-3-Week Dosage Schedule:

	Study 1		Study 2	
	Irinotecan hydrochloride	Best Supportive Care	Irinotecan hydrochloride	5-FU ^a
Number of Patients	189	90	127	129
Prior 5-FU therapy (%)				
For metastatic disease	70	63	58	68
≤3/6 months after adjuvant ^b	27	36	38	23
>3/6 months after adjuvant ^b	3	0	5	9
Duration of treatment (mean, months) [95% CI]	4.6 [4.2-5.0]	--	4.4 [3.8-5.0]	3.7 [3.3-4.1]
Median relative dose intensity (%) ^c	94	--	95	81-99
Survival (median, months) [95% CI]	9.2 [8.4-10.7]	6.5 [5.0-7.6]	10.8 [9.5-12.8]	8.5 [7.7-10.5]
1-year survival (%) [95% CI]	36.2 [29.3-43.1]	13.8 [6.7-20.9]	44.8 [36.2-53.4]	32.4 [24.3-40.5]
Progression-free survival (median, months) [95% CI]	--	--	4.2 [3.8-4.8]	2.9 [2.6-3.7]
Symptom-free survival (median, months) [95% CI]	5.9 [3.8-7.6]	4.1 [2.2-6.9]	8.1 [6.1-10.7]	7.0 [4.4-8.7]
Pain-free survival (median, months) [95% CI]	6.9 [5.8-8.4]	2.0 [1.8-5.1]	10.3 [7.8-**]	8.5 [6.2-10.2]
Median survival without performance status deterioration (%) [95% CI]	5.7 [4.3-6.6]	3.3 [1.9-3.7]	6.4 [5.2-7.6]	5.1 [4.2-6.2]
Time to weight loss ≥5% (median, months) [95% CI]	6.4 [5.5-7.6]	4.2 [3.4-5.1]	8.9 [6.7-12.3]	7.4 [4.7-11.6]

^a One of the following 5-FU regimens was used:

- (i) Leucovorin 200 mg/m² iv over 2 hours; followed by 5-FU 400 mg/m² iv bolus; followed by 5-FU 600 mg/m² continuous iv infusion over 22 hours on Days 1 and 2 every 2 weeks.
- (ii) 5-FU 250-300 mg/m²/day protracted continuous iv infusion until toxicity.
- (iii) 5-FU 2.6-3 g/m²/day iv over 24 hours every week for 6 weeks with or without leucovorin 20-500 mg/m²/day every week iv for 6 weeks with a 2 week rest between cycles.

^b Study 1 ≤6 months; Study 2 ≤3 months.

^c Relative dose intensity for irinotecan HCl based on planned dose intensity of 116.7 mg/m²/week. Dose intensity in patients receiving 5-FU in Study 2 varied depending upon the type of regimen.

** Cannot be estimated due to small sample size.

In the two Phase III studies, quality of life was assessed using the European Organisation on Research and Treatment of Cancer Quality of Life Questionnaire (EORTC QLQ-C30). In Study 1, the global quality of life scores were significantly higher for patients treated with irinotecan hydrochloride than for those who received best supportive care (p=0.0013). In Study 2, the global quality of life scores were similar for patients who received either irinotecan hydrochloride or infusional 5-FU.

Other Studies

A Japanese open-label, uncontrolled, late Phase II study in patients with non-small-cell lung cancer enrolled a total of 153 patients. In this study, pneumonitis occurred in 6.2% (9/146) of the patients. One patient died of interstitial pneumonitis. CAMPTOSAR was given at a dose of 100 mg/m² intravenously once weekly. Dosage adjustments were made according to toxicity and the duration of treatment was until disease progression or unacceptable toxicity occurred (with each patient to receive at least three doses).

5.2 Pharmacokinetic properties

Absorption and Distribution

After intravenous infusion of irinotecan hydrochloride in humans with various cancers, irinotecan hydrochloride plasma concentrations decline in a multiexponential manner, with a mean terminal elimination half-life of about 6 to 12 hours. The mean terminal elimination half-life of the active metabolite SN-38 is about 10 to 20 hours. In a study where irinotecan hydrochloride was administered at doses of 100-750 mg/m² by 30 minute intravenous infusion every three weeks, the plasma terminal elimination half-life was 14.2 +/- 7.7 hours for irinotecan hydrochloride and 13.8 +/- 1.4 hours for SN-38.

Over the recommended dose range of 50 to 350 mg/m², the AUC of irinotecan hydrochloride increases linearly with dose; the AUC of SN-38 increases less than proportionally with dose. Maximum concentrations of the active metabolite SN-38 are generally seen within 1 hour following the end of a 90-minute infusion of irinotecan hydrochloride.

Pharmacokinetic parameters for irinotecan and SN-38 following a 90 minute infusion of irinotecan hydrochloride at dose levels of 125 and 340 mg/m² determined in two clinical studies in patients with solid tumours are summarised in Table 13.

Table 13: Summary of Mean (\pm Standard Deviation) Irinotecan Hydrochloride and SN-38 Pharmacokinetic Parameters in Patients with Solid Tumours

Dose (mg/m ²)	Irinotecan					SN-38		
	C _{max} (ng/mL)	AUC ₀₋₂₄ (ng.hr/mL)	t _{1/2} (hr)	V _{area} (L/m ²)	CL (L/hr/m ²)	C _{max} (ng/mL)	AUC ₀₋₂₄ (ng.hr/mL)	t _{1/2} (hr)
125 (N = 64)	1,660 \pm 797	10,200 \pm 3270	5.8 ^a \pm 0.7	110 \pm 48.5	13.3 \pm 6.01	26.3 \pm 11.9	229 \pm 108	10.4 ^a \pm 3.1
340 (N = 6)	3,392 \pm 874	20,604 \pm 6,027	11.7 ^b \pm 1.0	234 \pm 69.6	13.9 \pm 4.00	56.0 \pm 28.2	474 \pm 245	21.0 ^b \pm 4.3

C_{max} Maximum plasma concentration.

AUC₀₋₂₄ Area under the plasma concentration-time curve from time 0 to 24 hours after the end of the 90 minute infusion.

t_{1/2} Terminal elimination half-life

V_{area} Volume of distribution of terminal elimination phase.

CL Total systemic clearance.

a Plasma specimens collected for 24 hours following the end of the 90 minute infusion.

b Plasma specimens collected for 48 hours following the end of the 90 minute infusion. Because of the longer collection period, these values provide a more accurate reflection of the terminal elimination half-lives of irinotecan hydrochloride and SN-38.

In vitro studies indicate that irinotecan hydrochloride exhibits moderate plasma protein binding (30% to 68% bound). SN-38 is highly bound to human plasma proteins (approximately 95% bound). The plasma protein to which irinotecan hydrochloride and SN-38 predominantly binds is albumin.

Biotransformation

The complete disposition of irinotecan hydrochloride has not been fully elucidated in humans. Irinotecan hydrochloride is subject to extensive metabolic conversion by various enzyme systems, including esterases to form the active metabolite SN-38, and uridine diphosphate-glucuronosyl transferase 1A1 (UGT1A1) mediating glucuronidation of SN-38 to form the inactive metabolite SN-38 glucuronide (SN-38G). Irinotecan can also undergo CYP3A4-mediated oxidative metabolism to several pharmacologically inactive oxidation products, one of which can be hydrolysed by carboxylesterase to release SN-38.

Irinotecan is oxidised by cytochrome P450 isozyme 3A4 (CYP3A4) to yield two relatively inactive metabolites, APC (7-ethyl-10-[4-N-(5-aminopentanoic acid)-1-piperidino]-carbonyloxycamptothecin) and the minor metabolite, NPC (7-ethyl-10-(4-amino-1-piperidino)carbonyloxycamptothecin).

Elimination

The urinary excretion of irinotecan hydrochloride was 11% to 20% of the administered dose; SN-38 <1% and SN-38G 3%. The cumulative biliary and urinary excretion of irinotecan and its metabolites (SN-38 and SN-38G) over a period of 48 hours following administration of irinotecan hydrochloride in two patients ranged from approximately 25% (100 mg/m²) to 50% (300 mg/m²).

Special Populations

Geriatric (> 65 years)

In studies where irinotecan hydrochloride was administered weekly, the terminal half-life of irinotecan hydrochloride was 6.0 hours in patients who were 65 years or older and 5.5 hours in patients younger than 65 years. Dose-normalised AUC₀₋₂₄ for SN-38 in patients who were at least 65 years of age was 11% higher than in patients younger than 65 years. There are no kinetic data on the use of the once-every-three-week dosage schedule in elderly patients. A lower starting dose is recommended in patients 65 years and older based on clinical toxicity experienced with this dosage regimen (see section 4.2).

Children and Adolescents

Information regarding the pharmacokinetics of irinotecan is not available.

Gender

The pharmacokinetics of irinotecan does not appear to be influenced by gender.

Hepatic Impairment

Irinotecan clearance is diminished in patients with hepatic dysfunction while relative exposure to the active metabolite SN-38 is increased. The magnitude of these effects is proportional to the degree of liver impairment as measured by elevations in serum total bilirubin and transaminase concentrations (see section 4.2).

Renal Impairment

The influence of renal insufficiency on the pharmacokinetics of irinotecan has not been evaluated.

Pharmacokinetics in Combination Therapy

In a Phase I clinical study involving irinotecan hydrochloride, 5-fluorouracil (5-FU) and leucovorin (LV) in 26 patients with solid tumours the disposition of irinotecan hydrochloride was not substantially altered when the drugs were co-administered. However, C_{max} and AUC₀₋₂₄ of SN-38, the active metabolite, were reduced (by 14% and 8% respectively) when irinotecan hydrochloride was followed by 5-FU and LV administration compared with when irinotecan hydrochloride was given alone. Formal *in vivo* or *in vitro* drug interaction studies to evaluate the influence of irinotecan hydrochloride on the disposition of 5-FU and LV have not been conducted.

5.3 Preclinical safety data

Carcinogenicity

Long-term carcinogenicity studies with irinotecan were not conducted. Rats were, however, administered intravenous doses of 2 mg/kg or 25 mg/kg irinotecan once per week for 13 weeks (AUC about 1.3 times the values of patients administered 125 mg/m²) and were then allowed to recover for 91 weeks. Under these conditions, there was a significant linear trend with dose for the incidence of combined uterine horn endometrial stromal polyps and endometrial stromal sarcomas.

Genotoxicity

Irinotecan was clastogenic both *in vitro* (Chinese hamster ovary cells) and *in vivo* (micronucleus test in mice). Neither irinotecan nor SN-38 was mutagenic in the *in vitro* Ames assay.

6. PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Sorbitol,

Lactic acid,

Sodium hydroxide,

Hydrochloric acid,

Water for injection.

6.2 Incompatibilities

Other drugs should not be added to the infusion solution.

6.3 Shelf life

3 years

6.4 Special precautions for storage

Store at controlled room temperature 15° to 30°C. Protect from light. It is recommended that the vial should remain in the carton until time of use.

6.5 Nature and contents of container

CAMPTOSAR injection is available in single-dose amber polypropylene vials in the following package sizes: 40 mg/2 mL*, 100 mg/5 mL* and 300 mg/15 mL.

* These presentations are not currently supplied.

6.6 Special precautions for disposal and other handling

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

7. MEDICINE SCHEDULE

Prescription Medicine

8. SPONSOR

Pfizer New Zealand Ltd
PO Box 3998
Auckland, New Zealand.

Toll Free number: 0800 736 363.

9. DATE OF FIRST APPROVAL

29 May 1997

10. DATE OF REVISION OF THE TEXT

10 October 2018

SUMMARY TABLE OF CHANGES

Section changed	Summary of new information
All	Reformatting according to new New Zealand PI template
Section 3	Dose form added in line with TPDR

Section 4.8	Updated in ADR-post marketing section for Infections and infestations
Section 6.2	Incompatibilities added in line with company held CDS.